Transcript of Proceedings

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 02/06/200

..DAY 8

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THE COMMISSION RESUMED AT 9.59 A.M.

COMMISSIONER: Before we continue with the evidence, unfortunately there are a few bits and pieces that we have to deal with. I will try and get through them as quickly as I can.

The first concerns a matter which has been brought to the attention of the inquiry concerning a former senior officer of Queensland Health who has chosen apparently to make it his business to put about a story concerning myself, and I think possibly the Deputy Commissioners, wining and dining the people whom he perceives as being the enemies of Queensland Health, with a view, apparently, to getting them to come here and give evidence and say bad things about Queensland Health.

The level of discretion that this gentleman has employed in putting about this story is illustrated by the fact that he even had the imprudence to convey it to the passenger sitting next to him on a flight this morning, who happened to be the parent of one of our counsel assisting.

He has also, apparently, chosen to share that story with a journalist from The Australian, Mr Sean Parnell. Those who are following this inquiry will recall that last weekend Mr Parnell published a story in The Australian suggesting that there was some favouritism being shown to Dr Molloy because the inquiry was sitting out of hours to accommodate, not Dr Molloy's convenience, but the convenience of his patients.

I quickly addressed that matter and pointed out that from the outset of this inquiry we have indicated our willingness to extend the same convenience and courtesy to any medical practitioner, nurse, or other health care professional whose clinical duties make it necessary for them to come after hours rather than during ordinary sitting hours.

On this occasion, Mr Parnell, obviously once bitten, was a little bit shy about repeating the story that this source had provided to him and he emailed me last night seeking details of the matter. Let me make three things clear to the gentleman concerned: one is that neither I nor anyone associated with this inquiry has anything to hide, and in a moment I will describe exactly what the situation is. Secondly, whatever might have been his experience when he was with Queensland Health, he is not going to succeed in bullying me or bullying anyone else associated with this inquiry. And, thirdly, if and when he comes to give evidence, he will have every opportunity to say from the witness-box why he feels it is either necessary or desirable, not only to attempt to derail this inquiry, but also to attempt to derail the Premier's and Government's stated intention to support this inquiry to the upmost.

In any event, since that gentleman has chosen not to raise his

concerns in any formal or proper way, but to peddle them to anyone who will listen, let me now take the opportunity to explain the position very clearly indeed. It is the case that I have met with a number of potential witnesses. Those meetings have invariably taken place in a public venue so that there can be no suggestion that I am getting together with people behind closed doors with a view to colluding with them in relation to their evidence or anything of that nature. One of the counsel assisting has been present at those meetings.

Let me say, more importantly, that the purpose of the meetings has been solely to assure those who are reluctant to come forward and to give evidence that this Commission of Inquiry will provide complete and unreserved support to anyone who has relevant information to bring to our attention. The people with whom I have met include not less than four extremely, extremely senior medical practitioners, each of whom expressed reservations about providing evidence to the inquiry, and wanted to have reassurances about our sincerity in protecting them from retribution in the event that they came forward.

I should add that inquiries of this kind have an investigative role as well as a Court-like role of receiving evidence. That's what distinguishes inquiries like this from proceedings in a Court of law. There has been a lot of talk in the media recently about the Schapelle Corby case in Indonesia and commentators have observed that the Indonesian legal system is different from our own, in that our system is adversarial whereas their system is one where the Judge takes part in the investigative process.

Similarly, inquiries like this one are set up in such a way that those conducting the inquiry have some degree of oversight in relation to the investigative process, and that is specifically provided for in the Commissions of Inquiry Act which allow the members of the Bench, in the exercise of our functions and powers, not to be bound by the rules or practice of any Court or tribunal as to procedure or evidence, but to conduct our proceedings and to inform ourselves on any matter in such way as we think proper.

As I say, the meetings that have taken place have been for one purpose only, and that is to reassure people who do have relevant information that they can come forward and give that evidence without fear of any adverse consequences.

It has also, though, had a sort of side benefit, and that is that information has been brought to our attention which we have been able to investigate and which we would not otherwise have been in a position to investigate. And to just take one example of that, the report in relation to orthopaedic issues at Hervey Bay, the very existence of that report was brought to my attention as a result of such a meeting and I immediately took steps to summon a copy of that report from Queensland Health. That would not have happened if I wasn't in a position to meet with potential witnesses to gain their confidence and to receive relevant information and intelligence from them, and, quite frankly, I make no apology

for doing that.

At the same time I want to say that each of the people that I have met with - and there have been several - and I understand that one or both of the Deputies have also spoken to people from the community - but each of the ones I have spoken with have been given the opportunity to speak off the record. I do not intend to breach any confidences to those individuals by revealing their names or what was said by them, any more than I would ask Mr Parnell, or any other journalist for that matter, to breach the confidences involved in an off-the-record discussion. Those are the facts of the matter. There is, as I say, nothing to hide. Everything has been done in a perfectly proper way.

The only concern arising out of any of that is why a former senior officer of Queensland Health would feel that it is in anyone's interest to be peddling this story, not only to journalists but also to people he meets on aircraft or anywhere else.

Before I go on to any other points, is there anything anyone wishes to raise in relation to that matter? All right.

The second point that I need to deal with concerns the witness Christina Wong. I shouldn't say witness, but the lady who rose yesterday with a view to asking questions of Mr O'Dempsey when he was in the witness-box.

In Ancient Rome when a general was given a triumph after a successful battle campaign, the authorities arranged to have a slave travelling in the chariot with the general whispering in his ear "Remember, you are still only mortal." Fortunately, in these proceedings, the solicitors for the Medical Board, Gilshenan & Luton, have arranged for Mr Devlin to be here with his vast experience in inquiries to fulfil a similar role, and yesterday he very properly and very helpfully reminded me of my shortcomings and mortality in this regard in pointing out that I had made a mistake, which I readily acknowledge.

I would like everyone to understand that the process that I put in place was done with the best possible intentions of increasing openness and transparency, and giving the public, in whose interests this inquiry is being conducted, the opportunity to contribute to it. What I ought to have realised, and what I probably would have realised if I'd first consulted with people of the experience of Mr Devlin, is that there are some risks involved in doing that.

Four risks in particular come to mind. Firstly, there is the risk that people who aren't experienced at the art of cross-examination find it difficult to formulate questions in a coherent way, rather than making speeches, or statements, or argumentative submissions.The second risk is that issues will be raised which ought not to be raised in these proceedings for legal reasons, such as issues which are the subject of parliamentary privilege – and it became apparent virtually from the first words of Ms Wong's

question that she wanted to go into matters which had been debated in the Legislative Assembly. And, for reasons already addressed in the context of Mr Messenger's evidence, those are matters which we simply are unable to go into.

The third problem is that matters may be raised in that way which fall outside the scope of our Terms of Reference.

And the fourth problem is that people from the general public who are given the opportunity to ask questions may, in some instances, have very sincere, very genuine, very heartfelt concerns, but, on closer analysis, they are not concerns which ought to be ventilated in proceedings like this.

Mr Devlin has provided me with documents, all of which come from the public record, relating to the lady who sought to ask that question. What emerges is that in 2002, the Queensland Health Practitioners Tribunal, chaired by a District Court Judge, his Honour Judge Forde, ordered that that lady's registration be cancelled for a period of five years on grounds fully set out in the decision of that tribunal. Now, I accept without hesitation that the lady has extremely sincere and genuine concerns about the process that was entered into, and equally sincere and genuine concerns about the alleged failure of the Medical Board subsequently to follow up complaints which she made about other medical practitioners.

All I can say for the moment is that, without exploring the truth or otherwise of her concerns, they all fall outside our Terms of Reference. They do not involve allegations against foreign-trained doctors, they do not involve allegations about clinical services at Bundaberg Base Hospital, and they are not matters which could on any view be said to fall within our Terms of Reference.

Therefore, I am declining to allow that area to be examined during this inquiry. But just so that no-one suspects for a moment that we're passing over that without close analysis, let me say that an officer of the Commission of Inquiry has interviewed Ms Wong at some length and taken details from her of her areas of concern. She has provided to the inquiry a very substantial bundle of material relevant to her concerns. All of that has been analysed. We have also been provided, by counsel representing the Medical Board, with documents which, as I say, come from the public record. From that, the very minimum that can or should be said is that if Ms Wong has concerns about the order that was made cancelling her registration for a period of five years, she had the right to pursue that matter by way of appeal through the Courts. If she has other concerns, sadly they don't fall within the Terms of Reference of this inquiry. So that area will not be further examined in these proceedings.

Is there again anything anyone wishes to say about that matter before I move on.

MS McMILLAN: Thank you, Mr Commissioner.

COMMISSIONER: Thank you. The third thing I was going to mention really follows from the point I said earlier based on Mr Devlin's very helpful submissions. Given what occurred yesterday, and taking on board the submissions made by Mr Devlin, reluctantly I am going to abandon the practice of inviting questions from the public gallery, or the press and media. But let me say at the same time that as an alternative to that practice, with a view to achieving the same objective, which is to reinforce the openness and transparency of these proceedings, we will ensure that at all times when the inquiry is sitting a member of the inquiry staff is available in this room, as Mr Atkinson is over there at the moment. Anyone from the press, media, the public, any other sector who feels that relevant facts have not been brought to the attention of the inquiry, is not only invited but encouraged to approach representatives of the inquiry, counsel assisting or the legal team associated with the inquiry, and pass on those matters of concern.

I said yesterday, and I would like to reinforce, that the people on the inquiry's team, including the legal team, have been handpicked by me as they are people in whom I have absolute confidence. Anyone who has even the most sensitive matters they wish to bring forward can feel total confidence that what they pass on to staff of the inquiry will be dealt with appropriately. But, as a further failsafe, anyone who feels that they can't put their confidence in the staff of the inquiry, however misguided that feeling may be, will have the opportunity, if they choose to do so, to put their concerns in writing and have them passed to me in open proceedings at the Commission of Inquiry, so that they can feel comfortable that it has been brought directly and specifically to my attention. Again, I will ask whether anyone wishes to comment on that aspect of the matter before we go any further?

All right. The fourth thing that I wanted to touch upon is another of the initiatives which have been adopted by this Commission of Inquiry, and that is the presence of television cameras and still photographers from the press and media. Unlike the other experiment, which has been such a swift and ignominious failure, I am persuaded at the moment that the experiment of allowing television cameras into the inquiry has been a complete success, and the level of information coming through to counsel assisting I think supports that view.

I announced initially that this would be done as an experiment during the first two week sittings in Brisbane. My present inclination is to extend that permission throughout the entire course of the inquiry, including the upcoming sittings in Bundaberg. But, again, I will welcome any submissions which anyone might wish to make to the contrary. Does anyone want to be heard on that? No, all right. Well - sorry, Mr Allen.

MR ALLEN: That would, of course, be on the basis, as it has stood, that it is open for witnesses to ask for that to be considered on a case-by-case basis?

COMMISSIONER: That is certainly the case, Mr Allen, and I want to - in fact, it is more rigorous than that, in the sense that I have directed that no person whose involvement is solely in the capacity of a patient or a member of a patient's family is to be filmed or photographed giving evidence in these proceedings unless that person's permission is secured in advance. With all other witnesses, which includes, for example, Mr Allen, your clients, members of the Nurses' Union, medical practitioners, administrative staff, people involved with the Medical Board or the Queensland Health Rights Commission, or other relevant entities, for all those other categories of witnesses, they can seek a similar order in their favour if they wish to do so.

So, in a sense, with patients or patients' family, the onus is on those who want to film them or take their pictures to get their permission, and without such permission that won't happen. With all other witnesses, the onus is on the witness to seek an order and that will be dealt with on a case-by-case basis.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Is that acceptable to everyone? Right. Well, unless there is anything that anyone else wishes to raise at the moment, we will proceed with the evidence of yesterday afternoon's witness. Dr Bethell, do you mind coming back to the witness-box?

JOHN HUGH BETHELL, CONTINUING:

COMMISSIONER: Dr Bethell, I will remind you that you remain under the oath that you took yesterday?-- Yes.

Mr Boddice, I think you had some questions?

MR BODDICE: Thank you.

CROSS-EXAMINATION:

MR BODDICE: Dr Bethell, could we commence with the terms of engagement. Yesterday in giving evidence you highlighted the clause in the agreement, which could I say is perhaps the exclusion clause, which is to protect your company in the sense that it provides that "the client must make and rely upon its own inquiries with regard to matters the client considers relevant in determining to engage the candidate."?-- Yes.

But I take it that part of your usual service is that you

undertake the referee checks, is that the case?-- As part of our usual service.

And so what happened here where you undertook the referee checks, and in effect had a checklist of what they told you, that's a standard thing that you do for any client?-- That's right. We have a standard pro forma that we use for verbal reference checks.

And do you normally send that information on to the client?-- Usually it is at the discretion of the client if they wish to. We certainly discuss it verbally as a minimum requirement, which is - fundamentally it is the client's decision to make that.

You also, as part of the service you provide to a client, arrange for the necessary documentation to go to the Medical Board?-- It is an administrative service that we offer to remove that onerous amount of paperwork from the client, yes.

So if - obviously when getting the approval of the Medical Board, there is material that comes from the doctor?-- That's correct.

And then there is also material that has to come from the employer, in terms of the signing of the sponsorship form, for example?-- That's correct, yes.

And the signing of the necessary form for Area of Need certification?-- That's correct.

But what you do is you are the repository of that, in the sense the doctor sends their material directly to you?-- Yes.

And the employer sends their material to you?-- Yes.

And then you undertake the process of sending it all to the Board?-- That's correct.

And so this - exhibit 45, which is the handwritten list?-- Sorry, I don't have a copy of yesterday's documents.

I can put it on the screen, if it helps. This is the handwritten list that was sent to you by Dr Patel?-- That's correct.

That came to you and you then sent those documents on to the Medical Board, did you?-- Yes, yes, those were received by mail in our office and then forwarded on to the Medical Board.

Did you ever send the second CV to Queensland Health, to Bundaberg Hospital?-- I have no knowledge of whether the second CV was forwarded to Queensland Health.

You had sent the original CV to Queensland Health, is that the case?-- The original CV was received in December and was passed on to Dr Nydam as part of the recruitment and assessment process.

Whereas these documents, of course, that you are getting now from Dr Patel, they are really - they are specifically designed for the material you need for the Medical Board, aren't they?-- That's correct, yes.

Now, you also yesterday gave some evidence about the CV - do you have a copy of your statement with you?-- I am sorry, I gave all my documents to my lawyer overnight.

Perhaps they will be able to get a copy for you. JHB2 is what we will call the first CV?-- I have that, yes.

And you gave yesterday some evidence about the Diplomat of the American Board of Surgery and the significance of that. The AIMR, which is the first dot point under education?-- Yes.

Do you know the significance of that?-- I don't recognise that qualification.

Did you think it was significant, however, that that showed a recency in terms of examinations?-- I didn't notice that.

You didn't notice it at the time?-- No.

Under "positions held", you referred to the first one but the second one, did you notice at the time that it spoke about a Clinical Associate Professor, 1992 to the present?-- Yes, I did notice that.

Which, of course, was different to the item before which actually said September 2001?-- That's correct.

Do you recall whether you noticed that at all at the time?-- I believe I would have noticed it, but this is an academic appointment to a separate institution from Kaiser Permanente.

You were asked some questions yesterday about the fact that he had ceased employment in September 2001. Was the fact that it said "to the present", did that suggest that that was a currency?-- It suggests it, yes.

But you don't recall whether you turned your mind to it at the time?-- Yesterday we were discussing the - his employment at Kaiser Permanente.

I know, but I am asking you about this one today?-- Yes.

Do you recall whether you considered that at the time?-- I don't have a specific recollection but I imagine that it would have been relevant at the time and I would have noticed it.

Well, certainly would you agree that what it suggests is whilst he may have stopped in September 2001, that seems to suggest that that appointment, anyway, at least, had been an ongoing appointment?-- That's correct.

Now, when you gave evidence yesterday you spoke about noticing

the September 2001. Did you raise that issue with Dr Patel when you spoke to him?-- In my first discussion with him we discussed that.

And did he give you an explanation which satisfied your concern at that time?-- Yes, as we discussed yesterday, he indicated that he was undertaking early retirement from his full-time position in the United States but that he was looking for an opportunity to travel with his qualification and work overseas.

Do you recall in your discussion with Dr Nydam whether you relayed that information?-- I don't specifically recall that, but it's likely that we discussed it at some stage. And there is an email in which I referenced the fact that he hadn't worked for a year with Dr Nydam in that particular role.

In that email, what you referenced it was as a concern as to whether the Medical Board-----?-- Yes.

It might be an issue for the Medical Board rather than raising it as an issue of concern?-- Yes. The Medical Board have their own policies and views on whether that's something that makes the candidate eligible for registration, and at the time that I wrote the email I wasn't aware of the Medical Board's view on that.

But that's what I am suggesting. Your email is actually suggesting that your concern had been satisfied in terms of the one year non-working, but what you flag was that it may be a matter that the Medical Board may have an issue about?-- That's correct.

Because you didn't know whether the Medical Board had some requirement about when you last practised, or something like that?-- The final decision that the Medical Board makes is at the time that the whole application is tendered, and we have no way of predicting 100 per cent whether the Board will accept an application or not.

Do you recall when you spoke to the two referees whether you raised with them the issue of, in effect, what Dr Patel had been doing with himself since he'd left there?-- I don't recall that and it is not reflected in my notes.

Yesterday you were asked some questions, I think by Deputy Commissioner Vider, in relation to the references and the date of the references, of being May and June 2001, yet he didn't finish until September 2001. Did you see any significance in that at the time?-- I didn't notice that fact at the time.

It could also be, of course, that he may have had to give a period of notice in terms of when he resigned, like the references referred to his recent decision to resign-----?-- Yes.

-----but he may have had to actually serve some months out under notice?-- That would be a reasonable assumption.

Which may explain why the references are May/June 2001, but his actual finishing date was September 2001?-- That - yes.

Now, yesterday you gave some evidence in relation to the instructions that Dr Nydam gave about offering the position. Now, can you recall whether, firstly, you sent the references and the reference check on to Dr Nydam?-- I had no record in my notes to that effect, but looking at the documents tendered in this passage it appears that a reference has been forwarded on by fax.

Now, in your statement at paragraphs 10 through to 12 you have the order in which things occurred as - you received the email from Dr Nydam giving permission to make the offer to Dr Patel, and then you say you made - and then paragraph 12 is that you made personal contact with two of the referees and, though you do not now recall the discussion, your normal practice would be that you discuss the contents with Dr Nydam?-- That's correct.

Are you saying that's the order in which it occurred? That is, that you received instructions to make the offer and you then did the check on the referees?-- That appears to be the case in terms of timing, but in terms of Dr Nydam's instructions, my reaction would have been that it wasn't appropriate to make an offer until such time as referees had been contacted.

What I'm suggesting to you is in fact the documentation shows that it is - it was the reverse. That is, you made the checks and sent them through to Dr Nydam before you received instructions from Dr Nydam to make the offer. Do you have a copy of your reference check? They're annexed to your affidavit as annexure-----?-- I do, yes.

Can you look at the bottom? If you have a look at the bottom - you'll have to turn them upside down - you'll see that there's a facsimile?-- Right.

I suggest that's a facsimile of these things through to the Bundaberg Base Hospital?-- Yes.

You will see that they were sent on the 20th of the 12th at 1458, or at 2.58-----?-- Yes.

-----in the afternoon, and that was the references and also your two reference checks-----?-- Right.

-----were sent through. And if we then have a look at the email that you tendered yesterday-----?-- I don't have a

copy.

Yes, I'm just trying to find the exhibit number so I can - Exhibit 43. Could the witness see Exhibit 43, please? Perhaps we could put it up on it screen. That might make it easier. You will see this is the email that you were speaking about yesterday?-- I see that, yes.

You will see half-way down the page is actually an email from you to Dr Nydam, and this is the one where you raise the question of perhaps a concern for the Medical Board about the 12 months?-- Right.

And you will see that's actually dated 3.12 p.m.. So we've seen that the fax was sent to the hospital with the reference checks at 2.58 p.m. and you sent an email at 3.12 p.m. on the 20th in which you raise that, and then if we just go to the top of the page you will see that Dr Nydam's email back, in which he gives instructions about the one year contract, is dated 5.55 p.m. on the 20th of December?-- I see that.

So do you accept that the order you have it in your statement is incorrect?-- It appears that way.

And that you had sent the references and the reference checks through to Bundaberg Hospital. You'd obviously had a discussion with Dr Nydam as well?-- Yes, I can see that the dates - sorry, the times are reflected differently.

It was after those things had occurred that you received the email instructing you to make the offer?-- It appears that way from this, yes.

And do you accept that's so?-- Yes, I mean, in terms of making my statement, it was my recollection at the time and I hadn't noticed the sequence of events. All I had in my database - there's no dates - there's no time stamped in my database to suggest what time-----

COMMISSIONER: Dr Bethell-----

MR BODDICE: It's not a criticism.

COMMISSIONER: -----I'm sure there's no controversy over this. You've said something in your statement which you believed to be right at the time. Learned counsel has now pointed out to you that from the documents it appears that that was wrong?-- Yes.

Do you accept that having had your attention brought to what appears on the face of the documents, that what appears on the documents is correct and your earlier recollection was mistaken?-- That does appear correct.

Thank you.

MR BODDICE: Thank you. Doctor, you also said in that - in evidence yesterday you spoke about conversations you had with

Dr Patel in which he raised about early retirement, that he had been looking at early retirement and his explanation. In your experience, is it unusual that professionals may choose, in their fifties, to have a change in lifestyle?-- It's not unusual for doctors, particularly from the United States.

Having, as you said yesterday, made a lot of money in their careers they tend to look for something else?-- Yes.

So the explanation that Dr Patel gave you wasn't really something that was unusual, in your experience?-- As I mentioned yesterday, we'd not had a significant amount of experience dealing with American candidates at the time that we placed Dr Patel, but my experience subsequent to that would suggest that there's nothing unusual, and we've had many other doctors who we've credentialled and checked out, and there's been no problem with them.

Now, you were also asked some questions yesterday about the airfare?-- Yes.

Remember that about the airfare? In your documentation - in your affidavit you have a copy of the offer to Dr Patel. It seems to be - it's JHB5?-- I think I have it, but there's no number on my copy.

It's on the sheet before which is the facsimile sheet. There was in fact in that document a section headed "Travel", you will see, on the bottom of the first page?-- I see that, yes.

Which said that, "The Bundaberg Health Service District will pay economy class airfares for yourself your wife from the place of residence to Bundaberg, and then if you wish to convert it to a business class airfare it's for yourself to do so."?-- I see that, yes.

So there was obviously something in terms of reimbursement of travel in the discussion in terms of an offer, because that appears in that document?-- That's in this document, yes.

Do you also recall that there were some emails exchanged - sent by you to Dr Nydam in late December in relation to the question of reimbursement of the airfare?-- Can you give me a specific date?

Unfortunately I have one that's marked. I'm trying to get an unmarked copy of it, but the mark is probably not of great significance. Perhaps if I hand it to you-----

COMMISSIONER: Yes.

WITNESS: Can I have a look?

COMMISSIONER: Perhaps I should just look at that before it goes to the witness in case there's - that's fine. I'll just ask you, doctor, to ignore the handwritten parts on it.

MR BODDICE: I now have a clean copy.

COMMISSIONER: Excellent.

MR BODDICE: I can hand up the clean copy instead, Commissioner. Again we can put that on the screen. I've got two clean copies now. You will see again, looking at the middle of the page first of all, which is the initial email from you to Dr Nydam, and you will see in the first paragraph that one of the issues was whether Dr Patel buys the airline ticket - was whether Queensland Health, in effect, bought the airline ticket and sent it to him, or whether Dr Patel bought the airline ticket and was to be reimbursed?-- Yes, I see that.

You don't recall that there was that discussion now?-- I've seen this email during my research for this Commission.

Then you will see that at the top of the page there's an email back from Dr Nydam about Dr Patel simply getting his own ticket and being reimbursed on presentation of the invoice?-- I see that.

So do you accept that as part of the employment contract or arrangements there was some agreement in relation to airfare?-- There was some discussion surrounding who would buy the ticket and how it was going to be reimbursed, yes.

COMMISSIONER: Mr Boddice, is it going to be suggested as part of your cross-examination that there was some arrangement for a return airfare? It's just that both the documents to which you've drawn attention - the offer letter bearing the date of Christmas Eve 2002 talks about economy class airfares from place of residence to Bundaberg, and the document that's on the screen at the moment again talks about the airfares from the US to Australia. Is it going to be suggested that there was some arrangement about return airfares at the end of Dr Patel's service?

MR BODDICE: Our instructions are that there had been an agreement to provide a return airfare.

COMMISSIONER: Yes.

MR BODDICE: But I can't go so far as to say that it was necessarily something that was arranged with Wavelength.

COMMISSIONER: All right. Is it going to be suggested that was something arranged directly by someone at Bundaberg with Dr Patel?

MR BODDICE: As far as my instructions extend at the moment that's what I understand to be the situation, and of course I don't act for Mr Leck or Dr Keating, so-----

COMMISSIONER: My concern is only this: Dr Patel will be leaving us, hopefully, before very long, and I'd hate to have to-----

WITNESS: I presume you mean Dr Bethell.

COMMISSIONER: I'm sorry. I do beg your pardon. I am truly sorry. I don't want to have to bring him back if something later emerges that he should have been asked about.

MR BODDICE: Perhaps I can do it this way: can you recall whether there were discussions about not simply the airfare to Bundaberg, but a return airfare?-- I have no recollection of that, and as I said yesterday, there's nothing in my notes to suggest that.

But yesterday you didn't even really have a recollection about a payment of the airfare to Bundaberg, did you?-- Sorry, could you repeat that?

Yesterday in your evidence you didn't have a recollection even of an agreement to pay the airfare to Bundaberg?-- I was aware of it through my notes that there was an agreement.

COMMISSIONER: I think in fairness to the witness the only questions he was asked yesterday related to the return flight to America, and that's what he didn't recall. I may be mistaken, and the transcript will show that up.

MR BODDICE: All right. Well, I suggest this to you: some time after Dr Patel started at Bundaberg Base Hospital, Dr Patel raised with Dr Keating that it had been agreed in negotiations with Wavelength and the Bundaberg Hospital that Dr Patel would be entitled to one return trip from the US to Australia per contract. Now, do you recall anything about that?-- I have no recollection of any discussion with Wavelength and I have no records on file pertaining to the return.

And I suggest to you further that in fact at that time Wavelength was contacted by telephone and agreed that that was in the negotiations?-- Again no recollection, and there's nothing in our records to suggest that.

If Wavelength was contacted, would you be consulted in relation to that or is there somebody else in your firm that would be able to provide that information?-- Because I was the only person involved in Dr Patel's appointment right up to the point where he accepted the position and the paperwork was initiated, I would be the logical person to be asked about any discussions pertaining to airfare and, in particular, return airfare.

Do your records show any contact from the Bundaberg Base Hospital in or about September 2003?-- Not to my knowledge.

Have you been through your records specifically to look for that?-- Not specifically for that, no.

COMMISSIONER: But you've been through the records generally to look for anything------?-- I have.

-----relating to Dr Patel?-- I have, yes. I've looked for any records that might refer to a discussion with Dr Keating regarding return airfare, and I found nothing.

MR BODDICE: Can you say categorically that that contact did not occur, or is it just that you don't recall any such contact?-- It would be hard for me to say categorically, because a conversation may have taken place that I wasn't aware of and that wasn't recorded, but I find it unlikely.

COMMISSIONER: I'd like to follow that up a little, but I don't want to break into your cross-examination.

MR BODDICE: By all means.

COMMISSIONER: Thank you, Mr Boddice. Let's assume for the moment that Dr Keating had telephoned you, say, six months after Dr Patel had started work at Bundaberg and said, "Look, Patel is claiming that there was a term of the contract that's not actually recorded in the formal offer document that he received allowing him to go back to the United States" - or "a return trip to the United States at the end of each contract", how would you respond to a suggestion that there was some oral term standing alongside what's in the written offer?-- It's hard for me to project my mind back to six months post the time that he actually applied, but-----

Well, let's put it a slightly different way. You have the formal offer made on the 24th of December 2002 which has quite a specific term in relation to travel providing for, in effect, two options. Either Dr Patel could have economy flights for himself and his wife from the United States to Bundaberg, or he could substitute a business class airfare for himself from the United States to Bundaberg, but nothing at all about flights back from Bundaberg to the United States. Did you consider at any time that you had authority to negotiate more beneficial terms for Dr Patel than those which were actually authorised by Bundaberg?-- Not to my knowledge.

And had some more generous terms been, for example, proposed by Dr Patel and discussed with Bundaberg, would it have been part of your usual business practice to make sure that those terms were recorded in some form?-- Yes, it would.

I mean, you know, let's be frank about this. The whole reason you go to the trouble of having a fairly closely typed four page letter setting out the terms of offer is so that there can never be any dispute about it. That's why we do things this way?-- That's right. That's what contracts are for, to prevent any conjecture at a later stage.

And if at any stage during the negotiation process something had been raised either from the Bundaberg end or from Dr Patel's end that was different from what was in the contractual documents, you would have made sure it was recorded in some fashion?-- I would imagine so.

Does that assist, Mr Boddice?

MR BODDICE: Thank you, Commissioner. Who is Suzy Tawse, T-A-W-S-E?-- She's a member of my staff.

It appears from the emails that Suzy Tawse was doing certainly the negotiations in relation to - some of the negotiations in relation to Dr Patel physically coming to Brisbane and meeting with the Medical Board members?-- She was assisting in the practicalities of it.

Could she be a person who was contacted in September 2003?-- I can't comment on that except to say that it would seem unusual that she would not refer that to me given that she wasn't involved in the initial discussions.

What's her position in your firm?-- At the present time she's a recruitment team leader.

But you do accept that she would have had some day-to-day involvement in the arrangements of Dr Patel physically coming to Australia?-- Yes.

And was she also the person who did the follow-up calls?-- She was, yes.

So she would be a person that Bundaberg Hospital staff would have had contact with-----?-- Yes, that's correct.

-----in the course of things. Does she keep separate files to you or is there one central file in your - in Wavelength?-- The database is a central file for all information pertaining to recruitment activities. The only other repository of information would be her email files and-----

Did you search that?-- Yes, in the course of researching for this Commission I've been extensively through all email files relating to Dr Patel.

COMMISSIONER: Presumably you can do some sort of key word search, put in "Patel" or "Bundaberg" or something like that?-- I've done as many key word searches as I could possibly imagine to try and retrieve everything.

When Mr Boddice asked you whether Suzy Tawse was involved in the negotiations, your response was that she made the arrangements. To your knowledge, was she actually involved in anything that could be described as negotiating the terms of Dr Patel's employment?-- To my knowledge there was no such negotiation took place with Suzy, and it would not be within her ambit to do so.

Your view is that she simply didn't have authority within your organisation to-----?-- That's correct.

-----involve herself in those negotiations?-- That's correct.

And so far as you know, your organisation as a whole, whether it's yourself or Miss Tawse or anyone else, had no authority

to renegotiate what's in the black and white letter from Bundaberg Hospital setting out the terms of employment?-- It's extremely unlikely that I would get involved in the retrospective negotiation regarding an airfare six months after the fact.

Thank you.

MR BODDICE: Commissioners, perhaps I should tender that email.

COMMISSIONER: Yes, that would be useful.

MR BODDICE: One is dated 28 December, and the return one was the 30th of December.

COMMISSIONER: The page comprising Dr Bethell's email to Dr Nydam of the 28th of December, and Dr Nydam's reply to Dr Bethell of the 30th of December, both comprised on the one sheet, will be admitted into evidence and marked as Exhibit 48.

ADMITTED AND MARKED "EXHIBIT 48"

MR BODDICE: Dr Bethell, yesterday you were also asked some questions about the level of wages offered by Queensland as opposed to the other states?-- That's correct.

And you indicated in evidence that looking at it vis-a-vis New South Wales and Victoria it's lower, although it's relatively comparable to the remaining states?-- That's correct.

Do you do recruiting for people other than doctors?-- No, it's exclusively medical practitioners.

Have you in the past, in your previous experience with other firms, done recruiting for other professions apart from doctors?-- Have I personally recruited in other sectors?

Yes?-- Yes, at Morgan & Banks I had responsibility for the clinical research departments of pharmaceutical companies, and to a certain extent management positions in hospitals.

And in that previous experience was it unusual that people who were being recruited for New South Wales and Victoria would be often offered higher packages - or higher salary than, say, those being recruited in the other states of Australia?-- In terms of my responsibilities at Morgan & Banks, I was exclusively limited to New South Wales so I had no experience with packages in other states.

Yesterday also you were asked some questions about the position of Director of Surgery?-- Yes.

And you gave evidence to the effect that you would - I'll just turn it up - place a greater scrutiny, if I can shortform your words, in terms of an applicant for a Director of Surgery, but you did that in the context of saying in order to qualify to be Director of a surgical department as a specialist then you would have done the greater scrutiny because of the need for the college requirements?-- It would have followed on as a mandatory requirement that the candidate would have to go through the Australian Medical Council assessment procedure which runs in parallel with the assessment by the appropriate specialist college, in this case the Royal Australasian College of Surgeons.

COMMISSIONER: But I think the point being made is when you're asked about the position of Director of Surgery you use the words to select a candidate for position of Director of Surgery "as a specialist"?-- Yes.

When you're asked to find a Director of Surgery or Director of some other clinical department, you're saying it, in effect, goes without saying that person has to be a specialist?-- It would be understood right at the outset that it would be a requirement that they would be a specialist and that in fact they would have to go through that procedure.

Yes.

MR BODDICE: There's two things we wanted to ask you about it. First was, I take it that when you were saying about as a specialist - because when you're recruiting - for example, when you're recruiting for Dr Patel, there are certain requirements that are required to satisfy the Medical Board?-- That's correct.

When you're recruiting for a person for registration as a specialist there are certain requirements that are required by the Medical Board which are different. For example, there's the need for the college requirement to be satisfied?-- That's correct.

But you then went on to give evidence that in your experience it's not unusual for - and this is at page 702 about line 15. You said this: "I might make the comment that around Australia there are a number of people who don't have specialist qualifications who go by the title of Director of any particular unit, and what that tends to imply is merely that they have a greater administrative workload rather than that they have attained specialist qualifications", and you gave the example in emergency medicine?-- It's more or less an exclusive example in my experience. We've not been involved in hiring any Directors of Emergency into such positions. We are aware of them because they come to us as clients.

And you're aware of them because what you're really being told by clients is that there is a lack of specialists to fill the role, so people who are SMOs or, as you said, Career Medical Officers as they're called in New South Wales, are employed to

fill the role?-- Yes.

You were also asked some questions yesterday in relation to Australian candidates and whether they would find terms - the VMO-type terms with some flexibility more attractive. I take it, however, your business really is based on - in terms of overseas trained doctors, is based on the fact that there is a shortage of available Australian candidates for positions and you're filling these positions with overseas trained doctors?-- Yes.

And you're doing so in circumstances where - you said yesterday that the clients are telling you that they've advertised and they get no responses at all?-- That's correct.

And so it's a matter of there not being the available - sufficient Australian candidates, which is what requires the overseas trained doctors?-- In our experience that's generally the case, yes.

Finally, you were asked some questions yesterday about the doctors being bonded, in effect. Is it your experience throughout Australia that when these overseas trained doctors come to Australia, they, of course, come under a form of sponsorship?-- They do, yes.

And the Commonwealth Government's requirements when you come into the country under a sponsorship is that you must work for the employer, that is the sponsor?-- In terms of the Commonwealth, are you referring to the Department of Immigration and Multicultural Affairs?

The visa requirements?-- The visa requirement is that the applicant must have a sponsor, and that sponsor is generally the hospital.

That's so, the employer?-- Yes, the employer.

And it's the visa requirement that they must work for that employer?-- That's correct.

And indeed if they cease working for that employer then the visa - they have problems in terms of continuing with that visa?-- They have an obligation to notify DIMA of that.

COMMISSIONER: We might take the morning break now so that further cross-examination isn't interrupted. We'll adjourn for 20 minutes.

THE COMMISSION ADJOURNED AT 10.58 A.M.

THE COMMISSION RESUMED AT 11.25 A.M.

JOHN HUGH BETHELL, CONTINUING:

COMMISSIONER: Who wishes to go next? Mr Ashton, I know you had some questions. I think Mr Allen, as well.

MR ALLEN: No, thank you, Commissioner.

MR DIEHM: I do have some questions.

COMMISSIONER: Sorry, Mr Diehm.

MR DIEHM: I indicated yesterday I didn't. There are some matters that I do wish to ask, and I won't be long, and I'm happy to go now.

CROSS-EXAMINATION:

MR DIEHM: Dr Bethell, can I ask you to have a look at Exhibit 47, if that could be provided to him, Commissioner.

COMMISSIONER: That's the bundle of documents relating to discussions between Dr Bethell's organisation and the Bundaberg Hospital?

MR DIEHM: It is.

COMMISSIONER: Yes.

MR DIEHM: Exhibit 47, yes. Now, within that bundle there are - or each of those documents are file notes, are they not, of conversations held between Suzy Tawse of your company and various persons named therein from the Bundaberg Hospital?-- That's correct.

In the time period those documents cover Suzy Tawse had become, had she, the regular point of contact between your company and the Bundaberg Hospital?-- That's right.

Did you have any contact with the Bundaberg Hospital over that time period?-- Specifically regarding the placement and the follow up of Dr Patel?

Yes. You do?-- No, Suzy specifically was the primary point of contact with Bundaberg Hospital pertaining to Dr Patel's placement.

Thank you. Are you able to say whether the contents of these file notes represent the only communications that Suzy Tawse

had with persons at the Bundaberg Hospital?-- To my knowledge they're the only notes that pertain to contact between Suzy and the Bundaberg Hospital.

By that do you mean that the only information you have about contact that Suzy Tawse had with staff at the Bundaberg Hospital is what is revealed by the file notes on the system?-- That's the only thing I can be stern of that took place.

Yes. There may have been other contact that she had from time to time, but you wouldn't know about it unless there was a file note of it?-- That's correct.

Thank you.

COMMISSIONER: Mr Diehm, if you've finished on that topic may I inquire of Mr Thompson, we hadn't anticipated a need to trouble Ms Tawse to give evidence. I wonder whether it would be possible through your good officers to obtain a statement from Ms Tawse as to her recollection of any discussions about Dr Patel's terms of employment, provide that to the inquiry and then if anyone requires her for cross-examination we will have to make those arrangements, but obviously I wouldn't want her to come unnecessarily from Sydney. Would that be acceptable?

MR THOMPSON: We will make inquiries, Mr Commissioner, about that and I will get some instructions, and we will revert the commission in respect of it.

COMMISSIONER: I appreciate that very much. Would that be satisfactory, Mr Diehm?

MR DIEHM: Yes, thank you, Commissioner. Dr Bethell, are you able to say whether you had any leave, holiday leave or other leave, during September of 2003?-- It's possible.

If the school holidays, for instance, fell in that time period does that assist you in thinking about whether you may have had leave at the time?-- At the time I had no children, so I wouldn't be of any assistance.

Nevertheless, it's possible you would have been on leave in September 2003?-- It's possible, yes.

If Dr Keating or somebody from the Bundaberg Hospital on his behalf made contact with your company to inquire about whether a return airfare was part of the negotiations with Dr Patel, that might be something that could have happened in September of 2003 without you knowing about it; is that right?-- If I was on leave and that conversation had taken place and Suzy had made no notes of it, then it is conceivably possible.

And even if you weren't on leave the same scenario could happen, couldn't it?-- That's within the bounds of possibility, yes.

Thank you.

COMMISSIONER: Doctor, I assume that such inquiries are fairly uncommon in your business, that is, inquiries from employers many months after an employee has commenced work asking for a retrospective input into what the terms of employment were?-- I can't immediately recall any circumstance where that's happened.

In accordance with your company's ordinary system of record keeping is that something which Ms Tawse or any other employee should have recorded if such an inquiry had been received?-- Ms Tawse is a very meticulous note-taker, and I would be extremely surprised if she had not recorded a conversation of such significance.

MR DIEHM: Thank you. Nevertheless, Ms Tawse is presumably as capable of failing to follow a system from time to time as any other employee, so as that she may not have documented such a contact?-- That's possible.

Thank you. Now, the other thing I wanted to ask you about Exhibit 47, if you can have a look at what I assume would be the first page on the document in front of you being a file note dated the 4th of April 2003?-- That's correct.

And in the "Comments" section after referring to the date and the name Suzy it reads, "Spoke to Lynn McKean"?-- That's correct.

That's the one you have, thank you. And should we take it from the contents of that file note that the purpose of the communication was for Suzy to find out from Lynn McKean whether the hospital was happy with Dr Patel?-- It isn't part of our normal procedure to follow up so soon, so I'm - it's not easy for me to comment on why Suzy would specifically contact on that occasion.

In any event, according to the file note, Suzy was advised that not only was the hospital delighted Dr Patel, but that he had been appointed Director of Surgery for the duration?-- For the duration, yes.

Should we take that to mean, you think, the duration of his contract?-- I would take it to mean that looking at that note, yes.

Yes. And can we take it from the balance of the document that apart from adding to the praise that Ms McKean was giving to Dr Patel, that Suzy was also advised that there was a new director coming to replace Kees Nydam who had been the Acting Director for the last two years?-- That's correct.

COMMISSIONER: If it helps, I'm reliably informed that the name is correctly pronounced Kees.

MR DIEHM: I apologise, and I'm indebted to the Commissioner.

COMMISSIONER: I made the same mistake, myself, and I apologise to the doctor.

MR DIEHM: In any event, what Ms McKean was advising Suzy was that prior to the arrival of the person replacing Dr Nydam in that position Dr Patel had been appointed as Director of Surgery on a permanent basis?-- That appears to be not - I wouldn't describe it as a permanent basis, for the duration of the contract it was agreed.

Yes, I'm sorry?-- The one year contract.

You are quite right, thank you.

COMMISSIONER: Who was the correspondent that was dealing with Suzy in that correspondence?

MR DIEHM: Lynn McKean.

COMMISSIONER: Is anyone able to inform me what her position was at Bundaberg?

MR BODDICE: I can't now, but I will have inquiries made.

MR DIEHM: I'm not able to say, Commissioner.

COMMISSIONER: Thank you.

MR DIEHM: Those are the questions.

MR BODDICE: I'm sorry, Commissioner, I'm informed that she was, I think may still be, the Secretary of Medical Services.

MS McMILLAN: I didn't hear Mr Boddice.

COMMISSIONER: Secretary of Medical Services. When you say secretary, secretary in the clerical sense?

MR BODDICE: I assume so, yes.

MR DIEHM: Those are the questions I have, Commissioner.

COMMISSIONER: Thank you very much indeed. Mr Ashton?

MR ASHTON: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ASHTON: Doctor-----

COMMISSIONER: I'm sorry, doctor, perhaps I should explain for your benefit Mr Ashton, learned counsel, is going to ask some questions. He represents Mr Leck the District Manager of Bundaberg Hospital?-- Thank you.

MR ASHTON: Thank you, Commissioner. There's a document in the bundle you have been provided which is marked JHB6 that's on your letterhead. It's a letter to Kees Nydam. Do you have that?-- I have that, yes.

You have that?-- I have it.

Now, that seems to be a letter - well, by its date and by its content - to have been sent after there's acceptance at least in principal of the appointment, is it?-- That's correct, yes.

Is that the way it works?-- Yes.

And under the heading "What We Will Do" there are four dot points there of work that your company will undertake. You're representing to Mr Nydam that those are the things you will do, is that right?-- That's what's written there, yes.

Were they, essentially, the things Suzy Tawse would do?-- That's correct.

What else would she do? You've explained that she wouldn't have been involved in negotiation of conditions or anything of that sort, but typically in an appointment of this kind what are the things she does?-- I can't think of anything that would be able - do you have anything specific?

You would know better than I. I'm happy for your help?-- During the time period of the paperwork being submitted to the Board and the Immigration Department and the candidate transiting to the client's location she would be the primary point of contact of most issues.

On all of these fronts?-- On all of these.

The Board, the hospital?-- That's correct.

Dr Patel?-- That's correct.

Immigration?-- That's correct.

All right. Now, the letter of offer, doctor, it's in the JHB5 section. Although it's the previous document that has JHB5 on it. Do you have that?-- I do, yes.

You will notice in the third paragraph there, "You will be employed under the provisions of the Senior Medical Officers' and Resident Medical Officers' Award - State. A brief summary of the major conditions of this award and additional information that will be of interest to you are as follows". Now, we can see that there's information then at the back of that document on the third page about orientation and private property loss or damage, and so on?-- Yes.

Which one would expect would qualify as the additional information to which that is referring?-- That's correct.

But in terms of conditions, remuneration package, et cetera, is that all just award, is it?-- Sorry, is that?

Is that all just award stuff, is that just - is everything that purports to summarise the award. Are those things all in the award, are they?-- I don't have a copy of the award in front of me, but it looks compatible with.

Does it?

COMMISSIONER: Do you know if the award says anything about travel entitlements to and from Australia for overseas employed doctors?-- I'm not aware, but that's a document that's easily obtained from the State Health Department.

MR ASHTON: So, for example, the reference to a motor vehicle, the communication package, mobile phones, pager, fax machine, study and conference leave, full pay with expenses, you don't know whether they are - you can't tell us and I appreciate, of course, you don't have a photograph of the award in your mind, but you are not able to assist us by telling us whether they are, in fact, as the letter purports a summary of the award or whether they are all or some of them negotiated outside it?-- I can't comment on that, no.

All right. Now, at page 7 of your - sorry, paragraph 7 of your statement you say that Dr Patel was initially reviewed by a colleague. Who was that colleague?-- Her name is Madeline Price.

And is she a Director of equivalent standing as you in the-----?-- No.

-----outfit. No. But she passed Dr Patel or his application over to you?-- She, yes, informed me of his application.

And then at paragraph 8 you explain that you were in touch with him, you gave him some information about Bundaberg and the hospital and so on. At what point do you - would it be your practice and, more specifically, if you can remember it, tell us at what point you did with Dr Patel start telling him something about conditions?-- It's unlikely I would have - specific conditions or general?

Well, some of the conditions - I imagine most applicants when you make the call-----?-- Yes.

-----to suggest they might be interested surely it's not uncommon in that fairly first conversation that the subject of money might arise?-- It may well and it often does, but I rather talk in generalities rather than specifics because at that stage it's uncertain where the candidate is going to go in terms of which state.

So that's probably what would have happened with Dr Patel?-- It's possible, yes. I can't-----

It's probable, isn't it? I mean, that's the way human nature is.

COMMISSIONER: You are suggesting that it's probable there was some very general discussion about how much money you would get?

MR ASHTON: Well, that's a starting point, Commissioner, yes. You have said to me, have you not, in response to my question - that question, the subject of money, don't let me put words in your mouth, the subject of money usually arises?-- I can't recall.

In those early occasions?-- Sorry?

If you can't remember-----?-- Yes.

-----what precisely - what happened with Dr Patel?-- Yes.

You tried to tell me what usually happens, what's the practice, and I put to you that you would usually get an inquiry about the money?-- It's quite - yes.

And I think you told me that you try to answer that in generalities, and I was coming to a question about what does that mean. Do you, for example, give the candidate some idea of the range that he could expect without saying it will be precisely this?-- That may be the case, yes.

In fact, to advance it at all you would have to mention some sort of figure, wouldn't you?-- At some stage in the process the issue of remuneration becomes-----

And usually at an early stage in the process?-- Depends on the candidate and their motivations.

So at any time it's probable at some point in time that you got the question about the ugly subject of money and that you had a conversation about it, though being careful to avoid any kind of commitment which, of course, you could make?-- That's correct.

Is that right?-- Yes.

What about other things? They would ask, would they not, again at a fairly early stage, about aspects of the package? What apart from money - what's your experience of what appointees like Patel regard as important in their package? What are they interested in?-- I would say the predominance would be money. For overseas doctors, probably the next thing that they would be most interested in would be assistance with the accommodation when they arrive, because obviously they are arriving in the country.

And travel?-- Potentially travel, yes.

Yes. And the overseas fellows are all interested - and ladies - would all be interested, too, would they not, in what degree of support they'll get to get home occasionally?-- It doesn't come up very frequently. It does occasionally.

Amongst the over - well, particularly amongst the overseas people - well, you don't do much local placement, do you; that is, placement for local core Australians?-- That's correct, but what I am saying is the issue of airfare often comes up in terms of their travel to the country but it is not-----

At any rate-----

COMMISSIONER: People from Kabul don't often say to you, "Look, we would like to go home to Afghanistan in 12 months"-----

MR ASHTON: What about the United States?-- Sorry?

What about from the United State, are they a little happy to get home occasionally?-- Generally speaking the positions that we place are either - for a specialist are either permanent positions, in which case there is really only discussion about the one way travel in the first instance, or they're coming for a fixed term contract, and the airfare is either presented as a one way or as a return flight.

All right. Well, you would expect, at any rate, to have had some discussion at some point with Patel about money, about the travel aspect of the package, about accommodation. Anything else that you think probably would have arisen in your conversations?-- Sorry, can you repeat the list?

Well, so far I think we've identified money, salary, accommodation and travel - specifically travel one way, you think?-- They would be the specifics-----

You would expect at some-----

MR THOMPSON: I am sorry, Mr Commissioner, my learned friend should let the witness finish his answers.

COMMISSIONER: Yes, I think so.

MR ASHTON: Sorry, doctor. You go ahead?-- The three that we've discussed would be the major things that come up.

All right. Now, doctor-----

COMMISSIONER: Mr Ashton, if you are moving on to another topic, I just wanted to follow up on some of the things.

MR ASHTON: It is connected but I have no problem.

COMMISSIONER: It is up to you, Mr Ashton. I don't want to take you out of your stride, as it were.

MR ASHTON: No, I am quite happy.

COMMISSIONER: Thank you. I would imagine, doctor, that if, for example, you have an applicant from John Hopkin's, or one of the leading medical centres in the world, it would be essential to say to that person at the very outset, "Look, you know, you are going to be looking at a half, or a third, or a quarter of your current salary if you are coming to Australia."?-- That's correct, yes.

Whereas if you are dealing with someone from a third world country, the Australian salary will be a lot more attractive?-- In our personal business experience we mostly deal with candidates from what you describe as the first world country.

Yes. You have told Mr Ashton already that any discussion at the early stage about the salary package, and so on, is in generalities?-- Yes.

I guess there are generalities and generalities. Is it a matter of saying, "It is likely to be between X and Y", or is it a matter of saying - how would you express in general terms the sorts of salaries that an applicant is likely to be offered in Australia?-- I mean, I like to be fairly upfront about the overall package that are likely, in terms of cash value-----

Yes?-- -----they are likely to encounter, simply because if that's going to be an issue, that's going to be a problem for them, then I would rather know that upfront.

All right?-- So that, you know, they can either move on and give up the notion, or we can, you know, talk around it in terms of-----

Let's then take - I appreciate you don't recall Dr Patel having such a discussion precisely, but using him as an example, you have got a man who, at least on the face of his CV, is a very experienced and quite senior surgeon practising in the United States, even though he has been out of work for more than 12 months. If he were to telephone you at an early stage or you were to telephone him and he said, "Well, what sort of salary am I going to be looking at in Australia?", how would you respond to that?-- I'd say, "As a specialist surgeon you would be looking at an overall package somewhere between 150 and $200,000."

Right?-- So it is pretty general.

Yes. Thank you, Mr Ashton.

MR ASHTON: Thank you, Commissioner. Now, doctor, I mean no criticism by this, but it is reasonable to say, is it not, that you don't have a substantial independent recollection of this placement, as you probably wouldn't of any particular placement, specially going back that far?-- It is quite a lengthy period of time.

Yes. So you are dependent, really, on your records?-- I am fairly dependent on them at this stage, yes.

All right. Now, doctor, could you take us to the telephone memoranda completed by Suzy Tawse in relation to her telephone conversations with the Immigration Department?

COMMISSIONER: They are the ones that the witness was looking at a moment ago, exhibit-----

MR ASHTON: They related, I thought, to the-----

COMMISSIONER: -----47.

MR ASHTON: To the reference checks.

COMMISSIONER: I beg your pardon. So is it exhibit 47 or is it a different exhibit?

MR ASHTON: I don't think it is in evidence.

COMMISSIONER: Oh, I see.

WITNESS: I am not sure that I have a copy of this one.

COMMISSIONER: Well, we're-----

MR ASHTON: Memoranda. No, I am asking for you to provide them - me with copies. Where am I getting them from?

COMMISSIONER: Mr Ashton, we have as JHB4 the documents which record the reference checking, and the witness has explained to us yesterday that this isn't the way it is written at the time, this is a computer-generated version.

MR ASHTON: I understand that, Commissioner.

COMMISSIONER: Yes. So are you asking for the original document from which JHB4 was generated?

MR ASHTON: No, certainly not. I am asking for the records of her conversations with the Immigration Department.

COMMISSIONER: Oh, do you have such records?-- I am not sure that we have any specific on file.

MR ASHTON: No. Well, could you let me see the records of her conversations with the Medical Board?-- There is - I think my counsel has copies of those.

Telephone - the telephone - the memoranda of telephone conversations. Have you seen any in your searches?-- I don't have any immediate recollection of it.

No, all right.

COMMISSIONER: Mr Ashton, you have asked for the documents. The witness has said that if they're here in the courtroom they will be with his counsel or solicitors. I think, since you have raised it, it is only fair that Mr Thompson and his instructing solicitor have the opportunity to respond.

MR ASHTON: We might as well cover them, Commissioner. Queensland Health; have you got the memos there of her conversations with Queensland Health?

COMMISSIONER: If any?-- In terms of conversations?

MR ASHTON: Pardon?-- Most of the correspondence would have been via letter.

Well, I asked you, didn't I, before what Suzy Tawse does and you told me that she makes telephone contact, she is the contact person for these people?-- I don't believe that I specifically said she makes telephone contact.

MR THOMPSON: I think my learned friend is misstating his evidence, with respect, quite grossly in that respect.

MR ASHTON: She doesn't do anything by telephone?

COMMISSIONER: He didn't say that either, Mr Ashton. Let's be fair about this. We were told earlier Ms Tawse looks after the administrative functions of arranging - I think it was Immigration Department requirements, Medical Board requirements-----?-- That's correct.

All of the-----

MR ASHTON: Queensland Health.

COMMISSIONER: Queensland Health, and so on. We have been told one of her jobs is to follow up with the hospital by way of telephone call and we have got the records showing she made those telephone calls. You are now asking about whether there were any communications between her by telephone, as opposed to email, or post, or something else, with Queensland Health or with the Immigration Department or with the Medical Board?

MR ASHTON: What I am asking for, Commissioner, is for the memoranda of those conversations. Of course, if they were made. If the witness's answer is there were no telephone conversations, that's the end of it.

COMMISSIONER: He doesn't know. All he can tell about is what is in the record, so the question is whether there are-----

MR ASHTON: Tell me, doctor, would you expect that Suzy Tawse would have been speaking at some stage to some of these people?-- Not necessarily, inasmuch as the process is a paper process.

I see?-- So I would - I would rather think that she corresponded in a hard format, a paper trail with indications of what documents had been sent where, and a clear set of instructions of what we were going to do, necessarily in a series of telephone conversations which are transcribed, because to my mind that's a hard trail of evidence of her activity and-----

So you don't think that she would have made a telephone call to Queensland Health?-- It is possible, if she had to chase up Queensland Health for documents-----

It is probable, isn't it, doctor?-- No, no.

A placement like this?-- No, it is not. It is possible if Queensland Health had been tardy in returning a document or something had gone missing, but if everything was moving smoothly it would not be necessary.

I see. It is possible, is it, that she telephoned the Medical Board?-- It is possible, if there was uncertainty about documents-----

What about-----?-- -----and that could not be cleared up by email or other correspondence.

What about the Department of Immigration?-- Again, exactly the same situation.

All right.

COMMISSIONER: Let's pause there, Mr Ashton. I think Mr Thompson is still checking the papers.

MR BODDICE: Commissioner, just a suggestion, it might actually be shorter if we just adjourn for a minute and Dr Bethell actually looked at the files. He might know what he is looking for.

COMMISSIONER: I am happy to do that without adjourning. Dr Bethell-----

MR THOMPSON: I think I am competent to identify records, with respect, thank you, Mr Boddice. They do have "telephone call" written on.

COMMISSIONER: Mr Thompson, without for a moment impugning your competence, if it would assist you to have Dr Bethell, I am happy for him to leave the witness-box and come and provide you with any assistance.

MR THOMPSON: Thank you. I am indebted to you, Mr Commissioner. I think we do have the records of Ms Tawse' phone calls here. Perhaps if I could - I am being hindered at the moment by my instructing solicitor.

COMMISSIONER: They are good at that.

MR THOMPSON: Perhaps it would be an idea, Mr Commissioner.

COMMISSIONER: Dr Bethell, you are free to leave the witness-box and help Mr-----

MR ASHTON: Could I just assist, Commissioner, by suggesting that while he is there you have a look, if you would be so kind, doctor, for telephone calls regarding informing the employer about the candidate's flight details and accommodation needs, if there were any, of course.

MR THOMPSON: I am instructed those already - they were some of the ones we were going to give Mr Ashton.

MR ASHTON: And liaising with the candidate. I am reading from the letter about the things she would do.

COMMISSIONER: Since a big issue has been made of this, I will stand down for five minutes so the doctor can satisfy himself that anything of the nature described by Mr Ashton is produced. And the other thing, Mr Thompson, is I asked earlier about possibly getting a statement from Ms Tawse. The doctor did mention in his evidence a moment ago another of his colleagues who may have had the initial contact with Dr Patel. Madeline Price. Is that the name?-- That's the name, yes.

All right, I wonder if we could do the same thing in relation to her. But if she has any relevant recollection or information to provide, you can furnish a statement, we will avoid calling her to give evidence in person, if that can be done, but if Mr Ashton or anyone else wishes to cross-examine, we will have to make those arrangements either by bringing her to Brisbane or by videolink, or whatever is the most efficient.

MR THOMPSON: I am not sure of her status, whether she is still a current employee.

WITNESS: She is not, no.

COMMISSIONER: No, she is not?-- No.

Well that may hinder you to a considerable extent.

MR ASHTON: Commissioner, if we're adjourning for this process, so as to try and avoid too much disruption, could I ask that the witness look for his own memoranda of the changeover, if there is one - that is the changeover of discussion, whatever occurred with your colleague; the telephone conversation referred to in paragraph 8 of the

statement; the telephone conversation referred to in paragraph 10 of the statement, and I am presuming that's a telephone conversation because you later refer to an email of the same date. And all of the telephone conversations in which you discussed with Dr Patel the package, which I think you said you would have told him 150 to $200,000.

COMMISSIONER: No, he didn't say that, Mr Ashton.

MR ASHTON: I thought he did, in response-----

COMMISSIONER: Let's be very careful. In response to my question - I put it on a very hypothetical basis - he couldn't recall the specific discussion with Dr Patel but the sort of information he would have provided to a person in Dr Patel's position was a package of 150 to 200,000.

MR ASHTON: Well, the memos will tell us if they exist. They will tell us what you told him, won't they? So if you could get those memos for us, please, of your discussions with Dr Patel. Thanks, Commissioner.

COMMISSIONER: We will adjourn for five minutes so that Mr Thompson and his instructing solicitor, in consultation with Dr Bethell, can identify any documents of the kind described by Mr Ashton. And Mr Ashton, if during the next five minutes you think of anything else that might be of interest to you, let Mr Thompson know so we don't have any further delays.

THE COMMISSION ADJOURNED AT 12.01 P.M.

THE COMMISSION RESUMED AT 12.27 P.M.

JOHN HUGH BETHELL, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Where do we stand, Mr Thompson?

MR THOMPSON: In the adjournment, Mr Commissioner, I have been through with Dr Bethell all the documents he brought with him from Sydney.

COMMISSIONER: Yes.

MR THOMPSON: He extracted all those that he thought would be relevant to these proceedings, and to meet Mr Ashton's concerns, we have extracted all documents covering the period from the beginning of December - or the 13th of December, I think it is, through until - we have organised them in chronological order - through until the 14th of November 2003,

which is the last communication, which is a telephone conversation between Ms Tawse and Dr Patel.

COMMISSIONER: Right.

MR THOMPSON: Now, I should mention two matters in relation to this bundle - these are the only copies we have, of course.

COMMISSIONER: Yes.

MR THOMPSON: There is a - there are two matters. The first one is this: that one of these documents, the first document generated, has some commentary which has been put in on 19th of April this year. It is a document which computer generates recording information originally on the database about Dr Patel but some comments were put in when these proceedings arose. They simply refer to the process of red flagging this particular candidate because of these matters.

COMMISSIONER: Yes.

MR THOMPSON: So the document could be confused, and that's why I have highlighted those parts which have been added-----

COMMISSIONER: Yes.

MR THOMPSON: ----- in April this year, but otherwise the information on that document, which is not highlighted, is information which was on the computer database from the outset. I think may have been supplemented during the discussion process but it is a sort of control document, as it were, concerning this candidate.

The second matter which I'll mention specifically, because it has been the subject of cross-examination, is that I directed Dr Bethell's attention in our discussions to the word "return" in the extract from an email which he had not previously noted or given me any instructions about. It's been flagged for the Commission's assistance. It's a discussion with Mr Kees Nydam on 20 December 2002 and the extract reads, "Relocation expenses. If he is coming for the year we would normally pay return" - that was the word that I brought to Dr Bethell's attention - "airfares economy for him and his spouse. If he came on his own I would be prepared to upgrade that to business class." That appears to be a telephone call between Mr Kees Nydam and Dr Bethell on 20 December.

COMMISSIONER: So in any event, it pre-dates the formal contract.

MR THOMPSON: There is no record as far as we can see of any such discussion with Dr Patel.

COMMISSIONER: Yes.

MR THOMPSON: It pre-dates the contract and there's no other reference in any of the material that I've now been through comprehensively

COMMISSIONER: All right. Has Mr Ashton seen that bundle yet?

MR THOMPSON: No, he hasn't. I'm reluctant for the documents to be distributed without them being copied first, because this is the sole copy.

COMMISSIONER: Yes, I understand. It seems to me, however, what we can do is let Mr Ashton look at them, perhaps put a post-it note on any that he wishes to have copied or wishes to tender - or were you proposing to tender the entire bundle?

MR THOMPSON: I'm content to tender the entire bundle.

COMMISSIONER: Why don't we do that and we might see if someone from the inquiry would be kind enough to arrange copies - probably about 10 copies - so that everyone can have a full set.

MR THOMPSON: Yes. The only difficulty will be that my yellow highlighting probably won't come out in the photocopying process.

COMMISSIONER: We'll have to live with that. Is that acceptable, Mr Ashton?

MR ASHTON: Yes, thanks, Commissioner.

COMMISSIONER: Is there something you'd like to go on with while that photocopying takes place? Because I had a few unrelated questions that I wanted to raise with Dr Bethell and I can do that-----

MR ASHTON: Commissioner, unless there's something arising specifically out of any of those documents, I have no more questions at all. I was concerned to establish what is his record.

COMMISSIONER: Yes.

MR ASHTON: Thanks.

MS McMILLAN: Mr Commissioner, I have some questions as well. I'm happy to fill up some space. They're obviously on an unrelated topic.

COMMISSIONER: Go ahead.

CROSS-EXAMINATION:

MS McMILLAN: I act for the Medical Board, just so that you're aware?-- Yes.

Exhibit 43, this was the email which there was an exchange with Dr Nydam on the 20th of December 2002. I'll just read you the two lines rather than bother with the whole document. "One minor issue of concern that I had was he has not worked for nearly a year. I'm not sure if the QMB" - which I think you agreed yesterday was the Queensland Medical Board?-- Yes.

"...might have an issue with this."?-- Yes.

That was in the email to Dr Nydam?-- That's correct.

Did you at any stage raise that matter with Dr Patel, that is, not working for a year might be an issue for the Board?-- I don't recall whether I raised that with him.

Would it be reasonable to assume that you may well have for this reason: your evidence yesterday was that Dr Patel, some time early in the New Year, unsolicited, sent you a second CV which you now know was altered in material respects, one of them being that he in fact worked until September 2002, not September 2001. So it in fact showed that he had worked for another year, and that, as you know, was the one that was forwarded to the Medical Board?-- Yes.

Correct?-- Correct.

Does that assist you at all to recollect whether you may have discussed that matter with Dr Patel?-- I don't believe it does for this reason: the second CV was actually requested by Suzy Tawse because it failed to mention - the original CV failed to mention his primary qualifications.

I see?-- In preparation for an application to the Board, Suzy asked Dr Patel to submit a CV which included his primary

qualifications. The original one doesn't have it.

COMMISSIONER: I think, Dr Bethell, you'd agree that what Ms McMillan is putting forward is at least a plausible hypothesis that it somehow came to Dr Patel's attention, possibly through you, that the Queensland Medical Board might be alarmed at the fact that he hadn't been working for 12 months-----?-- It is possible-----

-----or 18 months?-- -----yes.

And that then when he was invited to provide a further CV specifically for the Medical Board, he took the opportunity to falsify that CV with respect to his employment history so as to address that problem?-- That would make sense, yes.

I don't think anyone is suggesting - I'm sure Ms McMillan isn't - that you hinted to him that it would be helpful to change that detail. The suggestion is merely that possibly Dr Patel took it upon himself to falsify that information to get around a perceived problem with the Board?-- Yes.

MS McMILLAN: Yes, I'm not making any suggestion of impropriety.

COMMISSIONER: Of course.

WITNESS: If we had a full CV at the outset there'd be no need to go back to the candidate to ask them to add in their full history.

MS McMILLAN: The other matter I wanted to ask you about is if the missing attachment, which was the Certificate of Good Standing that obviously wasn't at any time annexed - if you had discovered that in a timely fashion, what steps, if any, would you have taken at that time about it?-- I would have immediately informed all parties involved. I would have informed the Medical Board, the client, and anyone else that was relevant in the process. We would have sought to withdraw the application in any case and it wouldn't have proceeded anyway. It's quite self-evident that that's the case.

Would you have considered yourself under a duty to do so?-- Absolutely, and I've done similar since.

You have?-- Yes.

I see. Have you taken those steps prior to the Dr Patel situation, or has that been since-----?-- I don't recall a circumstance previously. You must understand the volume of placements that we've made has increased rapidly over the last few years, and the range of different countries that we've brought doctors from has increased as well and that exposes us to practices that we weren't previously familiar with and it's increased our risk. Our overall systems and processes have been augmented to meet those challenges, and in circumstances where we've discovered candidates since, we've been very quick to bring that to the attention of our client in particular and

terminate the placement.

Okay. Given the Medical Board wasn't your client on that occasion, nonetheless you say you would have alerted the Medical Board had you discovered that?-- Yes, we maintain very open relationships with the Boards in line with the necessity to do so, given that we're all working towards the same end.

Thank you, Mr Commissioner.

COMMISSIONER: Thank you, Ms McMillan. Dr Bethell, I appreciate that you're really here to talk about your involvement in the recruitment of Dr Patel, but given your very considerable experience in the recruitment field, particularly with respect to medical practitioners, I wonder, subject to any objection from your counsel, whether I might take this opportunity to pick your brains on a couple of other things that are of interest to this inquiry, if that's all right with you?-- I have no objection.

All right. One of the things that we've been asked by the government - the Governor in Council to recommend upon is what can be done in Queensland to attract, to put it in very broad terms, a better calibre of medical practitioners. Is there anything, from your experience, that you can suggest Queensland is not doing at the moment which might assist in that regard?-- Well, I think the obvious one is the salary and addressing that issue, although I believe that that's an issue across Australia. However, I cannot think of specific examples, but I can certainly think in general of situations where candidates have been more interested in jobs in other states given the differential in salary.

One thing that has crossed our minds - and so no-one misunderstands me, this is far from being a concluded view, but it has emerged both from your evidence and the evidence of other witnesses that there's a category of overseas trained doctors which are quite different from the usual more senior doctors, and that consists of graduate medical practitioners from the United Kingdom and some other countries, Canada, New Zealand, possibly Ireland and South Africa, countries like that, who choose to come to Australia for a working holiday for a number of years at an early stage in their career, and we have heard, I think, that there is a significant number of doctors of that kind, particularly in Victoria. Are you aware of those details?-- Are you talking at a junior level?

At quite a junior level?-- I think in our experience Queensland would be the biggest employer of overseas trained doctors at the junior and middle grade level. In terms of the next, just on volume alone, I would imagine Victoria probably would be. Their processes are a little more straightforward. In New South Wales there tends not to be quite the demand as well. I think it has something to do with the number of graduates coming out of the medical schools.

Of course we Commissioners try very hard not to display any form of bias, but if I can show you one form of bias, I can't understand why anyone from overseas would want to work in Victoria if there was a choice of working in Queensland. Is Queensland Health or the Queensland government, as it were, selling Queensland as a destination for junior doctors coming from Commonwealth countries or the United States for those sort of working holidays?-- It's my understanding that overseas Queensland has a fairly healthy reputation, probably piggybacking off the back of a lot of tourist advertisements that take place around the world, and just as more of a holiday destination than other parts of Australia. So it's always been a popular destination amongst junior doctors.

The other thing that has passed through our minds is this: we've been told, again from a number of sources, that had Dr Patel come to Australia as a specialist rather than to fill a Senior Medical Officer position, he would have had to satisfy the requirements of the Australasian College of Surgeons?-- That's correct.

And that those requirements, at least at the time, were rather more rigorous than the requirements of some other bodies. That suggests, at least to my mind, that for any senior positions which are the equivalent of a position which you would expect to have filled by a specialist in Australia, it should be a requirement that the overseas trained doctor meet the appropriate college's conditions to practise as a specialist. In other words, if you're looking for a senior surgeon at Bundaberg, you don't fill the position with a Staff Medical Officer and then promote that person to Director of Surgery. You'd look for someone who qualifies as a specialist surgeon or a deemed specialist surgeon?-- Yes.

Would that sort of regime make it more difficult to fill vacancies in Queensland?-- Are you referring to the specialist credentialling process?

Yes?-- There's no doubt that the timelines and the amount of administration and paperwork deters some candidates, and an additional issue that deters some candidates, and potentially some clients, are the overall costs imposed by the colleges in terms of processing candidates. There's no guarantee with the costs that are put forward and paid for that service that the candidate will in fact be approved. So some clients demur at that point.

Mr Boddice raised with you again this morning something I touched on yesterday, and that is the recruitment of people to work as VMOs with some flexibility to earn additional income. Obviously that's most attractive in the context of advertising for Australian trained doctors rather than overseas trained doctors. You'd agree with that?-- I agree with that, although there is provision to employ overseas trained doctors with a degree of VMO rights and responsibilities through the District of Workforce Shortage.

Dealing firstly with the situation with Australian trained doctors, as I understand your evidence from yesterday, the usual, perhaps invariable, practice is that a client hospital won't come to you to seek to fill a vacancy with an overseas trained doctor until the position has been advertised in Australia and there have been no applicants?-- That's our normal experience.

But generally speaking, we would be talking about a situation where the position has been advertised in Australia as a Senior Medical Officer position or the equivalent and no-one in the Australian profession has shown an interest in taking on the position on that footing?-- As the Senior Medical Officer?

Yes?-- Yes, it would not be attractive to - and it would be inappropriate for someone with Australian specialist qualifications to apply for a job at that level.

Again something that just crosses our minds is whether it would be appropriate - and I guess I'm asking you and putting this question to you to take some of the bread out of your own mouth because it might reduce your company's income, but whether it should be a requirement that before offering a staff position overseas, Queensland Health authorities should at least explore the possibility of filling the position with a Visiting Medical Officer or even two or more Visiting Medical Officers between them, given the attractions which that may have for Australian trained specialists?-- I guess that's a matter of policy for Queensland Health, but by making it a more attractive offer, one would imagine that it would be more likely to attract local candidates and local applicants.

And similarly, if one is wishing to attract the very best candidates from overseas, those who would readily satisfy the requirements of the Australian colleges to get specialist registration, or at the very least deemed specialist registration, I guess that again offering the option of VMO positions in place of staff positions would be one way to make sure that the doctors who come to Queensland from overseas are the best doctors in the market?-- That would make it competitive and, as I said, the provision of District of Workforce Shortage to issue provider numbers on a listed basis to overseas trained doctors as VMOs.

Comparing Queensland with other states and, I guess, territories in Australia as well, do you know whether there are - whether it's the practice of any other state or territory to offer the sorts of positions we're talking about with the option of filling it with a VMO without private practice?-- Yes, we've filled such positions.

Are there any particular states which focus on using VMOs rather than staff officers?-- Certainly New South Wales and Victoria would be the ones that immediately spring to mind.

Mr Boddice, do you have anything arising out of those questions?

MR BODDICE: Not out of those, but out of the bundle there was something I wanted to raise.

COMMISSIONER: All right. We might come back to that when Mr Ashton is finished. Does anyone at all at the Bar table wish to raise anything arising out of my questions?

MR DIEHM: No, Commissioner.

COMMISSIONER: Thank you. Sir Llew?

D COMMISSIONER EDWARDS: No.

D COMMISSIONER VIDER: No, I'm right, thank you.

COMMISSIONER: Mr Ashton, I see that bundle has just arrived back. You will probably need a few minutes to look through it, will you?

MR ASHTON: Yes, Commissioner. I don't know how long, but I'll be as quick as I can. I don't mind doing it on my feet.

COMMISSIONER: That's fine. I'm quite happy to sit here quietly while you catch up.

MR ASHTON: Thank you.

MR BODDICE: Whilst we're sitting here quietly, could I raise a matter in relation to Dr Nydam who was to be the next witness?

COMMISSIONER: Yes.

MR BODDICE: It's really to seek an indulgence, if it's possible. Dr Nydam flew down from Bundaberg on Tuesday night because the indication was that we needed witnesses for Wednesday.

COMMISSIONER: Yes.

MR BODDICE: He's been here all day yesterday and today. Today, on my instructions, is in fact Show Day in Bundaberg, and he had been on leave this week hoping to spend some time with his wife when the children were still at school, but also with his children today. There are two witnesses that I've discussed with Mr Andrews that I understand will be available tomorrow morning to give evidence, and we have Dr Molloy, of course, this afternoon.

COMMISSIONER: Yes.

MR BODDICE: I'm wondering - Dr Nydam was booked to go back on a flight at four. Since he does live in Bundaberg and we're going to Bundaberg, I was wondering whether I could have an indulgence that he be allowed to go so he can go home to Bundaberg, and give evidence when we resume in Bundaberg.

COMMISSIONER: That makes a lot of sense, and I'm sorry that Dr Nydam has been put to that inconvenience. Obviously some of the witnesses this week have taken longer than we expected, and unfortunately Dr Nydam has borne the brunt of that. What you say is very sensible. Unless anyone seriously suggests we would finish Dr Nydam in time to let him catch his flight at 4 o'clock - and I don't think that's a realistic thought.

MR BODDICE: My is assessment is certainly not.

COMMISSIONER: Yes, all right. Now, we have Dr Lennox and-----

MR ANDREWS: Huxley.

COMMISSIONER: They're the two witnesses you mentioned.

MR BODDICE: Yes.

COMMISSIONER: They would both be available tomorrow.

MR BODDICE: On my instructions, yes, for tomorrow.

COMMISSIONER: Mr Andrews, if that's convenient with you, I do think, given that we have inconvenienced Dr Nydam to such an extent, it's only fair to make sure he catches his flight this afternoon and we'll see him in Bundaberg.

MR ANDREWS: Yes, Commissioner. That's satisfactory to me.

COMMISSIONER: Thank you for raising that, Mr Boddice.

MR BODDICE: Thank you very much.

COMMISSIONER: There are a couple of other things I might deal with during the lull in proceedings, which I hope won't interrupt Mr Ashton.

One is that through the good offices of counsel representing Queensland Health, the inquiry has received a copy of Dr Buckland, the Director General's memorandum to all Queensland Health staff which sets out in - you will forgive me for saying so - very clear, cogent and forthright terms the basis upon which all Queensland Health staff are not only authorised, but encouraged to provide their assistance both to this inquiry and to the Forster Review.

Given that there was earlier some mild criticism of Queensland Health in that regard, I think it's important that that document be received in evidence and marked as an exhibit. Is that acceptable, Mr Boddice?

MR BODDICE: Thank you, Commissioner.

COMMISSIONER: Mr Boddice, I hope you will pass on to Dr Buckland my thanks for the way in which he's dealt with that matter. It really is extremely satisfactory.

MR BODDICE: Yes, I will, Commissioner.

COMMISSIONER: The memorandum of the Director General of Queensland Health to all Queensland Health staff. The copy I have is dated the 31st of May 2004 and will be marked as Exhibit 49.

ADMITTED AND MARKED "EXHIBIT 49"

COMMISSIONER: The other thing I was going to canvas, because I think it's important for everyone to be aware of where we're going, is our expectation about the proceedings in Bundaberg. I think we'll be commencing at 9.30 on the Monday, the 20th of June, and we expect firstly to revisit those witnesses whose evidence is incomplete, which would consist of Nurse Hoffman, Dr Miach, and Mr Leck and Dr Keating. Is there anyone else that we need to complete?

MR ANDREWS: No, Commissioner.

MR ALLEN: Mr Messenger.

COMMISSIONER: And Mr Messenger. I'm sorry, that's right.

MR ANDREWS: I was absent for his evidence.

COMMISSIONER: Yes. That will give, Mr Diehm, those who instruct you, and those who instruct Mr Ashton two weeks to take final instructions from your respective clients and finalise their statements, if that's acceptable.

MR ASHTON: Thank you, Commissioner.

MR DIEHM: Yes, thank you, Commissioner.

COMMISSIONER: Following those witnesses, and possibly also Dr Nydam, I imagine there will be a number of witnesses who are giving evidence in their capacity either as patients or members of patients' families, and I think it's important to mention that because I realise that it will be an expensive exercise for the television networks to provide cameramen or people of that nature in Bundaberg, and those witnesses are unlikely to consent to having their evidence filmed or photographed.

So it may be that as the 20th of June approaches, the combined networks could approached the inquiry or counsel assisting to get a schedule of witnesses so that they're not put to any greater expense than necessary. Is that how you see it at the moment?

MR ANDREWS: Very practical, yes. That's how I anticipate the evidence will be.

COMMISSIONER: So it sounds like most of the first week in Bundaberg will be taken up with evidence that can be filmed, and by the second week we'll be turning over largely to evidence that will not be filmed, in practical terms.

MR ALLEN: Commissioner, there was discussion yesterday about whether in fact it may be four days in the first week and then a longer weekend and then four days in the second.

COMMISSIONER: What I had in mind is we will work the extended hours, including night shifts if necessary, Monday to Thursday of the first week, so that's from Monday, the 20th through to Thursday the 23rd, and then not sit on the Friday or the following Monday so that those returning to Brisbane have four days in which not only to catch up with their families, but to catch up with their paperwork and other commitments and so on.

The second week we will work Tuesday to Friday - I shouldn't say "work" because people will be working anyway, but sit Tuesday to Friday, and the third week sit Tuesday to Friday as well, so people will have a four day break after the first week and a three day break after the second week.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Does that suit everyone?

MR DIEHM: Yes, thank you.

COMMISSIONER: Mr Ashton, are we ready?

MR ASHTON: I shall be very brief, Commissioner.

COMMISSIONER: Thank you.

MR THOMPSON: Should I tender these first?

COMMISSIONER: Yes, certainly. I haven't seen them, of course.

MR THOMPSON: I did say, Mr Commissioner, that the last communication, I think, was dated 14 November. In fact there's a 2004 communication which I'll add to the bundle. I don't think it's particularly relevant. It may be relevant, Mr Commissioner. It refers to Dr Patel advising my client that he was making - or had made an application to FRACS.

COMMISSIONER: I don't think we've heard anything about that from any other source.

MR THOMPSON: I've highlighted on one copy at least both bits which were added to the control sheet, as it were.

COMMISSIONER: Yes.

MR THOMPSON: Could I also, for the record, record, Mr Commissioner, that we have not included in that bundle documents which are already exhibits.

COMMISSIONER: No, I understand. Now, just for descriptive purposes this bundle will be called Exhibit 50, and for the time being I will simply describe it as a bundle of documents from the records of Wavelength Consulting relating to Dr Jayant Patel and communications with various authorities in connection with Dr Patel. Is that a sufficient description for your purposes?

MR THOMPSON: Thank you, Mr Commissioner.

COMMISSIONER: That bundle will be Exhibit 50.

ADMITTED AND MARKED "EXHIBIT 50"

COMMISSIONER: Does Dr Bethell have a copy of those documents in the witness box to follow the questions?

MR THOMPSON: I'll give him mine.

COMMISSIONER: Thank you, Mr Thompson. Just for the record - because I've got one of the highlighted copies, but not all of them are - on the first page the material which was added in recent times consists of the status "red flag" and then the comments dated the 10th of April 2005 commencing with the words "red flagged because of undisclosed legal action" and so forth.

Yes, Mr Ashton?

MR ASHTON: Thank you, Commissioner. You have that bundle there before you now, doctor. Doctor, it's been mentioned, it's not - the bundle starts at - I can't find the date now, 12th of December 2002, is it? Yes, the front sheet or the candidate profile sheet to which the Commissioner was just referring, it's a bit hard - I don't think that's actually dated. The first E-mail is dated the 12th of December 2002?-- Sorry, can I just point out that it's dated under "Entered"?

Oh, is it?-- 15th of the 11th 2002.

So that would be the date on which this was created?-- That's the date that the candidate applies on line.

Thanks, doctor. And the last document is the one that we've just been supplied, I think, which is 15 September 2004?-- That's correct.

So that's the period of time we're covering. I have counted two phone calls made by you, doctor. Do you want to count them for yourself or do you want to accept my count?-- Can you point them out?

They're not numbered, are they, so it's probably just quicker if you go through them and find them, yourself, because I can't refer you to page numbers?-- This is the one pertaining to - on the 17th of the 12th.

I'm really interested in the numbers for the moment. If you just find how many there are, memoranda of your telephone calls. I found two. Sorry, can I just mention to you, doctor, when I say I found - I have identified two, I am not counting those which translate into forms that are reference checks?-- Oh, okay.

Apart from that-----?-- I found the two that I think you are referring to.

Now, please understand there's no criticism implied in this, it's very probable that you had more than two phone calls in this matter?-- In the initial phase, my initial contact with him and his placement and my hand-over to Ms Tawse, yes, it's likely that I made a number of phone calls.

It's very unlikely there weren't a considerable more than two in a period of two years?-- I'm sorry?

I shouldn't have introduced the other negative. It's very likely, are you agreeing with me, that you had considerably more than two phone calls?-- Post 30 December 2002 it's not likely that I would have made very many phone calls.

Not very many; certainly fewer than you would have at the front end?-- Yes, and potentially not.

But the fact is there are two recorded?-- There are two

recorded.

I have nothing else, thank you, Commissioner.

COMMISSIONER: Thank you. Mr Ashton, just in relation to that bundle, if you go through to the fourth page, you will see there's - the fourth page is really an E-mail from yourself to Dr Kees Nydam, but it incorporates an E-mail from Dr Patel to yourself; is that right? It's dated Friday the 13th of December?-- It incorporates some text from an E-mail that Dr Patel sent to me, yes.

I'm just intrigued by the second line of Dr Patel's note to yourself where he refers to a strong desire to accept the consulting position in Australia. I know that the word "consultant" has a very special meaning, for example, in UK hospitals where consultant is always a specialist?-- Yes.

Would you read that letter from Dr Patel as using the word "consulting" in the technical sense in meaning a specialist or in some other sense?-- In this sense, yes, if you recall he actually applied initially as a specialist.

Yes?-- But the position that we eventually put him forward to was very much a senior medical officer position.

And not a specialist position?-- And not a specialist position, but I believe he had been working as a specialist for at least 12 years in the United States, so I think he would probably refer to himself that way.

D COMMISSIONER VIDER: But yesterday, Dr Bethell, you were quite clear that Dr Patel understood the position he was being offered, that is, Senior Medical Officer Surgery?-- I don't recall that comment, but there's no doubt, given the written documentation, that the position was a senior medical officer position and he accepted and took up that position.

My point in asking that question is to clarify that Dr Patel did understand that, because the title suggests that he must practice with supervision?-- Yes.

And given where he was coming from-----?-- Yes.

-----he's quite entitled to take that position, but he would certainly need to know-----?-- Yes.

-----the definition by title in the State of Queensland and he would come here expecting to be supervised?-- There was reference to supervision in his contract - sorry, his letter of offer - sorry, the job description, and so there was-----

That job description says he would be responsible to the Director of Surgery?-- That's correct, yes.

And then he goes on and becomes the Director of Surgery?-- That happened after he started, yes.

COMMISSIONER: I guess, apart from anything else, if you had known that you were recruiting someone for a position as Director of Surgery you would have expected a higher fee, because your fees are based on a percentage of the salary?-- Well, that's a point that's not come out so far, but certainly if I was going to place someone as a specialist, a fee would be based on a Specialist's Award and on this occasion it wasn't, it was based on the SMO Award, and even though we heard he had been promoted to director we didn't pursue a higher fee.

D COMMISSIONER EDWARDS: Can I also ask, Commissioner, in the E-mail, just very quickly looking through of the 13th of the 12th you stated that there is no actual surgery and then you go over on the letter to you from Patel on the 13th of December, he says he expresses a strong desire to accept a consultant position in Australia and-----

COMMISSIONER: Sorry to interrupt you Sir Llew, I think there's some confusion because we've had included in this bundle correspondence relating to a different position that - for which Dr Patel was considered at Kaitair Hospital?-- Yeah, that's a small hospital in New Zealand, and my colleague Madeline had discussed that position with him.

D COMMISSIONER EDWARDS: I take that point, Commissioner, I missed that point, but then you also in the E-mail of the 13th of the 12th re the "passed on to John" it says "does not involve much surgery"?-- That pertains to the Kaitair position, I believe. Sorry, can you direct me to which page we're on? Is this the second page?

The letter - it's actually about the sixth page in of the bundle. Perhaps you should have more time to read them, but it seems as if - unless I'm getting completely confused over - without reading them deeply, but there seems to be an impression given to him that there would not be a great deal of surgery even in this position?-- I'm fairly convinced that's the Kaitair position.

You are convinced that's the case.

COMMISSIONER: Just so it's perfectly clear, the sixth page is the one headed "Candidate Trekking Profile: Patel Jayant. Status: Open. Date: 13th of the 12th 2002"; is that the page we're all looking at?

D COMMISSIONER EDWARDS: Commissioner, yes.

COMMISSIONER: Doctor, do you have that page open in front of you?-- Can you read the first line of the-----

It's the 6th page in the bundle?-- Right.

And the comments commence, "Thank you for the response. I am certainly a little hesitant about the position since it does not involve much surgery."

MR ANDREWS: It's the seventh page in my bundle, Commissioner.

COMMISSIONER: Sorry, you are right, I have to go back to kindergarten. It's page seven.

WITNESS: It's a little unclean, but in the same statement he goes on to say, "I'm very interested in the position in Australia."

COMMISSIONER: Yes?-- And I think he was referring to the Kaitair position which was at an even more senior level in New Zealand than an SMO position and more to do with being a surgical doctor working on the wards, but I - you know, I can't be absolutely certain.

To avoid any further confusion, if we go back to the second page, which canvases the Kaitair proposal-----?-- Yes.

-----Kaitair spelt K-A-I-T-A-I-R, that's dated the 12th of December?-- Yes.

Where he's offered a position in New Zealand?-- I have got that one in which it says there is no actual surgery.

Yes. And then there are several items of correspondence all dated the 13th of December, and just as they have come to us in this bundle one of those is the one that seems to relate to the Kaitair proposal, but that should probably be at an earlier stage in the bundle because it responds to-----?-- I think I have possibly cut and pasted that out after an E-mail that Madeline copied to me from Dr Patel and, therefore, states-----

MR THOMPSON: I think that emerges in the next pages.

WITNESS: Oh, yes, the next page is, in fact, the original E-mail. It is a copy of that original E-mail to Madeline pertaining to the - if it's to Madeline it's definitely about the Kaitair job.

COMMISSIONER: Sir Llew's understanding is perfectly understandable in that if you read the E-mails in order it looks as if he might have thought that there was not much surgery work at Bundaberg, but it's clear when you put them in the right chronological order-----?-- Yes.

-----that he was first offered New Zealand or first - that was the first proposal-----?-- Suggested to him, yes.

He wasn't interested in that because there wasn't much surgery, then he was told about Bundaberg and he was keen on Bundaberg because there was a lot of surgery?-- Yes, I think that's probably accurate. Mr Thompson, that's a fair summary, is it?

MR THOMPSON: Yes, I think that is.

COMMISSIONER: All right. Mr Boddice?

FURTHER CROSS-EXAMINATION:

MR BODDICE: Thank you. Just taking that last point up, Dr Bethell, if you can look at the second page which is the E-mail of the 12th of the 12th you will see down towards the bottom of the E-mail there's actually a reference by Madeline to the fact that you may have a position in Australia?-- That's correct.

So the E-mail of the 13th he's actually dealing with something which the E-mail of the 12th - where you raised about the position in New Zealand?-- Yes.

But that there had also been flagged the possibility of a position in Australia?-- That's correct, yes.

Can I just take you further into the bundle? If you go about five pages into the bundle you will see there's an E-mail from yourself to Dr Nydam of the 13th of December?-- That's correct.

Is that a summary of what you had been told in your discussions with Dr Patel as to why he was looking for overseas work?

COMMISSIONER: Sorry, there are several in December E-mails.

MR BODDICE: Oh, sorry.

COMMISSIONER: I think if you count from the beginning, even though my elementary maths is not good-----

MR BODDICE: Not including the cover sheet, we won't count the cover sheet, it's five pages in?-- That commences, "He's near retirement".

"He's near retirement"; is that the summary of what you had been told by Dr Patel as to his reasons for wanting to come-----?-- I believe so.

-----overseas? And then if you go another three pages on from that you will see there's a very short document headed "Candidate Tracking Profile"-----?-- Yes.

-----dated the 17th of December?-- Yes, I see that.

You will see there in the comments there's a reference to a wage, no mention of on-call, will get phone rental assistance, car, hotel for four weeks, airfares; so does that suggest there was a discussion about airfares at that early stage?-- Just looking at that, I - yes, it refers to Dr Patel, but I'm thinking it may have been on the basis of a conversation with Dr Nydam to withdraw that information in order to pass onto

Dr Patel.

So if it's a conversation with Dr Nydam it's still the fact that at that early stage there is a discussion about the payment of airfare?-- Yes.

Would that have been conveyed to Dr Patel?-- Possibly no more than is actually in that tracking record.

And then if we look at the next page which is comments from, it appears Dr Nydam because it has "from Kees"?-- Yes.

And the second paragraph "relocation expenses", if he is coming for the year would normally pay return airfares, economy for him and his wife, "if he came on his own I would be prepared to upgrade that to business class"?-- Yes.

So there was certainly a discussion with Dr Nydam about the payment of airfares?-- Just - I'd just like to clarify, I believe that this is, in fact, an E-mail from Dr Nydam rather than a transcript of a discussion that we had, just on the sort of completeness of the-----

So could you have, in effect, cut and pasted-----?-- Yes.

-----the E-mail?-- That's right.

Anyway, you were told by Dr Nydam that the position was a payment of the return airfare?-- This is the issue that was raised by me.

Yes. Now, would that have been passed onto Dr Patel?-- It's likely that I would have passed on that information, yes.

So it's likely that in the conversation with Dr Patel about the position you would have conveyed that the - if it's a one year position there would be payment of return airfares?-- That's a reasonable assumption on the basis of this.

Now, the next page is interesting, I want to take you to that because you will see there it actually refers to three names as referee details under comments and it has three telephone numbers in - there's Dr Singh, that is one of the people you spoke to, Dr Feldman is one of the people you spoke to, there's also a Dr Dentas, D-E-N-T-A-S?-- Yes.

Did you speak to him?-- I didn't. I normally ask for referees, for three phone numbers. I ask candidates for three phone numbers. Given we were ringing overseas, it's hard to track down referees. Our requirements for our procedures is to speak to two, and I'm satisfied after speaking to the two that I was concerned with there was nothing concerning.

So they were three names given to you by Dr Patel?-- Yes.

And you actually spoke to two of those three?-- Yes.

Was it just a random selection as to which you picked?-- Not

entirely. I felt that speaking to an anaesthetist that had worked in theatre with him and a surgeon that worked alongside him were more credible referees than - I believe Dr Dentas is a general physician and would have less direct experience and exposure to his practice.

Dr Bethell, the final matter was in relation to the copy of the E-mail which is the page before, if in fact Wavelength had been contacted in or about September 2003-----?-- Yes.

-----by somebody at Bundaberg Base Hospital with a query in relation to whether the issue of a payment of a return airfare had been part of the negotiations and it hasn't been referred to you, but a staff member goes back on file, they would in fact see that that was the case?-- I can see that that's in our notes and, yes, I overlooked that.

And, indeed, they could in those circumstances convey information to the effect that it was part of the negotiation?-- They could, yes.

Thank you.

COMMISSIONER: Although it's unlikely that anyone would convey that it was - there was a negotiation that there would be one return trip to the United States for each year of the contract because there's nothing there to suggest any negotiation?-- There's nothing to suggest that, no. I think the additional issue of whether it was business class or not, you know, there's no record of whether an actual business class flight was paid for in the first instance.

If you go - I'm sorry.

MR BODDICE: Just on that last point there is a reference to the fact if there's only one person coming, if Dr Patel is coming then the economy airfare would be upgraded to business class?-- I would be prepared to. I don't know whether that transpired, but surely the records say that.

Also is it the case that each contract is negotiated each year so if he stays is that a further contract?-- Well, his contract was a one year contract in the first instance.

Yes?-- And any onward negotiations would have happened between him and Bundaberg Hospital, and to my knowledge and understanding there were no involvement of Wavelength.

That's what I'm saying, your involvement was for the first year in terms of the negotiation?-- That's correct.

And in terms of a one year local contract?-- That's correct.

Thereafter anything in terms of a renewal of it would be a matter between the Bundaberg Base Hospital and Dr Patel?-- That's correct.

COMMISSIONER: If you can just go back two pages in the bundle

to the one that Mr Boddice asked you about with the comments showing a particular figure per fortnight. Do you have that page?-- Sorry, yes, I see that.

So that's - that - I think you agreed with Mr Boddice is most probably a record of something that Dr Kees Nydam told you about?-- Yes, yes, he was my point of contact at the time.

Then if you go forward four pages in the bundle you will see a - an E-mail of the 29th of December?-- Yes, I have that.

"Dear John" signed "J" in the top section?-- Yes, I have that.

And set out below that is the text of an E-mail from yourself to Dr Patel of the preceding day, the 21st of December, which was a Saturday?-- Yes.

And it says in the second paragraph of the text of your E-mail to Dr Patel, "Given the conditions outlined by Kees do you think you would be likely to accept"?-- Right, yes.

Does that suggest to you that you somehow passed onto Dr Patel either by E-mail or by telephone the information you received from Dr Nydam on the 17th of December?-- It seems to imply that he was in receipt of some details, but not the final draft - not the final contract.

So at some stage he may well have been told that his terms would include a certain amount per fortnight rental assistance, car, hotel for four weeks, airfare, and one year locum?-- Yes.

And he might also have been told that there was a possibility of a return economy airfare and a possibility of an upgrade to business class?-- It's possible, but I can't - I have no tangible evidence.

But all of those things are consistent with what's in the documentation?-- Yes.

But what is clear is that after he was told any of those things he was given a formal contractual document which says what it says about airfares?-- Yes, yes.

And to your knowledge that was never then revisited, no-one went back and said even though the document talks about a flight from the US to Bundaberg it's been agreed that Dr Patel will have a return flight?-- To my knowledge that didn't take place.

Anything arising out of that? Mr Thompson, any re-examination?

MR THOMPSON: Just one matter.

RE-EXAMINATION:

MR THOMPSON: If I can take up the point that you were dealing with, Mr Commissioner, that E-mail which the Commissioner took you to of Saturday the 21st of December, which refers to "given conditions outlined by Kees"?-- Yes.

By the 21st of December had there been discussions directly between Dr Patel and Dr Nydam?-- Given the record in our database that an interview reminder was to take place on the 17th of December 2002, I would imagine that the conversation took place some time between the 17th and the 20th.

Thank you.

COMMISSIONER: Thank you, Mr Thompson. Mr Morzone?

MR MORZONE: Very briefly.

RE-EXAMINATION:

MR MORZONE: Dr Bethell, during the time that you refer to involving Suzy Tawse, what was her position at that time, that is through to the end of 2003?-- She was providing administrative support to the two directors of the company who had been consulting Claire Ponsford and myself.

Now, could I show you an exhibit to the statement of Mr - Dr Nydam and, in particular, it's Exhibit KN4, and this hasn't been tendered as yet, but it is a copy of - the first two pages of that Wavelength reference check which we identified as having a facsimile number along the bottom, and I think your evidence was that probably you had sent that to Dr Nydam; is that correct?-- That's right.

That document that's been exhibited to Dr Nydam's statement which has just been prepared recently has more pages to that exhibit, as well, and it seems to include all the references; is that correct? Can you just check for me? If you just follow on from the reference check?-- You are talking about the two "it may concern references" or-----

Yes.

COMMISSIONER: What you described as the open references?-- The open references, yes.

MR MORZONE: Is it correct that they all seem to be part of that E-mail that went with those two reference checks to somebody?-- That's true, yes, it does.

I think in your statement you have only got the two pages of that E-mail rather than the complete one that we now see in that document?-- In my statement I was only aware of discussion. I had no record of this fax having been sent, so I could only really attest to the two verbal references that I felt that I would in normal practice have discussed with Dr Nydam. I was unaware that I faxed these, although I'm pleased that I did.

That's come from Queensland Health and I just want to clarify, in fairness to everyone, that that looks like the fax did include those other references?-- It looks like it, yes.

And the only other thing I might ask you that arises out of that bundle of E-mails is if you go to the E-mail which is, I think the 10th document in and it's the E-mail or an extract of E-mail from Dr Nydam dated the 10th of December 2002 to yourself and you've been drawn - your attention has been referred to it because it referred to airfares?-- Yes.

Could I ask you also to look at the last paragraph where there's reference to "payment in the first instance would be as an SMO". It seems to suggest that there might have been some payment at a later date on a different basis. Do you have any recollection about that?-- No, I don't, but given that Dr Patel subsequently made - appears to have made an application to the College of Surgeons there may be some relevance to that.

Yes, thank you Mr Commissioner.

COMMISSIONER: I am just thinking about that last point. The suggestion, Mr Morzone, is that when the words say "payment in the first instance will be an SMO" that might, perhaps, be interpreted as meaning that from as early as December 2002 Dr Nydam was contemplating that Dr Patel would be promoted to something other than an SMO.

MR MORZONE: It does, yes.

COMMISSIONER: I should ask whether anyone has any questions regarding that aspect? It hadn't occurred to me, but it's a valid point?

MR BODDICE: Just one, I suppose, in relation to that.

COMMISSIONER: Yes.

FURTHER CROSS-EXAMINATION:

MR BODDICE: This is the same E-mail, Dr Bethell, the paragraph before "Expenses For Goods and Shackles" is dependant on how long he was prepared to stay and what he was wanting to bring over. Now, the other E-mails indicated that

Dr Patel was looking for an overseas position and may stay longer than one year?-- Yes.

And there's that paragraph there talking about, well, relocation expenses would depend on how long he's prepared to stay. Would it equally be open that "payment in the first instance will be as an SMO", is that when he first comes but obviously if he chooses to stay longer the matter can be - will be renegotiated?-- It could mean that, yes.

COMMISSIONER: I know I have, perhaps, inappropriately used the expression "bonded slave" once or twice, but I suspect "goods and shackles" is meant to read "goods and chattels".

MR BODDICE: I'm sure.

COMMISSIONER: Thank you so much for coming up from Sydney to give evidence. We thoroughly appreciate your assistance. It has been tremendously helpful to the inquiry, both in relation to your recollection of the relevant events and the documentation, but also the assistance you have provided to us about the resolution of some of these issues, and I am especially grateful that you have provided that assistance in a way that may be contrary to your own personal professional interests which, at least, demonstrates the sincerity of the evidence you have given. You are excused from any further attendance and you leave with our very sincere thanks and gratitude.

WITNESS EXCUSED.

COMMISSIONER: Mr Thompson, you and your instructing solicitor are also excused from further attendance. You are welcome to come back at any time, particularly if you wish to make submissions, but you also might find out about those other two witnesses and liaise with Mr Andrews.

MR THOMPSON: We will attend to that and we will inform the Commission of how we proceed.

COMMISSIONER: Given that we're not going to start with Dr Kees Nydam this afternoon, I suggest - I imagine that means we have nothing further until 4.30 when Dr Molloy returns.

MR ANDREWS: It is possible that Mr Atkinson might have a witness who could be available at short notice, but I would have to take his instructions as to whether the witness is - I see the witness is here. It's a question of whether it's convenient to put him in to evidence.

COMMISSIONER: Oh, I see. Yes, I think - given if you and I are thinking along the same lines, I think given the nature of that witness it's probably better that everyone be given an opportunity to prepare for cross-examination if they think

appropriate.

MR ANDREWS: In the circumstances there is no witness to proceed with until Dr Molloy gives evidence this afternoon.

COMMISSIONER: We will adjourn now. We might - well, the Deputy Commissioners and I will be available from 4 o'clock onwards in case Dr Molloy arrives earlier, but - and if everyone is here we will resume early, but otherwise we're adjourned until 4.30.

MR ANDREWS: Thank you.

THE COMMISSION ADJOURNED AT 1.30 P.M. TILL 4.30 P.M.

THE COMMISSION RESUMED AT 4.27 P.M.

COMMISSIONER: I know that we're a couple of minutes early but I wanted to use up the time, before Dr Molloy is here, to raise another matter. I am apologetic that each session of this proceedings seems to involve a little statement from the Bench, but these things do come to our attention and, consistently with my views about openness and transparency, I feel that the best way to deal with them is from the Bench.

Journalists from a number of news organisations have been in touch with the Secretary during the course of the morning inquiring about a story which has been in the press over the last 48 or 72 hours concerning the Premier and his visit to Bundaberg on 12 September 2000, or, as one version gives it, 5 September 2000, and the question has been asked whether we propose to have the Premier come and give evidence in these proceedings. The Premier has provided to me a complete dossier of the material which his office holds relevant to that issue.

Having perused that material, it seems to me that the important fact, and probably the only important fact, is that a series of problems at Bundaberg were brought to the attention of the government through the Premier in September of 2000. Complaints were raised about poor leadership at corporate district and local level; the recent retirement of three directors, including a situation with one of them being suspended, or resigned, or placed on study leave; issues in relation to Mental Health Unit; lack of consultation; failure to have replacements available for senior staff who go on leave; complaints about the human resources management arrangements; complaints about the zonal system of regionalisation; complaints about harassment of union office bearers; complaints about workplace bullying; and a request for a full independent judicial inquiry.

The fact that those matters were raised with the Premier at that time is a matter of public record and I don't see that it would be a useful purpose to trouble the Chief Executive of the State Government to come here simply to tell us things that are already well-known on the public record.

The only issue of any factual controversy appears, from the material which has been provided to us, to be a question of whether the Premier agreed, as one version would put it, to conduct an investigation, or to have one of his staff do so, or whether he merely arranged for one of his staff to take notes of the complaints that were made for the purpose of referring them to relevant departmental and other people to deal with.

Again, I can't see that the resolution of that factual dispute will assist anyone in these proceedings. It doesn't go to the employment of overseas-trained doctors at Bundaberg, it doesn't go to the essential questions relating to Dr Patel or

the standard of clinical services provided at Bundaberg, and it doesn't go to the broader Terms of Reference that we're asked to consider.

Having said all of that, if anyone involved in these proceedings - Mr Allen, Ms Kelly or anyone else - wishes to advance a proposition that there is some issue within the Terms of Reference which would justify inviting the Premier to come and give evidence, I have no reluctance in doing that, and, indeed, I would be prepared, if satisfied that there is a need for his evidence, to issue a summons for that purpose. As things stand, I am not satisfied that there is any need or, indeed, any benefit in pursuing that course.

There is, obviously, an area of political controversy involved in all of this, in that there are those on the other side of politics who wish to contend that the Premier or the government failed to act either quickly enough or with sufficient flexibility and dollars to address the problems which were brought to the Premier's attention in September 2000. That is a political issue and I am content to leave that political issue to be debated in political forums amongst professional politicians rather than attempting to have that matter addressed in this forum. As I have said, though, if anyone wishes to urge the position that the issues that arose in September 2000, or the Premier's recollection of them, or, indeed, any other individual's recollection of those meetings has any bearing on the Terms of Reference of this inquiry, I am happy to consider those submissions and take the appropriate course. I am not inviting those submissions now, I am simply foreshadowing that if anyone wishes to pursue that course, they will be given the opportunity to do so.

I see now that Dr Molloy is here, so we might invite him to come back to the witness-box and resume his evidence. In the meantime I will ask the secretary to mark as Exhibit 52 the bundle of material provided to the inquiry by The Honourable Premier of Queensland under cover of his letter of 2 June 2005, which will, of course, include that covering letter.

ADMITTED AND MARKED "EXHIBIT 52"

DAVID MOLLOY, CONTINUING:

COMMISSIONER: Dr Molloy, I will remind you you took, I think, an oath on Tuesday afternoon and you are still bound by that oath?-- Commissioner.

At the completion of proceedings on Tuesday afternoon, my recollection is that both counsel assisting, Mr Andrews, and counsel for the AMA - where is he - Mr Tait - in any event, it is usually not hard to spot Mr Tait in a crowd - but Mr Tait

had finished their evidence-in-chief. I was simply asking, Mr Tait-----

MR TAIT: I am sorry.

COMMISSIONER: Not at all. I was simply asking whether there is any further evidence-in-chief that either you or Mr Andrews wishes to lead before Dr Molloy is made available for cross-examination?

MR TAIT: The only matter involved the evidence of Mr O'Dempsey about the disciplinary regime and reporting to the Medical Board which was covered in his evidence. Dr Molloy has some views about that which I anticipate somebody will raise.

COMMISSIONER: Well, perhaps it is easiest if you do so.

MR TAIT: Yes.

COMMISSIONER: Then it is, as it were, on the table and everyone else can consider whether they want to cross-examine on that issue.

MR TAIT: Thank you, Commissioner.

FURTHER EXAMINATION-IN-CHIEF:

MR TAIT: Dr Molloy, you are familiar with the evidence Mr O'Dempsey gave?-- Yes.

Do you have any comments on that from a practical point of view?-- Yes, Commissioner. I felt it may be helpful, in that in the transcripts and evidence that I have seen so far, I am not sure that anyone has really explained to the Commission and put as a matter of evidence how medical standards are maintained, particularly in specialist practice in Australia.

COMMISSIONER: Certainly?-- And I felt that the drift of Mr O'Dempsey's evidence was possibly alarming, from the medical profession's point of view, in that there seems to be some confusion about the role of the Medical Board in the maintenance of standards and the true maintenance of standards in the Australian medical community.

Well, Dr Molloy, I don't mean this as criticism, but rather than advancing your views as a challenge to those put forward by Mr O'Dempsey, why don't you simply tell us what your views or your association's views as to dealing with those matters?-- That's perfectly reasonable. Look, medical standards are maintained in Australia in specialist practice mostly by the specialty colleges. The specialty colleges administer accredited training posts, they check the Registrars in terms of logbooks, reports, recurrent

examinations, and then when the Registrars have completed a number of exams at different stages through their training, they are awarded a Fellowship of the college. After they are awarded a Fellowship of the college, they will be then registered as a specialist in the State of Queensland, and then the colleges will nearly always have continuing medical education programs and reaccreditation, usually on something like a three-to-five-yearly basis based on the number of courses, educational activities and quality assurance activities that the doctor does. Colleges also have a role in the maintenance of standards, in that complaints about professional standards can be made to colleges, and colleges do set up panels of review to assess the competence of their members. Colleges are also closely involved in health complaints units. They're involved in terms of providing the Medical Board with advice. They are also involved, of course, you know, at the right top end of the scale when someone may be - unfortunately civil action is taken against a doctor who maintains an error. Also, importantly, hospital accreditation committees - because very, very few specialists work solely out of their rooms or their offices; they nearly always are admitting patients - and that is the - the hospital accreditation committees have a very important role in assessing the work of specialists, and if problems are seen with individual specialists in the private practice sector, then hospital accreditation may be withdrawn or modified in consultation with the college. And it is not rare for colleges to set up panels of review and ask doctors, for example, to attend certain courses, have their work mentored, stop doing something till they go away and have their skills assessed, perhaps at an interstate level. So that is a whole different set of standards maintenance that is quite different from what the Medical Board does, and what the Medical Board does - and I don't mean this by way of rebuttal - the Medical Board has a legislative role in the maintenance of standards. In other words, they have a line and they say, "The standard of this doctor, is it above the line and, therefore, suitable for registration, or is it below the line and then that doctor is not suitable for registration." But the nuances of standards and the real maintenance of standards rests with the colleges.

In a sense, the line you are speaking of is almost the lowest common denominator; is this particular person of a sufficient standard to practise as a doctor at any level in Queensland, whereas the colleges are concerned about higher levels of skill and specialisation?-- That's correct, Commissioner, and therefore moves that might therefore take the maintenance of standards away from colleges will probably lead to a reduction in standards, and, you know, the real point, of course, of this inquiry is the fact that all of the things that maintain the standards of Australian medicine were in fact bypassed in this particular situation, and that simply making government, through the Medical Board, an arbitrator of standards is likely to lead to a reduction rather than an increase in standards or the maintenance of the high quality of standards that we have.

Dr Molloy, I am not sure that there is any inconsistency between what you have just said and the evidence from Mr O'Dempsey. Indeed, from my memory it was Mr O'Dempsey who said that there was a possible suspicion that Dr Patel had chosen not to seek registration as a specialist because it was well-known that a more rigorous process would need to be gone through in order to get such approval from the appropriate college?-- Yes, I think it was really more the views that perhaps compulsory - you know, there may be - introduce a regime of compulsory reporting of levels of competence to the Medical Board and the Medical Board, with its limited resources and its narrowly defined view of competence, may therefore become an arbitrator of standards of compulsory reporting of adverse incidents. And that's of great concern to us because on the one hand, you know, we accept the need to look at adverse incidents, but there are actually risk management programs coming through the system where we're going to look at compulsory reporting of adverse outcomes in a similar way to airline pilots. And if, as is suggested in yesterday's transcript, there may be a series of systems of compulsory report of adverse incidents to the Medical Board which may or may not be complications for investigation, almost certainly that will cut across risk management, if there is a reporting to a disciplinary board as opposed to an investigatory board charged with the management of patients - sorry, the management of standards and risk management in the medical profession.

Well, the evidence that you refer to - and I think it would be fair if you cast your blame on me rather than Mr O'Dempsey because I raised with him an idea that has been canvassed between myself and the two Deputies, and that is whether there would be some merit in having a one-stop shop for medical complaints, and we tentatively suggested the title of a medical ombudsman on the basis that that office would then relay the complaint to the appropriate authority to deal with it. And for the moment I can't see why the appropriate authorities would not include specialist colleges where that is the appropriate body to investigate a situation where a doctor doesn't necessarily fall below the line that you have described for medical practitioners generally, but does fall below the line for an appropriate specialist?-- Commissioner, it has been a hard week. I have taken everyone on, from the Premier down. I have no intention of laying any blame on you at all. But, look, may I say, I think that's worthy of further investigation and I think the way that we manage adverse incidents in the total context of everything, from risk management, which is an enormously beneficial program for patients and for the community, through to the disciplining of the truly aberrant doctors, has to be teased out. And that concept is - you know, that suggestion is an important one. I just wanted to draw to your attention that in the total context of everything we're trying to do to raise and maintain standards, it has to be seen in a broader context and I thought I should draw that to your attention.

I appreciate that. Can I ask you - you have said it is an idea worth consideration - do you or your organisation have

any views as to the desirability of avoiding some of the confusion that presently exists as to whether a complaint should go, for example, to Queensland Health or to the Medical Board or to the Health Rights Commission in having some sort of one-stop shop system?-- There may be. The question is what sort of complaint is it? You know, I firmly believe that the first portal of entry of any complaint should be back to the doctor in the unit concerned.

Yes?-- You know, I don't - I think almost every complaint other than complaints obviously of - I don't know the correct term - but, you know, for example, patients that may be, for example, sexually interfered with, or criminally assaulted by a doctor. Obviously that's not the correct portal, but complaints of a clinical nature should be addressed first of all to the clinical service so that they can be - you know, any competent caring doctor or nurse should have the opportunity to engage that patient, explain the nature of what has happened, and my understanding from all the risk management talks that I attend with my medical defence organisations and things is that something like 80 to 90 per cent of those issues will be resolved by appropriate communication, honest explanation to the patient, a laying open of charts, the reports and things so that patient understands the nature of what has happened to them. So I think the first portal of any complaint in the health system should be back to the practitioners and the hospital units involved in that complaint to see if it can be resolved in an honest and open way with that patient.

I raise two points with you about that, Dr Molloy. One is in these proceedings we're primarily concerned with the public sector rather than the private sector, and that may make a difference. The other thing that emerges clearly from the evidence in these proceedings is that complaints raised by, for example, nurse Hoffman through what might be regarded as the proper channels, went unheeded and that's why we're at least interested in the idea of having a central complaint office, not necessarily to investigate complaints or even necessarily to refer them on, but as a monitoring process, so that if a patient complains to the clinical unit or to the hospital, or to the doctor's surgery, or whatever, there is someone monitoring that. So that within a particular period of time, let's say 45 days, for the sake of discussion, that unit has to be informed whether the complaint has been dealt with, how it has been dealt with and what the outcome is. I share your confidence that the great majority of cases, 80 or 90 per cent of them, will be satisfactorily dealt with at the clinical level, but it is the 10 or 20 per cent that we have to worry about, and it is that 10 or 20 per cent where people need to know a number of things. They need to know that if they are not listened to, there is a public authority which will push the barrow on their behalf and they need to know that there is a straightforward way of escalating their concerns if they are not properly addressed at the hospital or clinical level, and that's why we see some merit in having a central office, a one-stop shop that deals with all complaints, at least to the stage of ensuring that they're

dealt with at the appropriate point, whatever that is, and escalating them if they are not adequately addressed?-- I think that's very fair, Commissioner, in that - but just - I guess, first of all, the difference between the private and public sector, I am not sure there needs to be a difference. You know, a bad clinic - I guess I am drawing the distinction between a patient complaint, which form the majority in the system, and a systemic complaint of the nature of Ms Hoffman's. If we go back to patient complaints, I still believe that they should be dealt with first at source.

Yes?-- I understand the problem that Ms Hoffman had, and that was a systemic complaint of someone working within the system who didn't get satisfaction from her line managers and that's, I guess - that's a different situation from a complaints mechanism from a patient that has an unresolved issue.

I think the other thing we've got to be realistic about is that having in place the sort of health sector ombudsman that we're postulating won't prevent people from raising issues at hospital level, and I think for the moment the example of the banks, where there is now a banking industry ombudsman, that doesn't eat away from the fact that probably 99 per cent of banking complaints are dealt with by the customer speaking to their local manager, or even the teller and getting it resolved, but it is a huge comfort for banking customers to know that there is a central source to which they can make complaints if they don't receive satisfaction at branch level. And comparing the provision of medical services with the provision of banking services perhaps isn't a fair comparison, but I am inclined to think that even if there were such an ombudsman, the great majority of patients would raise their concern at local level in the first instance?-- Yes, I do think that's very important in terms of our resourcing the system. I would - the issue of how complaints are conducted in fairness of those complaints is very important to people working in the system. Now, I really do understand the difficulty in how we've ended in this Commission with complaint systems that have gone awry-----

Yes?-- -----but the resourcing of the health sector, in fairness to people who are working in the health sector and the consumers of health services, it is very important that the balance of complaints is maintained, because on one hand we have got to have nurses and doctors who can work in the system without the fear of a big brother looking over their shoulder - and that applies to all the health professionals working in that sector - and on the other hand we have got to protect, very importantly, patient rights and make sure that patients have due redress through the system. And achieving that balance is sometimes, you know, very, very difficult. So, you know, one of the defining things why I left the public sector to become - I resigned my full VMO visiting post for several reasons - but one of them was the fact that at the time, the Health Rights Commission - which I support completely in concept; I think they do a very, very good job - was being set up at that time, and all through the Royal Brisbane Hospital there were signs put up in the clinics,

"Have you got any complaints? Call the Health Rights Commission direct.", not, "If you are not satisfied with your - with the complaint being" - and there was even stuff, "Have you been kept waiting? Call the Health Rights Commission direct.", not, "Go to the nurse in charge of the clinic and complain about the fact we have kept you waiting and we will see what we can do about it." To me, and the other doctors working there at the time, that was a very offensive thing for the Royal Brisbane Hospital to do, to actually put us in with the Health Rights Commission without ever having the chance to resolve an issue in a local level.

To have the HRC, in effect, the portal for complaints rather than the last resort?-- That's right. Even the second resort. I would have been happy with the second resort. I just think - you know, there are many other doctors who were very offended by those signs at the time, so I just would like to share with you, while putting on record I think the HRC, with the model we have in Queensland which mirrors the Victorian model, is an extremely good organisation.

If I can move you back just one step, I suggested to you there is a difference between public and private sector, and I think you quibbled with that. Let me tell you why I feel there is a difference and you can explain then why you disagree with me. You mentioned the various checks that were in place to protect standards within the profession - particularly amongst specialists. My impression is that there is one other check, so far as applies to private specialists, and that is that private specialists, under the Medicare system, only get work from GPs. That's the only way the ordinary patient ever gets to see a private specialist. That seems to me to have a bit of an analogy, some analogy with my own profession in the sense that people don't get to see a barrister unless they have been through a solicitor. What it means is that barristers don't get work unless solicitors, who are themselves qualified professionals, are satisfied that the barrister is of a reasonable standard of competence. Similarly, if a private specialist is not maintaining a reasonable standard of competence, the GPs will simply stop referring the work. I think that's one reason why there is a difference. The other reason why I think there is a big difference is that patients do have a choice. The difficulty at Bundaberg, or one of the difficulties at Bundaberg is that the patients who went under Dr Patel's knife simply didn't have the option of saying, "We don't want Dr Patel, we want someone else.", whereas in the private health sector there is that choice. And that's why I think we find ourselves in the situation where there are complaints about public sector practitioners that simply have not arisen in relation to private sector practitioners like yourself. That's why I think we've got to be very astute in looking at an appropriate complaints system, particularly taking into account problems in the public sector?-- Yes. I think those are very good points, Commissioner. I - it may be appropriate in your - in forming your views to get some advice from perhaps senior administrators in the public sector who, you know - in talking to them over the years, I know that they do spend quite a lot

of their time untangling complaints directly into the hospital, and I am surprised - you know, one of the things that I don't know - I don't know if the Commission of Inquiry has done this, and certainly I haven't seen it in any of the submissions so far, but I am not - I would be interested to look at the complaint profile against Dr Patel to the administration of Bundaberg Hospital because I know when I have spoken to administrators at other big hospitals, they do spend a lot of time sort of investigating and appropriately dealing with complaints at hospital level.

The other thing I feel that I have to raise with you, since you have referred to the undoubtedly very good work that the colleges do in maintaining high standards amongst specialists, is the suggestion that one hears and sees in many quarters, that whilst that may be true in relation to the colleges, they have also created a cartel, which is at least partly to blame for the shortage of Australian trained specialists available in the country. I know you are not here to represent the interests of the colleges as such, but what would you say to the suggestion that the colleges have themselves to blame for the fact that there are shortages in the various specialties?-- Well, I'm - I'm always glad of an opportunity to clear up that urban myth, Commissioner. This - it is an argument that I believe has no validity. Look, what has initially caused the work shortage has been the reduction in medical school numbers. Now, every medical student that comes out as an intern has been placed - for the last decade has been placed in a job in a Registrar's job in a college or by a college. No-one has missed out and there are very, very few vacant posts. The colleges do not get to control the number of training posts directly. Now, what they do is that when you create a training post, the college has minimum requirements in terms of the number of specialists that can teach that Registrar and the amount of work that's flowing through that hospital, clinic or unit, and the - when the supervision levels drop or when the work goes down, the college may de-accredit a training post. When the government goes up, they can ask the government whether they can fund a training post. At the end of the day, the number of training posts in Australia is determined by the amount of funding the States Governments will put into creating Registrar posts in the public sector. That's for specialists. And for general practices, the number of accredited training posts is fairly strongly controlled by the Federal government, by the provision of interim item numbers. Now, you know, the colleges will tick or cross off a post based on, you know, a strict formula of numbers. But, you know, this idea that the colleges are trying to create a cartel really has no basis in fact. We can't actually - you know, it is just - I have never seen or never been to a college meeting where they talk about reducing the number of training posts to protect jobs. It just doesn't happen.

Well, people would say to you - and actually I think it is a fair question to ask - why is it then that even in the private sector, let alone the public sector, it takes six or 12 months to get an appointment with a dermatologist? Why is it that

that college simply isn't admitting enough practitioners so that there are sufficient to cover the State?-- But in the balance of all the specialties, I mean, we need more GPs. I mean, all of the training posts are filled nearly all of the time by the number of graduates that are coming out of medical school. I mean in a mathematical sense-----

You can't have more than 100 per cent?-- Exactly right. The surgical college, for example, is trying to create more training posts. I've been recently at a very high level meeting with Dr Russell Stitz, the President - the Australian President of the Royal Australasian College of Surgeons, where he was begging the Health Minister for funding for more advanced surgical training posts. See, you know, every Registrar you employ costs $100,000 in oncosts - in salary and oncosts, but they also have to work. It's no point in having an advanced surgical registrar, even junior ones sitting around just doing a few clinics. You need the number of operating theatres. The problem is it's going backwards. We're eating our young. Over at the Royal Brisbane Hospital with one-third of the operating theatres not working, three subsections of the College of Surgeons are looking at whether accreditation for Royal Brisbane Hospital will continue to train surgeons, and it's simply based on the mix of operating that is now being done there and the numbers. The registrars are just not getting enough training at the biggest hospital in the southern hemisphere.

We can't fix up what's gone wrong in the past, but there are increasing numbers of students coming out of the medical schools over the next few years. Are the positions in place to accommodate that increased number of students and to give them the necessary specialist training?-- No, they're not. Our organisations and the colleges have had a series of preliminary meetings - that's not true - have had a series of meetings - not preliminary meetings - with Queensland Health. There is every intention at a political level and a departmental level in Queensland Health to have enough funding in place and enough posts in place to be able to give everybody an intern year with the increased output from James Cook University, from Griffith and eventually Bond. But, you know, in all the meetings - this is an area that I would be happy, perhaps, to be corrected on if more information comes to light. I'm not aware that people have thought really beyond the intern year to give all of these extra doctors two residency years and then a guaranteed entry to a funded registrar post. I just don't believe that level of planning is in place yet.

D COMMISSIONER EDWARDS: Wouldn't it be fair to say that those medical schools will not be producing any graduates for four to six years from now? They're just starting to enter now and next year?-- Yes. JCU come online next year.

They're only a small number?-- That's 70. Yes, that's right. Then-----

COMMISSIONER: Seventy is a 25 per cent increase in output?-- There's been an increase in the number of places at UQ. It's now gone from 240 to 300. So in fact we've got 130 coming online within the next two years.

From 240 to 370?-- Yes.

An actual 50 per cent increase in the output of doctors?-- That's correct, and then Griffith is about another 65 and Bond's another 70.

When are they likely to come online?-- Bond will be four years and Griffith will be another four years.

But your understanding is that the registrar positions and training positions beyond the intern year simply aren't in place at the moment?-- No, they're not. Now, having said that, I think there is every intention of trying to create more, but if we can hark back to Bundaberg for a moment, I've been talking to more of the surgeons that worked in Bundaberg. Nine years ago in Bundaberg, Bundaberg had a Director of Surgery who was Australian trained - this is an extension of what I told you on Tuesday.

Yes?-- Nine years ago Bundaberg had a Director of Surgery and a staff surgeon, both of whom were Australian trained. They had a Senior Registrar in Surgery, which was an advanced training post for the college, and they also had a Junior Registrar which was an accredited registrar post. So they were training two surgeons under the auspices of the Royal Australasian College. Now, the college can give no bigger tick to the quality of the Surgery Department of a hospital than to accredit it for a training post. That's the ultimate tick of quality from the college. As the administration - I'm going to be deliberately controversial - destroyed the surgical service at Bundaberg over the last eight or nine years, we lost all of those staff surgeons, and because the staff surgeons went and were replaced by SMOs, the college de-accredited both training posts at Bundaberg. Now, you know, you couldn't have Dr Patel teaching registrars. So in the blame game, the government could turn around and say to the college, "Well, you took away the training posts at Bundaberg, you terrible cartel people", but it was the destruction of the Surgical Department that forced the college to step in and say, "There's no-one left to teach surgeons here."

I suppose that takes us on to another issue. You've described the process that the colleges go through in accrediting Australian trained specialists, but as I understand from Mr O'Dempsey's evidence that the colleges also have a responsibility for some role in giving either full accreditation or deemed accreditation to overseas trained specialists. Are you in a position to assist us with how that process operates?-- Only in the most superficial sense, Commissioner. Basically there may be a designated person within the college - in my own college I know in Melbourne that it was done mainly by one of the junior vice presidents or the secretary of the college, but some of the colleges have proper committees to do that, and basically they look at the basic specialist degree of the applicant, then they look at their CVs and they look at the mix of work that they've done both as a training registrar and since they've graduated as a fully qualified specialist, and they look to try and assess - there's basically a test of equivalence which has a level of

subjectivity in terms of saying, "Well, this person has either been trained to or has been working at the same level of competence in a similar environment that we would expect a specialist in Australia to be working."

Well, you've said something that you described as being deliberately controversial. Without going so far as to admit that I'm being deliberately controversial, could I raise with you one possibility that we may consider - and I won't put it any higher than that. Where there is a suspicion that a cartel or a monopoly exists, the easiest way to explode that suspicion is by opening the situation up to competition. My own profession, again, has been through that in the last 12 months so that the Bar Association no longer has a monopoly on granting practising certificates to barristers, and one can obtain a barrister's practising certificate without being a member of the Association. Similarly, if the colleges are committed to showing that there is no cartel, would there be merit in a provision which allows the Medical Board to say, "Well, if you're a member of a college you automatically get approved as a specialist in a particular field", but that the Medical Board itself would have the power to consider other bases for approving people to be accredited as specialists - for example, on the basis of registration in an overseas college or passing of an exam by an Australian-based college in a different specialisation - so as to show that applying the most rigorous standards in the world what the colleges do in Australia isn't a cartel, isn't a monopoly, it's simply a matter of maintaining the highest medical standards?-- Well, I guess the other way you bust a monopoly in Australia is you give it to the ACCC, and the ACCC actually is reviewing the processes of all the colleges and has started with the surgical college, and this has been one of the few remaining areas, and again you may wish to get more expert evidence - Dr Stitz is listed as one of our witnesses - but my understanding is that there is a difference of opinion between the ACCC and the College of Surgeons as to how you assess the competence of overseas trained surgeons. I mean, the ACCC has been a little quiet on this since the Dr Patel case, but the point is that there is one way of assessing degrees and there is another way of assessing clinical competence. The colleges very much, with the process that they've done, is they've been looking at assessing the clinical competence of the applicant, and I guess in terms of protecting the public that's the important thing.

Yes?-- Again you talk to the Medical Board - and I didn't totally understand the process that you were proposing, but the Medical Board is not in a position to be an arbitrator of clinical competence in terms of the nuances of standards of specialists and their fitness to practise within the range of a specialty. That would be much better decided by the college in consultation with the Medical Board.

Well, to take a concrete example, and not to be offensive, but just by way of illustration I'll take your own branch of specialisation. At the moment to be registered as a specialist in Queensland in gynaecology and obstetrics you

have to be a member of the Australian college. That is the only way of getting in the door, or you have to have the approval of the college to be a deemed specialist. What would be the harm in a system by which of Medical Board could, if they were satisfied, say, "Well, the standards of the Canadian college are just as good as the standards of the Australian college and therefore we will give automatic registration to any foreign trained doctor who comes to Australia who is already a member of the Canadian College of Obstetrics and Gynaecology."?-- Well, with due deference to the Medical Board of which I'm a strong supporter, the current make-up of the Medical Board - truly, that Medical Board is not in a position to assess the competence of the O & G content of the Canadian degree, nor are they in the position to assess the clinical competence of an obstetrician and gynaecologist without some input from the college. They just simply don't have the resources or the expertise, unless they wish to employ an inhouse obstetrician and gynaecologist to do the assessments for them. The whole bete noire of a profession - for all of us in this room - is that one of the tenets of a professional is that you maintain your standards and you control your standards as a profession.

I understand part of the problem is that it's very politically incorrect to talk about being a member of an elite, but I don't think there's anyone in Australia who would want to have people given specialist qualifications who aren't the very best at what they do. The difficulty is this perception that that has allowed colleges to treat themselves as the gatekeepers, the key holders, and to say, in as many words as you just said, "Well, not only do we hold the keys, but we're the only people who are competent to hold the keys and therefore we'll never give them to anyone else."?-- Yes, and you know, I can understand that view, and I understand some of the political difficulties of that view being held, but I must remind you that if Dr Patel had been run through that gatekeeper system, none of us would be sitting here today.

I'm sorry, Mr Tait. I've had you standing there for some minutes.

MR TAIT: Not at all.

COMMISSIONER: Oh, I'm sorry Deputy Commissioner Vider-----

D COMMISSIONER VIDER: I'd just like to ask your opinion, Dr Molloy. You talk about the colleges' input into standards, and certainly the colleges, in my understanding, have a considerable input into the clinical standards that are the basis for the ACHS review in hospitals?-- That's correct.

Would you be of the opinion that the colleges are satisfied that most of that auditing and review of clinical standards that we've become familiar with through the ACHS process is acceptable to the colleges?-- Again I have a limited authority to speak of colleges - we all work together. I believe that to be the case, but again, if you intend to call more college experts during the course of the Commission, I

would suggest, Commissioner, that you put that question to them directly.

Okay. Thank you.

COMMISSIONER: Sir Llew?

D COMMISSIONER EDWARDS: Could I ask Dr Molloy who appoints the hospital accreditation committees and to whom do they report?-- The hospital accreditation committees - you mean in a private hospital, Sir Llew? The hospital accreditation committees are usually appointed - different hospitals have their different processes, but mostly in consultation with the doctors who are visiting the hospital who may be asked to nominate people, but essentially the final decision to appoint the accrediting committee rests with the board of the hospital, and they report to the board.

Does that committee, as well as recommending appointments, have any power of dealing with somebody who has not met the standards compatible with the college requirements?-- Very much so. I'm aware of at least two situations in the last 18 months in Brisbane where private specialists of quite significant profile have had their privileges - admitting and operating privileges withdrawn from major private hospitals in Brisbane.

It should be fairly easy, should it not, if there was cooperation between the various levels of government, to forecast medical numbers in training posts for say the next 10 years according to population, experiences so far. Why isn't that done?-- Well, there is an organisation who does nothing but that which you'd be familiar with, the Australian Medical Workforce-----

Nobody seems to take much notice of it, unfortunately?-- I'm sorry, I'll change what I'm going to say. I think sometimes their forecasts have not appeared to have turned out to be as accurate as one had first hoped.

Could I ask one other question. In the area of a registered specialist working in a hospital who is not performing as the standard would require for the best outcomes for patient care, do you have a process by which, first of all, the complaints can be made to the college and, secondly, how would the college deal with such complaints? For example, did the college become aware of Dr Patel's performance as a so-called surgeon within the system and - sorry, would the college have been made aware of that, and would they have taken action from outside the system to demand that the hospital withdraw his accreditation?-- Well, I can't speak for the surgical college, Sir Llew. I know how my own college works, and I've been involved-----

Could you tell us about that?-- Yes. What would happen is a complaint would be made to the college. The college does have a board to review these things, and depending on the seriousness of the complain and the nature of it, particularly

in relation to someone's competence, the college may interview that doctor. The college may also carry out an investigation. I have seen a number of situations where hospital accreditation boards have actually asked the college to come in and formally investigate the competence of a doctor, and that may include an audit of all their work, chart reviews, interviews with patients, if they're prepared to, and interviews with the actual doctor or with colleagues. My college has arranged formal operating assessments where a member of the college will come along and stand with a doctor while he or she is performing surgery, and my college has also arranged upskilling courses at major hospitals for Fellows whose clinical - particularly surgical competence would be below the accepted skill level, and then ongoing review including log books and the presentation of all cases back to the college over a defined time period.

As your role as President of the AMA rather than an obstetrician, do you have any concept as to why there was no report or concern expressed amongst the medical profession to Dr Patel's performance when it was Miss Hoffman who actually rang the bell mainly, from evidence given to us so far?-- Well, I did partly allude to this on Tuesday, as I recall. The first alarm that was rung in the system was actually raised by a doctor, and I understand that evidence has been tendered to the Commission with the assistance of the AMA, and that happened two months after Dr Patel had started work. That evidence was - those alarms were passed up the line - or supposedly passed up the line in Queensland Health, and it's up to this Commission to decide what may or may not have happened to that.

COMMISSIONER: You're referring to Dr Peter Cook from the Mater Hospital?-- That's correct, Commissioner. I remember on Tuesday we talked about the context of complaining within the system or without the system. So, you know, I think that's one of the first things that happened. Then, of course, as I recall, Commissioner Morris did actually then discuss the action of Dr Miach in terms of complaining again within the system, but was ignored. I think the difference that we talked about on Tuesday was the fact that a nurse chose to go outside of the system, whereas we had doctors complaining inside the system and the balancing of those roles of trying to complain within a system versus without a system, and I guess that then leads us into a circle to where we started earlier this afternoon about complaints mechanisms.

I just have two other matters. One is a request rather than asking for your evidence on a subject. I was discussing with the two Deputy Commissioners at lunchtime the desirability of this inquiry receiving submissions from the colleges, and there are 24 or so specialist colleges?-- I'm not sure of the final number because there are subcolleges within the colleges, particularly within physicians and surgeons, and the definitions of those colleges is really quite difficult.

In any event, you did mention, think on Tuesday, there's a body which comprises the Presidents of all of the specialist

colleges?-- That's correct.

And I was wondering whether we could ask you to use your good offices to see whether that committee representing all of the colleges would consider putting a joint submission to this inquiry so that we have the benefit of input across the range of specialties. Accepting, of course, that there may be some specialist colleges that wish to put in their own separate submission, it would be useful to have one voice speaking on behalf of the colleges?-- I'm sure that we would be very happy to facilitate that. We can easily do that with the email loop we have with this group, and the response is usually excellent. Perhaps yourself and Mr Andrews - or yourself through Mr Andrews could give us some guidance as to the sort of information you would like in the submission and we could undertake to facilitate that.

All right. Thank you for that. The other thing is going back to your comments earlier about the way in which colleges maintain standards, and you identified a number of ways, and I added in the fact that I guess in a free enterprise system GPs also regulate the amount of work that flows to the specialists. I've also been told that particularly in the surgical fields - not just general surgery, but orthopaedic surgery and other specialist forms of surgery - the strongest regime to protect standards is in fact the interrelationship between anaesthetists and surgeons because, every anaesthetist works with half a dozen or more surgeons, and every surgeon works with half a dozen or more anaesthetists, and if someone is not competent, the anaesthetists are often in the position of the whistleblowers. Is that your experience?-- To a limited extent. I think there are actually - I mean, in the private system I guess there are people who pair off, and in general terms the standards across most of the procedural specialties these days are actually very high, and the standards across most of the anaesthetist specialties - sorry, most anaesthetists are now very high too. What's happened in this country in the last 20 years is that, first of all, the colleges have become very, very professional in terms of their training and examination programs, and part of that's been driven by things like the ACCC where they've had to be absolutely transparent in how they license someone finally as a specialist, and that's led to a very, very good quality of candidate passing the exams. It's been very even. For example, in anaesthetics - the standard of anaesthetists in Brisbane is simply excellent, and has been for over a decade. What happened when I first went into practice, Commissioner, in about the mid-eighties is there were still a group of grandfathered specialists who, as the colleges were setting up their degrees and processes, which happened from about the sixties onwards, there was more variability in specialist ability than is evident now. So I was sort of under the impression when I first went into practice that perhaps there was a twinning of people who might have been considered in the first division and people who may have been considered in the second division, but I'm really very convinced now that those divisions have almost disappeared in specialist practice.

I guess that's also inevitable given that - I can't remember the number of years, but it's quite a number of years since the number of places in med school in Queensland has increased. That means that it's simply harder for 17 or 18 year olds to get into med school, and that means that the very, very brightest young Queenslanders are the ones entering med school, and there would be people of an older generation who simply would not have even qualified to start a medical career if they were working under the standards that exist today?-- Yes, that may have some impact. Yes, I guess that that's probably had some impact as well.

Thank you, Mr Tait.

MR TAIT: Thank you, Commissioner. Dr Molloy, turning to one of the questions asked by Sir Llew, the question of the colleges dealing with someone for breach of clinical standards, that would, of the college's own volition, only apply to a member of the college?-- That's correct, Mr Tait.

So for Patel, the College of Surgeons would have no jurisdiction over him?-- That's correct. Commissioner, I only partially answered your question. I doubt that the College of Surgeons, even if there'd been complaints to them, would have interfered in the Patel case because they simply had no jurisdiction over him.

COMMISSIONER: The likelihood is they didn't even know he existed in a formal sense?-- No, that's correct.

MR TAIT: The likely course would be, if they heard about it and said, "We have no jurisdiction", they might have complained to the Medical Board if they thought the Medical Board - if the breaches were serious enough and they thought the Medical Board was in a position to act?-- Well, yes. I mean, the specialty groups do have a history of doing that. I guess the parallel to that is Bundaberg, where the Australian Orthopaedic Association formally acted-----

COMMISSIONER: Hervey Bay?-- Sorry, my apologies, Commissioner. Hervey Bay, where the AOA formally took action to ensure a maintenance of orthopaedic standards.

MR TAIT: The other point I wanted to go back to, you talked about the loss of training positions at Bundaberg, the two positions. Is there a committee - I can't remember the name of it - headed by Professor Peter Roser that looks at accreditation of hospitals as training institutions?-- Yes, that's correct, but I know very little beyond what you've just said, that's correct.

COMMISSIONER: I think, Mr Tait, you might have to go into the witness box next.

MR TAIT: After dinner. I'll read it out first. I'm getting a lot of enthusiasm for cross-examining me.

MS McMILLAN: Yes, please, Mr Commissioner.

MR TAIT: Thank you.

COMMISSIONER: Mr Farr?

MR FARR: I'm ready to proceed. I don't know that Mr Allen had finished.

MR ALLEN: I thought I had, but given the evidence that's been now given, I might have a few more questions.

COMMISSIONER: Yes. It's better that you finish any questions you have before we move on.

MR ALLEN: Thank you, Commissioner.

FURTHER CROSS-EXAMINATION:

MR ALLEN: You've told us that the colleges can actually take complaints about Fellows of the colleges?-- That's correct.

Is that somehow made known to the public?-- I don't think that the colleges run advertising campaigns, but, for example, it is available if someone looks up a college website, a member of the public, or was to speak to the college or was to make a formal approach to a member of the college, then they would be told yes, the college does have a complaints mechanism about its members.

Okay. Well, obviously the utility of any avenue of complaint regarding clinical competence to a college would depend upon the patient knowing about that avenue?-- Yes, that's correct, but they may also be referred there in that they may make a complaint to, for example, a hospital or - and I understand that it's not beyond the bounds of possibility that other institutions like the HRC and things can, for example, refer cases to the college for advice or further action.

But you're not aware of any proactive approach on the part of any college to advertise the fact that they're there to receive complaints about their Fellows?-- I don't think the colleges regard it as something that they particularly advertise, no. I mean, it's just part of their functions.

I see. What sort of procedure exists in relation to the college you're a fellow of to receive and investigate complaints of such a nature?-- Well, I did go through that only a few minutes ago. I mean, there are a series of options that the college can take from interviewing the Fellow to being involved in a formal investigation, right up to actually standing with that Fellow in an operating theatre and assessing their competence.

There's some type of further appeal avenues for dissatisfied complainant in that situation?-- I'm not sure. I think that the complainant would have to - do you mean the initial complainant, not the Fellow being investigated?

The initial complainant?-- Well yes, I would think so. If they're not happy with what the college has done there's other avenues such as the Health Rights Commission or civil action.

That's an alternative avenue. It's not that this complaints mechanism of the college itself is able to be reviewed by any independent agency?-- No, that's correct. Yes, I think that's correct.

That would be unlikely to inspire too much public confidence in a system where it would seem that doctors are judging a doctor?-- Well, as I said to the Commissioner, the maintenance of your professional standards is one of the things that defines you as a professional, and in Australia we - in Australia where our medical standards in specialty groups are amongst the highest in the world - and I will back our Australian medical standards in any specialty in this country against some of the world's best, and that's come about because we've trained our specialists well, we maintain our standards well, we've got some of the most advanced continuing medical education programs and recertification programs for specialists in this country anywhere in the world, and our quality and our standards of those colleges is excellent.

Why would allowing the Medical Board to have a concurrent power to examine the competency of doctors lead to a reduction of standards?-- Well, the Medical Board already has that power under certain circumstances, where something is referred to the Medical Board they can decide to undertake an investigation.

Has that led to a reduction of standards, that the Medical Board has that power?-- I think in some cases that I'm aware of, I think the Medical Board, because it does not have an understanding of the nuances, has inappropriately prosecuted doctors or investigated doctors.

Has that led to a reduction of standards then?-- Well, I think that when you pressure a system and you accuse people of inappropriate practice you run the risk of driving good doctors out of the system that will lead to a reduction of standards, yes.

Do you suggest that the Medical Board has inappropriately investigated doctors so as to drive them out of the practice?-- No, of course I don't.

Well, how then has the current Medical Board's powers to maintain certain standards led to a reduction of standards overall?

MR TAIT: It was exactly the same question he was asked before, and he has answered it.

COMMISSIONER: He has, but this is cross-examination and I think, with respect to Dr Molloy, he is quite able to handle himself under cross-examination even if he finds it slightly offensive to be asked the same question three times in three ways.

WITNESS: We have seen cases go before the Medical Board where we believe that there was inappropriate prosecution. In fact, what - the answer to what you are saying is that at the moment the Medical Board has some limited powers to deal with clinical situations. The Medical Board, where there may have been inappropriate clinical practice almost always now has to pass these problems onto the Health Tribunal, which is not an appropriate forum at times for questioning - questioning minor matters of clinical competence; major matters of clinical competence we have no problem with, but minor matters of clinical competence it's not a good forum, you know, cases of matter, of public record. Recently there was an issue relating to an - a psych - a doctor who had treated a mentally ill patient and was charged with inappropriately sedating her. The charge was dismissed, but a better understanding of the issue by the Medical Board and also the power to deal with that other than referral to the tribunal would have saved that, you know, in our view quite difficult and inappropriate situation.

COMMISSIONER: I guess then in a sense what you are saying in response to Mr Allen's question is not that it's reduced

clinical standards or standards of competence, but it has created other problems for the medical profession?-- To be fair, what I was talking about was in response to some of the work shopping that had been done about where we could go in the handling of complaints and raising a number of issues for the Commissioner's information. It was really not an attack on the Medical Board's current complaint handling or the fact how they handled clinical complaints. It was, really - what I was concerned about is if we are approaching an extension of those powers in the context of an overall larger complaints mechanism drawing a number of matters to the Commissioner's attention which I think was, you know, reasonable and legitimate.

And I think, in fairness, it's worth mentioning that I have certainly seen reports from within the insurance industry that indicate numbers of medicolegal claims fall dramatically, and I'm talking percentages of 75 or 80 per cent, simply if a doctor takes the time to sit down with the patient and explain what went wrong and that a lot of problems in the medical world are solved by doctors, to use an old fashioned phrase, having a good bedside manner?-- Yes. That's quite correct, Commissioner, and I guess, you know, sort of following on from the medical indemnity line one of the things that all our organisations have committed to is more formal programs of risk management that encompass a whole series of ways of both preventing complaints, but also very quickly handling them at clinical level when they do arise, so that there is consumer satisfaction.

Sorry, Mr Allen, I will try not to interrupt again.

MR ALLEN: Thank you, Commissioner. What Mr O'Dempsey seemed to be proposing in relation to any hospital expanded role for the Medical Board in relation to competence issues was a process which would not lead to the adversarial process involved in going before the Health Practitioner's Tribunal but, indeed, having another line of approach where the Medical Board could address issues of clinical competence without having that fear of investigation and charges, and one of the advantages he saw was that that might mean that doctors would be more prepared to raise issues of clinical competence with the Board?-- Yes. I think that's a good point and, actually, we would support that and we have been in preliminary discussions with the Board about that. I think one of the issues relating to - for example, to the Andrew Donovan case was that the Board had nowhere else to put an unfortunate event except for the tribunal. So, in fact, we're very supportive of that and, in fact, I've had preliminary discussions with both the Medical Board and the Minister about such an amendment to the Medical Act.

So if the Medical Board was able to investigate concerns about clinical competence on the part of doctors, in that context, that would not lead to any reduction in clinical standards, would it?-- No, providing there was appropriate input from the specialist groups to help the Medical Board understand the particular complaints.

Yes. Now, correct me if I'm wrong, but I believe that you mentioned in your evidence that we are going to look at compulsory reporting of adverse incidents, but you may have been referring to the colleges or the AMA?-- Oh, the AMA and the colleges are working together on a national extent to set up adverse incidents reporting schemes and - in the various specialties all within the various health systems. The model is yet still to be determined, but it was actually a commitment given by the AMA and the colleges to the Federal Government as part of the solution for medical indemnity that we would proactively involve risk management and part of the risk management is adverse incident reporting.

So how is that process continuing?-- Well, there have been a large number of meetings involving the medical insurers, the Commonwealth, the AMA and the CPMC, that's the Committee of Presidents of Medical Colleges, which represents nationally all the colleges to further this process. I know that there's been a lot of good work done on that, but you know, I mean, I'm not - I don't have the level of knowledge here today to actually brief you on that fully, I'm sorry.

All right. Are you able to say whether it would be - it's directed towards a process whereby doctors report adverse incidents?-- Yes. Oh, yes, that's the intention, is that - that medical - that doctors are able to report adverse incidents and there will be a collation of those - of those incidents and several events.

COMMISSIONER: But you are really talking about doctors dobbing themselves in rather than reporting incidents by other doctors?-- Well, the - it's meant-----

Sorry, I shouldn't use the vernacular, but evidently everyone knows what I mean?-- Yes, well, I - yes, doctors presenting their own cases or cases on behalf of the unit. It's really based on the airline industry model, Commissioner, you know, where pilots have an open reporting scheme which is a no fault way of reporting things, so that basically you reduce the number of adverse incidents by detecting commonality of events.

I just wonder if you are looking at that sort of model one of the problems of doing that in a private organisation like the AMA, and I only mean private in the sense that it's not Government sponsored, is that you then, sort of, run into trouble with defamation and other sort of considerations where you have one doctor reporting the - or making adverse comments about another doctor and that may be another reason why having a central referral agency through a Government sponsored ombudsman's office may assist to facilitate the very sort of thing that the AMA and the colleges are talking about?-- These risk management programs actually will be done as a partnership with Government.

Yes?-- And will have appropriate protection in terms of the reporting and, I think - I think a fair amount of the

reporting will, sort of, be more event related than personal related.

Yes?-- But, you know, there are other programs, of course, being set up, for example, the Surgical Mortality Audit that's being set up as a partnership between the College of Surgeons and the Queensland Government along the lines of the very successful and mathematically proven Edinburgh model that's also been tried in Perth will be a major step forward in terms of surgical morality reporting in this state; so thereby a lot of these impacting on incident reporting complaints and the mathematical detection of problems in the system.

Isn't the difficulty with a lot of that that when it comes to the Jayant Patels of this world they're not members of the AMA, they're not members of the college, they're just going to drop under the radar?-- The AMA doesn't have any control over these sort of processes in the medico-political world. We act as facilitators and we advocate for them or, occasionally, if we're not agreeing with them we advocate against them in a general sort of sense, and what we do is we convene and we help the colleges get the best ear of Government and things like that. So under a surgical audit system, the proposed surgical audit system, you know, there's very little doubt that Dr Patel would have been picked up after some time. Now, whether he would have been picked up after one year or two years depends a little on the mathematics of the model, but there's no doubt he would have been picked up.

My point is still valid, that any system of compulsory reporting or adverse incident reporting that is set up simply by private bodies within the medical industry, such as the colleges or the AMA or the Nurses Union or any other private body, non-Government body, is going to miss out on people like Patel because he's not a member of any of them?-- Oh, well, no. No, the - we set up these things usually in partnership with Government.

Right?-- So although Patel wasn't a college - member of the college, the College of Surgeons is providing the standard input and the technical expertise to make sure this project works for Government.

Right?-- So this is a Government project that would apply to all Government and, indeed, private hospitals. So - but the College of Surgeons, because it's very interested in the maintenance of standards in the community would be as - providing the technical expertise, the committees of review, and the input - the standards input to make sure this project works.

Sorry, I'm then getting a bit lost. If this is a - something that's been contemplated to put in place with the Federal Government-----?-- No, this is a State Government project.

This is the State Government?-- This is the Queensland Department of Health. It's an excellent initiative in terms of the Queensland Department of Health.

Right. Okay, thank you.

MR ALLEN: And I believe in your last answer or second last it would - it's a system which is envisaged as applying to both public and private hospitals?-- That's my understanding.

And, obviously, there would be much merit in applying to both the public and private system?-- Obviously, yes. I mean, we have - the Perinatal Committees and the Maternal Death Committees, for example, which are also audit processes for the deaths of babies and the death of mothers apply equally to both the private and public sectors.

COMMISSIONER: Mr Allen, if you're moving onto something else I was just going to raise with Mr Farr whether - to the extent that that's under consideration by Queensland Health at the moment, I realise there are difficulties in going into policy issues which are still under consideration, but if it's possible it probably would be of assistance to us to have a short report or something like that from Queensland Health as to where that planning is at at the moment.

MR FARR: Oh, certainly. I'm sure I should be able to get something in that regard.

COMMISSIONER: Thank you, Mr Farr.

MR ALLEN: Thank you, Commissioner.

WITNESS: This has been publicly announced, Commissioner, and there should be no problem with that.

COMMISSIONER: Thank you.

MR ALLEN: You were asked some questions by the Commissioner regarding the view held in some quarters that the colleges act as cartels which restrict the number of qualified doctors. Now, part of that view held in some quarters is that - is to the personal advantage of the existing fellows of the colleges because by increasing the demand for their services it increases their earning potential. You are aware of that being a view held in some quarters?-- Yes.

Now, you said that, for example, that there's no validity to this urban myth because colleges do not get to control the number of training posts directly, I think you put it?-- That's right, the primary control of training posts rests with the state health departments who fund them and if the job isn't funded it doesn't exist and the there are innumerable examples of colleges trying to create new training posts and being told that there is no funding for a new Registrar's position in that hospital. You know, the Government just doesn't want to spend the money on another doctor.

Haven't there been instances to the contrary where training positions are available, but the - a college has refused to accredit them?-- Only if there is - only if those training

posts don't meet the criteria of supervision and numbers and - and, you know, the colleges have got transparent requirements of what constitutes an appropriate training post in terms of the numbers of trainers that are to be available and the amount of work that a Registrar can be expected to do, and also the mix of work. See, one of the problems, say, for example, at the Royal at the moment is that in the orthopaedics department the mix of work is swung very heavily to trauma and because so many operating lists have been cancelled very little elective orthopaedic surgery is being done. Now, it's no point - you know, the college is very concerned because, you know, the Registrars are getting great at fixing broken legs and broken arms, but they're not learning how to do any elective orthopaedic surgery, which means when they graduate if they don't go and train somewhere elsewhere when they graduate they will be able to be very good traumatologists and nothing else. They are looking at that level of accreditation at training posts. Neurosurgeons at Royal Brisbane are doing the same. This is really serious because of the financing in the health systems and the resourcing of the health system. You know, we have only got 15 neurosurgeons in this state and if we can't train our own neurosurgeons because all they're doing is road trauma and industrial trauma, and they're not learning how to operate on brain tumours or doing elective surgery, the sort of elective surgery that neurosurgeons do, we will not have neurosurgeons and there's nothing about cartels.

D COMMISSIONER EDWARDS: Are you saying, therefore, that it's been a policy of Government or someone to actually reduce the number of elective surgery lists in neurosurgery so such planned operations can no longer be done?-- Over at the Royal Brisbane Hospital, because of the sequential shortages that have occurred in the hospital and the loss of so many beds and the underfunding of intensive and higher dependency beds, Sir Llew, a fact is that a third of operating theatres are closed.

Do they - have sessions for existing, say, neurosurgery or general surgery been reduced as a result of that?-- Very much so. You know, I was speaking-----

The number of operations listed in the annual reports indicate, and I know it's a pretty poor indicator, that it is actually increasing?-- Well, the number of elective procedures - they're still doing - that annual report wouldn't be current for this year, though, would it?

Last year?-- If you look at the numbers - if you look at the quarterly figures for the waiting - the waiting lists figures for the latest quarter are available on the Queensland Health web site, Sir Llew, and they indicate a significant reduction in activity at Royal Brisbane Hospital. They also indicate that there's been a change in the waiting list but, in fact, a lot of the change in the waiting list at the Royal Brisbane Hospital has been because they took patients off the waiting lists. They didn't end up operating on them. Now, you know, I spoke to one ENT surgeon two weeks ago at Saint Andrews who has been a VMO at the Royal for over 15 years, he's done one

elective operation list since December. The orthopaedic surgeons are regularly-----

Is he being paid? Has he done only one elected list? I don't understand that?-- All the elective surgery - not all, but a significant amount of elective surgery has - is being cancelled at that hospital because there are not enough anaesthetists and-----

Can the AMA give us some figures like that?-- Sorry?

That really is quite disturbing information?-- Well, you know, Royal Brisbane Hospital - the hospital has lost one third - it's lost - it's down about eight full-time equivalent anaesthetists. The Anaesthetic Department is running about a half to two thirds of its capacity plus we have long identified resourcing issues at that hospital in terms of beds. In my submission HDU and ICU bed numbers - the hospital has frequently access block. When you have access block you don't do elective surgery.

COMMISSIONER: Has the number of administrators fallen at all consistent with this one third drop in the number of operating theatres?-- Commissioner, you know, I - I don't know about the - I don't know about the administrator numbers at Royal. I mean, you know, it's very hard to define what an administrator is. It's a bit like trying to chase down waiting lists. There are lots of tricks to make administrators not appear administrators. For example, a simple one is that you might have, for example, you know, a nurse in an administrative position which is an office based position, but she will still be registered on the clinical staff as a clinical nurse and will not appear to be an administrator, if you want to count administrators. And that can similarly go with, sort of, for example, medical staff or other staff.

All right. Yes, Mr Allen?

MR ALLEN: In relation to training posts, you mentioned that you're, of course, not a Fellow of the Royal Australasian College of Surgeons, but you mentioned your knowledge in relation to ACCC investigations into that college and its practices?-- Yes.

And you would be aware of public statements made by the ACCC as to suggestions that the hospital training posts accredited as meeting that college's standards in some cases existed alongside identical posts that were not accredited by the college?

COMMISSIONER: Is that said to have been the case in Queensland?

MR ALLEN: No, that's said to be the case overall.

COMMISSIONER: I think we're probably straying a little bit from the terms of reference, but if Dr Molloy has some

response for that he's welcome to give it?-- Look, you know, the AMA, the colleges and the ACCC have been at loggerheads for about four or five years. You know, there's a political component to it. There's a standards component to it. You have to understand that the ACCC with - and the colleges have diametrically opposed views, in that one has a free market philosophy and one has a philosophy that if you have a - a standards institution which is there to create standards and maintain standards, that that is very different from having a free market philosophy where everybody competes, for example - for example, you know most of us in this room could make a fair fist of running an ice cream shop and we go out in the market and we compete on our ice cream shops and we rise or fall on the quality of the ice cream we sell and, perhaps, the business management that we learn or pick up along the way. But learning to be a surgeon isn't like that. You know, you - there are serious standards that we believe we should obtain to be a surgeon or obstetrician or gynaecologist or physician in this country. Now, the ACCC tries to apply an ice cream shop approach to the practice of medicine and that has had very, very serious deleterious effects in some ways on the practice of medicine in this country. One of the simplest examples is that they view four or five country GPs in a town who may be in an independent practice forming a cartel in the ACCC's view to provide a weekend roster for the town. Now, there are - have been really serious implications about doctors getting together to provide in, particularly, provincial cities after hours care covering the provincial city. If they're not all in the one practice they're three competing practitioners. They all like each other and talk to each other and on the weekend in the ACCCs view they form a cartel. I would remind you of the Rockhampton case for the ACCC where their view was the obstetricians form an after hours cartel. Did they bust up the competition in that model? They went in there, there were three practicing obstetricians, they perfectly fixed problem in Rocky, now there's only one. There's no competition at all. So, I mean, if you want to apply an ice cream shop model to medicine where it's basically market based and we just compete on the market rather than our qualifications and our standards, that's fine, but when you do what you will end up with is more commissions like this.

MR ALLEN: So your understanding is that the ACCC in its investigations in relation to the Australasian College of Surgeons had no regard at all to the question of standards?

COMMISSIONER: Oh, I think it's an exaggeration. Dr Molloy's explained his dissatisfaction with the approach of the ACCC and I think to over simply it in that way is a little unfair.

WITNESS: I think the ACCC and the College of Surgeons have reached a fair level of concordance and the ACCC has shifted its stance on free market philosophy towards a recognition that professions do have a core maintenance of standards that make them very different from free market businesses that, perhaps, you know, people can enter just in a purely commercial sense. We're not just simple commercial entities.

MR ALLEN: And have the physicians moved closer so that the colleges have taken up the recommendation that bodies such as Queensland Health should have a role in deciding which training posts should be accredited?-- Well, I - my understanding and, again, I think you should get more expert evidence if a college person comes along here is that there was always a level of negotiation between a college and Queensland Health in that, you know, whilst Queensland Health controlled the purse strings there would be negotiation between the college and Queensland Health about the appropriateness of it, and in most cases this was not an adversarial process, this was a cooperative process between the college and Queensland Health.

COMMISSIONER: You put it in terms of negotiations with Queensland Health. Are there no Registrar or training positions at, say, the Mater Hospital or at private hospitals, Wesley or St Andrews?-- Yes, there are privately funded Registrars posts now, Commissioner. My own IVF unit has had - was one of the first in the country in O&G and there are also privately funded - there 's a privately funded surgical training post at the - actually, that's not totally correct. There is a private practice Registrar's post now, I think, at the Wesley in surgery, but that has actually got some joint funding from Queensland Health. So, yes, we have more now innovative models of funding Registrar training.

But the bulk of it is still in public hospitals?-- The vast majority except for GPs.

What about pathology? I understood that there was a move to have Registrar or equivalent positions in the private pathology companies?-- Yes, my understanding is that the major pathology companies here in Queensland take one or two, I think it may be two each, private practice Registrars, but they are tending to take senior Registrars in their last or second last year of training.

All right. Thank you.

MR ALLEN: And given the general public importance of the availability of suitably qualified doctors, it would be appropriate that any type of cooperation between, say, Queensland Health and the colleges regarding accreditation of training places also apply to, is such training places as might exist in the private system?-- Yes. A private system training place, though, may not involve any Queensland Health input. For example, when my IVF unit employed a private practice - a Registrar in his final year of training we simply had to convince the college that we could provide a sufficient depth of training and experience for that Registrar that would be effectively equivalent to the sort of training and experience they could get in a similar hospital post.

COMMISSIONER: I mean, we're really talking about a very minor issue here, aren't we?-- We are.

Out of 240 graduates each year, from what you have said, it may be 10 or a dozen at the most which would be - have Registrar positions in the private sector?-- That's right. In the future, Commissioner, this - I think there will be an increased interface between the private and public sectors for training. And you may recall on Tuesday we discussed outsourcing. One of the really big problems with outsourcing is making sure that Registrars - and one of the models that we have been putting to Queensland Health in our negotiations on outsourcing involved taking the Registrars out of the public hospitals to work alongside the consultants when they are doing outsourced work.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. Mr Farr?

MR MULLINS: I think Mr Farr has kindly allowed me to go first.

COMMISSIONER: Deferred to you.

MR MULLINS: I think I will be shorter.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR MULLINS: Dr Molloy, my name is Mullins. I appear on behalf of the patients. The patients of the Bundaberg Hospital have some concern about the obligations of the doctor who is aware that a particular surgeon or practitioner is endangering the health or life of a patient, and about that person's obligation to both the direct patient and other patients of that doctor. Can I ask - I have a copy of the AMA's Code of Ethics that I have simply printed off the website?-- Thank you.

On the first page of the document at the bottom of the page-----

COMMISSIONER: Can you zoom out so we can see more of the-----

MR MULLINS: It is highlighted in yellow.

COMMISSIONER: Yes.

MR MULLINS: These are the two sections that I suspect would apply: "Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person,

where required by law, where part of approved research, or where there are overwhelming societal interests." Can I just ask you to turn two pages through? This has to do with professional conduct: "Report suspected unethical or unprofessional conduct by a colleague to the appropriate review body." Now, can you help the Commission, and the patients, with an explanation as to what the responsibility is of the doctor who learns that another doctor is endangering the health or safety of their patients?-- Yes, I guess at the first - at the first level, there should be an obligation perhaps to the patient in an acute sense. Do you know what I mean? If you learn of something acutely and a patient is in trouble, there are various ways that you could take action to try and help that patient. You know, arrange support. At the simplest level, representing who you do I suspect you are talking in a slightly - episodes of negligence, but in fact there are a lot of episodes of care that occur where inadvertently a patient may be put at risk or their life even put at danger simply because things go wrong, and the colleague may or may not ask you for help, but it is very appropriate to sort of poke your nose in and ask them if they want any advice or offer to assist them. Okay, so that's one of the first ways and a very good way that you can do that. The next way that you can do that is sort of just going - one step up the ladder is that perhaps if you haven't - you know, in a more subacute sense, is that you can actually seek that colleague out and try and tease out if they're having any particular problems, you know, offer to assist them. There are other ways you can do it, too. You know, "Have you seen this review by, did you know that?", and so what you could do is offer to share a paper or - by a paper, I mean a journal paper - with them or something like that, do you know what I mean, and bring a problem to their attention. Maybe start a discussion with them or you then - perhaps the next level beyond that is that within your hospital and your review committees you may bring the case up. So make sure that the case comes on for clinical review by a group of peers, at which point, you know, the criticism or the education may be either helpful or merciless, depending on the particular situation, and we do have those structures. For example, in my own specialty, all baby deaths at the hospitals are investigated by perinatal review committee. Then there is a meeting of the clinicians at the hospital, which all cases may or - the cases are presented for discussion. So I guess there are then - there are those various tiers. And then you sort of - going beyond those, you can then address issues of problems to the medical superintendent at the hospital, which may then lead to various actions, or it may be then you review - or to the director of the department, or very often departments have sort of committees, you know, standards committees. So you may actually draw attention to those standards committees. And then sort of at the next level beyond that you may actually go up to the privileges committee at the actual hospital or the Board of the hospital itself. Then sort of, you know, beyond that, depending on what the colleague has done, you may draw the attention to an official body such as a college, or the Medical Board, or the Health Rights Commission.

Do you say in this case that most of those safeguards that you talk about were actually in place, except that Dr Patel was placed into the hospital without any supervision at all, and the infrastructure of supervision that should otherwise have been around him to ensure that these things were teased out was never present?-- Yes. I mean, I feel competent discussing the supervision of Dr Patel because I know that to have been absent. You know, he didn't have any supervision as an SMO. I know there wasn't a Director there. I can comment accurately on that for you. I don't know what other peer review mechanisms were present, you know, apart from the administration at Bundaberg Hospital. I am not party as to whether they have peer review committees, journal clubs. I don't know what associated professional things they would have. That would normally be a bit of an arbitrator of standards in most hospitals, particularly public hospitals.

You answered in a question to Deputy Commissioner Edwards earlier that the 2003 - I think it is the year ended 30 June 2004 - figures for neurosurgical procedures - I think the Deputy Commissioner suggested they were actually increasing or appeared to be increasing, and you said, "But if you look at the current figures one will see they are decreasing." Is the Commission to infer from that that this is actually a recent problem?-- Oh, we were talking, I think, about the general surgical figures, numbers of procedures done at Royal Brisbane. And in the system generally there has actually been a drop in the amount of work done at most of the hospitals around Queensland. So I am - no, we didn't cover the neurosurgical bit. I am sorry, I just lost the train of thought with the second part of your question.

Did you suggest that this is a recent phenomenon, that the number of surgical procedures is reducing - and by recent I mean the last 12 months?-- No, no, I think there has been a restriction of - you know, a restriction of work. See, what there is, there has been a blip in the figures because of the waiting list initiative. Remember when the government was elected they announced a big waiting list blitz from April to June last year, and that's made last year's figures look good, because they spent 20 million on instant surgery.

Dr Molloy, just one matter, harking back to the first point I raised about the complaints and what a doctor should do faced with the prospect that another doctor is endangering the health or safety of a particular patient, should that patient be told?-- I think patients should be completely informed of everything that's happened to them, yes. Now, I don't think necessarily that that patient should be told by - necessarily by the concerned doctor. There is a question of professional ethics in terms of interfering with the care of somebody else's patient. But I think it would be reasonable, you know, mandatory for that doctor to say to that colleague, you know, "The patient should be told." Look, to be honest, you know, I think that's a minimum professional standard. If something happens to a patient, I think you should tell them about it.

The AMA, as you said, is the peak body in Australia representing doctors?-- Yes.

You accept that it is highly respected by the public and by the medical profession?-- Yes.

It holds itself out as an advocate on behalf of the profession within the community?-- Uh-huh.

And with the media?-- Yes.

The staff - you said, I think, 38 in the Queensland secretariat?-- I said approximately 38.

That staff includes media specialists?-- Yes.

Now, you did say in your evidence - and I only picked it up this evening - that you accepted that there were three avenues of complaint: one was a complaint to a college in respect of a specialist's conduct, the second was a complaint to the Health Rights Commission, and the third option was, of course, civil action. Can I get a concession from you that the third is a legitimate and important part of that system of complaints?-- Yes, and, in fact, the AMA always supported that. We only ever had an issue with frivolous legal action.

You mentioned in your evidence on Tuesday evening that it was important when speaking on public issues that you get your facts right because if you get the facts wrong the consequences could be very serious. Do you accept that?-- Yes.

Now, the fact that SMOs were being held out as surgeons you have described as being problematic and a cause of concern for the AMA for some extended period of time?-- Yes, that's correct.

Can I just take you briefly to a passage in your evidence - I have a copy of it - I am going to take the witness to page 569 through 571 of the transcript. In the passage starting 569 about line 32, you speak about the third alternative, which is the option or gateway through which Dr Patel passed?-- Yes, that's correct.

Which is practising specialist or conducting specialist procedures while in fact an SMO?-- Yes, that's correct.

And if I can ask you to look at page 570, from line 30 through 50?-- Yes.

You told the story, or the anecdote about your argy-bargy with a medico in Rockhampton, about the number of specialists working in Rockhampton, when in fact many of them or some of them were not specialists at all, they were SMOs carrying out specialist-type procedures?-- Yes.

On the next page, reading down through to line 29?-- Are you talking about page 571 now?

That's correct?-- Yes. Sorry, which line did you want me to look at?

Starting at line 1?-- Yeah.

The Commissioner asks you about the language that one uses in respect of a specialist surgeon?-- Uh-huh.

You agreed that there weren't many people in Bundaberg who would have been told that Dr Patel was not a surgeon at all?-- Yes, I did say that. I guess I should make that clear, that that's speculation on my part based on, you know, what I have heard around the State, and, you know, for example, media cuttings I have been sent over time and things that - I don't know the particular situation, of course, in Bundaberg, in that I don't know what media was done in Bundaberg in relation to Dr Patel on his arrival; whether the hospital heralded a new surgeon in town or something like that, okay.

Mr Tait asked you at about line 15: "So have you known for some time that a Director of Surgery in Queensland may not be a surgeon?", and you respond that "We have understood the system for some time that people doing specialist work are not the specialists they are held out to be." And that's been something that the AMA has known for a number of years now?-- That's something that we've had concerns about for at least two years, and it is possibly - possibly for longer. I mean, part of the work that we were doing since 2001 in relation to overseas-trained doctors was partly about general practitioner overseas-trained doctors, but also about these issues of how overseas-trained doctors were being used by Queensland Health. That's exactly correct.

And the misrepresentation that a senior medical officer practising surgery was in fact a surgeon?-- That's correct. We have had numerous disputes about this. For example, we supported the ENT doctors in Townsville when there was a very similar situation of someone who did not have ENT qualifications being brought in as a staff ENT surgeon. That's now been - I understand because of this publicity, that's now been stopped.

Can I ask you to comment on a matter raised again by the Commissioner yesterday with Mr O'Dempsey? It is at pages 626 through 627 of the transcript. The passage starts at page 626 at line 35 - have you had the opportunity to read through Mr O'Dempsey's evidence overnight?-- No, I haven't. I was at a meeting last night and have been working all day today.

If you turn to page 627 - I am sorry, you probably should start at 626, to get the full flavour, at about line 52, and I think this is the Commissioner. He says, "All right, but, as I understand it, leaving aside the public health sector, there has been this sort of turf war. So to take the example of a cosmetic surgeon, a GP might hang up a sign saying 'specialising in cosmetic surgery' or 'practising in cosmetic surgery'", next page, 627, "and that wouldn't be a breach of

the Act. So it is a matter of the form of words rather than the substance?" And the answer from Mr O'Dempsey is, "Yes, in fact, unless you use the specific restricted title, you are not in breach. You can say that you do surgery, you specialise in this particular area, or you have special skills in this. As long as you are not false or misleading in that, you are not in breach of the Act." And then the question is "Similarly, if Queensland Health give someone the title Director of Surgery but doesn't actually call him a surgeon, that's not a breach of the Act?" Answer, "No, that's correct." Now, there is some reference there to what you thought should have been the situation in respect of that, which I think is referring back to your evidence yesterday, but the concern that you have always had is that these SMOs are being held out as a surgeon, not as senior medical officers who have the ability to conduct surgery?-- Yes.

That's correct?-- Well, that's right. And, I mean, I guess that's the crux of the matter in Hervey Bay, in that we had two doctors who, it would seem, in the opinion of the orthopaedic doctors, were really more suited to be at a Registrar level were employed as SMOs and held out to be orthopaedic surgeons.

And that was one of the issues that was identified by the Lennox Report, was it not?-- Yes. I think that to be the case. I read up the Lennox Report in preparing this for several days. You know, if you would like to refer to a specific section, I could agree more completely. I don't carry - I haven't got all of the Lennox Report just in my brain from memory, okay.

What was the AMA doing about that problem at the time, if anything?-- Well, the AMA has been trying to sort these problems with Queensland Health, the government and the - and also the Commonwealth Government since 2001. I mean, you know, it was the AMA's work through 2001 and 2002 that led to the Lennox Report being produced. And so, you know, I mean the first thing that we had to do this has been an enormously difficult lobbying exercise in government because it strikes at the very core of Queensland Health's employment practices. And, so, after about a year and a half we managed to get Queensland Health to do their own report in it. It was a very good report. It promptly got buried and then we had to go back on to the front foot with a whole series of meetings through our groups and the working parties that we had set up, you know, with Queensland Health and with the Medical Board, the Commonwealth Government, everybody, and what we did was we expanded the working group to include all of the GP groups and the colleges so that we actually could really start to put some measure on the system to try and sort this all out.

All right. You express some concerns about doctors being bullied by Queensland Health. On Tuesday evening, one of the examples you gave was Dr Giblin and Dr North. You expressed, page 588 of the transcript, that after they had provided their report they received a letter from Dr Buckland suggesting that there was no hard evidence to support their recommendations

and they wanted an urgent meeting. That's correct?-- That's correct.

And you interpreted that as bullying by Queensland Health. That's correct?-- Yes.

Because Queensland Health were putting pressure on them after they had provided some controversial-----?-- That's right, Queensland Health had commissioned the report, they had had the report, to my knowledge, for some time. You know, the report was in the process of being made public. And, you know, I had had concerns which I had expressed public. They are a matter of public record. I have done media interviews on it, about the length of time that that report was taking to appear because I knew it had been completed.

Does the AMA have a specific policy in respect of whistleblowers?-- I don't know the answer to that. I don't know if we - I don't know if we have - our policy book is about that thick and, again, not committed to memory. I could come back to you with an answer to that from the policy book.

COMMISSIONER: For the record, you indicated a thickness of, what, about two or three centimetres?-- Yeah, it is about two centimetres. Actually three centimetres, yes.

I see that - I am not quite sure what Mr Gallagher's position is - Chief Executive, whatever he is - is in the gallery. If you want to speak to him about that over the dinner break and come back with any information about a whistleblower policy, that would be appreciated?-- Thank you, Commissioner.

MR MULLINS: Thank you, Commissioner. Was Dr Strahan the local AMA representative?-- No, we don't have a local AMA representative. As I explained to the Commissioner, the AMA's State Council is elected on the basis of a number of specialty groups and GP groups and then geographical areas in Queensland. Bundaberg is represented by - is in the Wide Bay area, which includes obviously Wide Bay, Maryborough and Bundaberg. And the representative is a general practitioner who lives and practises in Wide Bay. And I explained, I think, that there may be confusion between the historical local medical associations, which, you know, a large number of years ago were subbranches but have not been for many years subbranches of the AMA. I understand that Dr Strahan is, you know, a very competent practitioner and a member of the AMA but has no status other than that of ordinary membership.

On the 22nd of March 2005 there was a disclosure of certain matters by Mr Messenger in Parliament. That's correct?-- I - not sure of the date but I understand it was around that time.

Did you know at the time or now whether Mr Messenger had any particular medical qualifications?-- No, I don't. I am not aware of medical qualifications.

COMMISSIONER: Well, he has given evidence and we know that his pre-parliamentary career was that of a journalist rather

than a doctor?-- I was aware, sorry, that Mr Messenger had worked for the ABC but that was all I knew of his - you know, I didn't even know if he'd gained a first aid certificate, to be honest.

MR MULLINS: It has been asserted that you had a certain conversation with him about a press release and you suggested that under no circumstances would you have made an assertion that this was the fault of lazy nurses?-- That's correct.

Or in any way the fault of - any way the fault of any other person because you said in your evidence, "I knew nothing of the work ethic at the Bundaberg Hospital, nothing of the situation at the Bundaberg Hospital, I was not in a position to even start to make that sort of comment" - that's in respect of the lazy nurses, that's correct?-- Yes.

You knew nothing about what was happening at Bundaberg at the time and you only had the most minimal information that there was a problem there. That's correct?-- That's right. I - I have difficulty recollecting because so much has happened since then about the exact time sequence, but I seem - I am sure that I knew that there was some investigation in train. You know, I was aware that Mr Messenger - I think I was aware on that day that Mr Messenger had named Dr Patel in Parliament.

You had very little knowledge about the matter at all?-- That's basically correct, and I was - what we were doing was we were trying to find out what was going on and trying to sort of understand the situation that had happened in Bundaberg.

COMMISSIONER: And, as I understand your evidence from Tuesday, the big concern of the AMA in the immediate context was the - what you regarded as the very unsatisfactory precedent of having a doctor named in Parliament whilst he or she was still under investigation?-- That's right, Commissioner. Look, this was just a simple matter of principle, and, in fact, I was asked by a journalist today whether I regretted doing that, and I said, "Well, you know, basically bad doctor stories are meat for the press", and I made it very clear that most of the press - the press I've treated during my presidency, you know, with great professionals and great courtesy. But the fact is that bad doctor stories make good press and the AMA wanted to make it very clear that it would not support a situation where where there are a number of investigations - there are always investigations through the Medical Board, the Health Rights Commission in train in Queensland, and that, you know, a Parliamentarian using a medical investigation to get guaranteed press was not acceptable. Medicine would simply become unworkable in this State. So we felt it was important, as a peak professional organisation, to defend that principle. It was simply the defence of that principle.

And I am sure you wouldn't adopt these words, Dr Molloy, but I guess in some senses the AMA has a trade union function, and

you were looking after your members, not Dr Patel in particular, because he wasn't a member, but as a matter of principle looking after your members in protecting them against the precedent of being named in Parliament before an investigation had finished its course?-- I would be very happy - and I am very aware I am still under oath - that I really was very concerned with the principle. Yes, that's the follow-on, the logical sequence of what I felt, but, no, I just really felt the principle was wrong, Commissioner.

Yes.

MR MULLINS: Dr Molloy, you must have been concerned, though, that Dr Patel was an overseas-trained doctor?-- No. There are - there are 16 hundred or more overseas-trained doctors. There are large numbers of overseas-trained doctors who are exceptionally good. There is no association between the fact that Dr Patel was an overseas-trained doctor and my being extra concerned, you know what I mean? I didn't make that association at all. There are Australian-trained doctors who run into trouble as well, and, you know, the issues surrounding those Australian-trained doctors have to be dealt with as well.

Can I show you a copy of your press release of 23 March 2005? This release was issued the day after the naming in Parliament. Do you recognise - I can give you a complete copy of that document?-- No, that's all right. No, I recognise the press release.

Dr Molloy, in the second paragraph you say: "AMA Queensland President, Dr David Molloy, said the surgeon in question has spent many years training and practising in the United States and has not been given an opportunity to respond to the allegations."?-- Yes.

You didn't comment any further on your concerns about parliamentary privilege and naming people?

COMMISSIONER: Well, he did, actually. I mean, it is there in black and white. "The Opposition"-----?-- It is further down the press release, and I didn't say "specialist surgeon", I simply said that he had spent many years training. That's a truthful statement. "And had not been given the opportunity to respond to the allegations", and was in line with the principle that we were trying to defend.

And two paragraphs on, "The Opposition has acted irresponsibly by accusing a Bundaberg surgeon of professional incompetence in the interest of gaining chief political gain." Where is this going?

MR MULLINS: If the Commission will let me, it will only take a few minutes.

COMMISSIONER: Okay.

MR MULLINS: The point I was making was that's obviously the

body of the document. There are some other matters I want to raise with Dr Molloy in the document.

COMMISSIONER: Get on with it then.

MR MULLINS: You call him a surgeon yourself. Had you established he was a surgeon at the time?-- He was practising. He was doing surgical procedures. I did not say "specialist surgeon". We were careful not to say "specialist surgeon". I mean-----

That's the difference - from your perspective, that's different to what the Commissioner identified yesterday in the specific terminology, that it is the use of the term "specialist surgeon" as opposed to surgeon. That's correct?-- I think this is in my statement which has been tendered to the Court, we draw the difference between people who are qualified to practise surgery as specialist surgeons and people carrying out surgical procedures or doing surgical work. I mean, there is this semantic circle that we run around. The guy did 982 or 962 operations. He was practising surgery. Whether he was practising it well or not, there is no doubt he was acting as a surgeon.

But the distinction is critical for the people of Bundaberg, isn't it?-- The distinction that we're trying to draw out was whether he was a specialist surgeon whose qualifications could be reasonably - in my view - reasonably have been understood by the people of Bundaberg to be that of a comparable standard to the access to a specialist surgeon in Brisbane or Nambour or the Gold Coast. I see that as the key issue.

Let's look at the next line. "There is every probability that there was no negligence involved in the surgeon's practice." Upon what did you make that statement? Upon what evidence?-- That, very clearly, is now likely to be a wrong statement. I understand that we had had some information - I'm not sure of the source, I just simply can't remember in the swirl of events at the time - that the big issue that was being investigated was scope of practice, and I still suspect that maybe the key issue is that - I mean, I still suspect that in Dr Patel's practice there were a large number of patients who have fundamentally survived the surgery well, and it seems to me - and Commissioner, sir, I'm not pre-empting your decisions in any way, but one of the key issues will be that Dr Patel was doing operations that were way too big for him and way too big for Bundaberg Hospital, and that's what we call about scope of practice. It's still a subsection of negligence in some ways in that if you're not choosing the right surgery for the right situation it could be construed - and I think in a Court of law would be considered negligent behaviour, but it's really more that your judgment is very poor, and I guess that was the message that we were trying to convoy.

Are you unable to tell the inquiry what evidence there was that you could make the statement to the people of Bundaberg-----

COMMISSIONER: What does it matter? This is what Dr Molloy said at the time. He's accepted that in hindsight it wasn't accurate. What's it matter who told him that?

MR MULLINS: It matters to the patients, because at the time the whistleblowers made a statement - Toni Hoffman, and Mr Messenger - the first response from the AMA was that there was every possibility that there was no negligence involved in the surgeon's practice, and the patients would like to know what evidence that statement was based upon.

COMMISSIONER: Well, I would have thought the patients would be totally satisfied by the fact that Dr Molloy has very properly conceded to this Commission of Inquiry that that's something which ought not to have been said, that it wasn't right to say that there was no negligence involved. Isn't that enough to assuage your client's-----?-- That's quite correct. Events have moved on. There is now a lot more information available and, you know, involving the patients of Bundaberg - I personally went up to Bundaberg. I was very, very pleased that I attended the first patients' meeting there because that was a really important process. I think I was the only doctor there, and I really thought it was important that a doctor went and heard what those people had to say, and

we have continually, since then, worked very hard to try and make sure those patients have had the best possible treatment. I was personally asked by the Minister and the Chief Health Officer to set up a team to make sure that the patients had quick treatment here in Brisbane, and I did that with Russell Stitz, the President of the College of Surgeons. So I have a great deal of concern for your patients. I've demonstrated that both in a practical sense and a verbal sense on a large number of occasions.

MR MULLINS: As long as - my understanding of the witness's questions - and I want to cut this short because the Commissioner obviously doesn't want me to dwell on this too long-----

COMMISSIONER: If it goes to one of the Terms of References or something, take as long as you like, but at the moment it doesn't seem to me that it's anything more than an attempt to embarrass Dr Molloy by pointing out that he said something with limited information that in hindsight he recognises he oughtn't to have said.

MR MULLINS: If the concession is that there was no evidence upon which that statement can be made, I'm happy with that concession?-- We had - I had been given second-hand information - and I don't remember the source - that the primary focus was scope of practice - the primary focus of the investigation was scope of practice.

COMMISSIONER: And you now accept that whatever that second-hand information was, it was most probably wrong?-- That's correct.

Does that content you, Mr Mullins?

MR MULLINS: Yes, I've been handed some instructions that it's the patients that were operated on after that time that have concerns about some of the statements that were made-----

COMMISSIONER: What's the date of this?

MR MULLINS: 23 March, as I understand it. I understand that the surgery continued for another 48 hours.

COMMISSIONER: Yes. Do any of the patients you represent fall into the category of those who were operated on in the 24 hours or 48 hours after 23 March?

MR MULLINS: I can't tell you specifically, Commissioner.

COMMISSIONER: Let's see if we can move on to something perhaps a little bit more important.

MR MULLINS: Thank you, Commissioner, nothing further.

COMMISSIONER: Thank you. We might take the dinner break, Mr Farr, before you start, if that's convenient.

MR FARR: Yes.

COMMISSIONER: Just before we start, there were two things I wanted to deal with. Firstly, most of those present will recall that first thing this morning I made a statement about remarks made by a former senior officer of Queensland Health. I deliberately refrained from identifying that person so that he would have an opportunity to respond and provide instructions if he thought it appropriate to do so.

However, I've been handed an email from Professor Robert Stable, as he now is, the former Director General of Queensland Health, in which he chooses to identify himself both as the person who had a telephone conversation with Sean Parnell from The Australian at 5 p.m. yesterday - which he describes as Wednesday, the 2nd of June, presumably he means Wednesday the 1st of June - and also as the person who had a conversation this morning with Mrs Sallyanne Atkinson on a flight to Melbourne.

So given that Robert Stable has chosen to identify himself in that way, I'll ask that document be marked as Exhibit 53.

ADMITTED AND MARKED "EXHIBIT 53"

COMMISSIONER: The other thing - and this is relevant to Dr Molloy's evidence - is that you will recall that on Tuesday, when giving evidence, Dr Molloy rejected the attribution to him of the comment about "lazy nurses".

I've received a letter from the Leader of the Opposition, Mr Lawrence Springborg, in which he seeks to defend Mr Messenger for his comments at this inquiry, although in fact nothing in the letter seems to in fact support the contention that Dr Molloy actually used the words "lazy nurses" that Mr Messenger attributed to him.

I really think this is all a storm in a teacup, but since Mr Springborg seems to feel it's important that he put his member's point of view to the inquiry, I'll have that marked as Exhibit 54, but I'll also ask that a copy be provided to Dr Molloy over the break so that if Dr Molloy wants to respond to it, he can.

Frankly, I think the issue is trivial, and I'd be happy to leave it rest at that. Dr Molloy has one recollection and Mr Messenger apparently claims to have a different one.

WITNESS: Thank you, Commissioner. I think this is petty political argy-bargy, frankly, and I'd like to rise above it. I would also like to see it recorded as convincing evidence of the AMA's famous impartiality towards all political parties.

COMMISSIONER: All right. The letter from the Leader of the Opposition addressed to myself and bearing today's date will become Exhibit 54, and hopefully that's the end we'll hear of that matter.

WITNESS: Thank you.

ADMITTED AND MARKED "EXHIBIT 54"

COMMISSIONER: We'll now adjourn until 7.30.

THE COMMISSION ADJOURNED AT 6.37 P.M. TILL 7.30 P.M.

THE COMMISSION RESUMED AT 7.49 P.M.

DAVID MOLLOY, CONTINUING:

COMMISSIONER: Sorry to take you by surprise. Mr Farr?

MR FARR: Commissioner, I understand Ms Kelly would like to ask some questions before me.

COMMISSIONER: Certainly. Ms Kelly?

MR ALLEN: Excuse me, Commissioner, I'm sorry to interrupt Ms Kelly. In light of the admission into evidence of Exhibit 54, which is now in the public domain and in fairness to this witness and to members of my client, I would seek to ask some further questions of this witness.

COMMISSIONER: Yes, all right, Mr Allen.

FURTHER CROSS-EXAMINATION:

MR ALLEN: Could I see Exhibit 54, please, Commissioner? Doctor, you've had an opportunity to have a look at a copy of this, have you?-- No, I haven't.

You haven't?-- No, I haven't.

Excuse me?-- Let me refrain that, yes, I have had an opportunity but, no, I haven't taken it.

Okay. I probably don't need to show it to you?-- Is that the letter from Mr Springborg?

It is?-- Oh.

It's a letter from the Leader of Opposition, today's date, to the Commissioner. I just want to give you a chance to respond to certain propositions. You know the Shadow Minister for Health Stuart Copeland MP?-- Yes.

On the 22nd of March 2005, the same day that Dr Patel was named in parliament, did you leave a message on Mr Copeland's mobile?-- I'm sorry, my apologies, I forgot to turn this off.

COMMISSIONER: Not at all, doctor?-- It's all right, I will just turn this off. I don't recall.

MR ALLEN: What would you say to the suggestion that in a message left on that person's mobile phone you stated in part that you were going to give the Nationals a belt for naming

the doctor?-- That could quite possibly have been true. I'm quite - I'm quite frequently - I act in what I think is - what I think is quite a professional sense; if I'm going to criticise a politician publicly I will tell him privately that that's going to happen. I don't know if I did, but that would be consistent with behaviour that I had.

What would you say to the proposition that during the message you stated that once we start naming doctors in parliament we were on a slippery slope?-- That - I have said that numerous times since then.

And may have said that during such a - in such a mobile telephone message?-- If the message existed, yes.

That there were better ways of highlighting problems in the health system than naming doctors?-- That - well, that's probably true, too. I mean, I have certainly said that, as well.

What do you say to the proposition that during such a telephone message you said that it appeared to be a nurse's vendetta?-- I don't recall saying that, and I have never said that. I mean, the - I have - you know, I have really at that point in time had so little information to work on, that I had no way of making comments like that. I truly have no idea as to whether that message even exists.

That would be a completely baseless comment to make, wouldn't it, that it appeared to be a nurse's vendetta?-- I have no evidence that there's a nurse's vendetta there at all. I have seen no evidence of that then, and I have seen no evidence of it now.

So it would be a most unwise comment to make?-- Well, not only that, it would be wrong.

It would be - if it was made indicative of some type of knee jerk response on the part of complaints by nurses of doctors that doctors simply call it a nurse's vendetta?-- Well, if doctors were doing that, but as I said I have no - had no knowledge of what was going on at Bundaberg Hospital at that time.

So you deny making that comment?-- Yes.

Now, on the 1st of April 2005-----?-- And I would just like to point out the other comments that I made I have made numerous times in the press since.

Mmm?-- And, you know, it could be taken that I - that comments - those comments could be taken from anything I have said over a large number of occasions.

Yes, but you deny saying anything about a nurse's vendetta during a-----

COMMISSIONER: Mr Allen, Dr Molloy has denied that twice. How

many more times do you want him to deny it?

MR ALLEN: Do you know the senior research officer to the Leader of the Opposition, a Mrs Fletcher?-- Yes.

And on the 1st of April 2005 did you have a discussion with her concerning matters regarding Dr Patel?-- I don't know if I did on the 1st of April. I certainly had a - I certainly had a discussion with her, because I think she rang me distressed that we had actually criticised the Nationals for naming a doctor in parliament. I don't - I'm pretty sure that I didn't ring her, that she rang me.

During that - during a conversation with Mrs Fletcher regarding Dr Patel, have you ever stated that you had heard from your sources that "the nurses were lazy and Dr Patel was whipping them into shape"?-- No, I had no sources at that point. I hadn't chased down our Bundaberg membership. I hadn't spoken to the anaesthetist or anything like that. I had no sources. That's the whole point about this. You know, the only sources that we had were from some rumour within Queensland Health and Mr Messenger's staff. I just didn't have any sources to make - that's the whole point about what I've been saying, is that I had not spoken about that and my recollection of the conversation was that Mr Messenger initially had workshopped this around his electorate in Bundaberg getting some advice from different people, and that's my understanding of where that comment came from. It came from somewhere within Bundaberg. I had no knowledge at all of what was happening at the Bundaberg Hospital. The work ethic of the nurses, I hadn't - didn't even know, really - I mean, I knew that - I knew in recent times that Dr Patel had been reasonably prolific, but until I saw, I think, the Queensland Health submission which listed the number of cases I had no idea that he had actually been such a busy surgeon.

So you didn't tell Mrs Fletcher that you had heard from your sources that "the nurses were lazy and Dr Patel was whipping them into shape"?-- No, I didn't.

Thank you?-- Thank you.

Thank you, Commissioner.

COMMISSIONER: Ms Kelly?

MS KELLY: Thank you, Commissioner.

CROSS-EXAMINATION:

MS KELLY: I had indicated on Tuesday night that I would only ask one or two questions, but I expanded to six-----

COMMISSIONER: Things change.

MS KELLY: -----six areas, if I may. Dr Molloy, do you agree there are three principal reasons for doctors to work in and remain in the public health system in Queensland and that those reasons are altruism, the opportunity to teach, and the opportunity to do research?-- They're three important reasons. I don't think they're the only three reasons.

All right. Are there other reasons that you want to point to?-- Yes, I think so. I think that the doctors have a level of security. You know, private practice doctors are notorious insecure people. The - there's also a level of lifestyle. There's - there is more guarantee in the number of hours you work and in guaranteed after hours cover and, you know, rostering and things like that. So there are lifestyle advantages for the doctors, as well, and there's also an intellectual satisfaction, in that the public hospitals often get our sickest patients, and the clinical array of material and patients that they have to look after, you know, is intellectually very challenging and, therefore, very satisfying.

COMMISSIONER: And, I guess, another reason is that some very obscure areas of medical practice, if that's the area you are interested in specialising in, the only place you can practice that is in public hospitals?-- Yes, that's quite correct, Commissioner, particularly, for example, children. You know, paediatrics, for example, the subspecialties of paediatrics almost only exist in the public sector.

MS KELLY: Dr Molloy, I failed to tell you that my name is Kelly, and I'm instructed by a group called the Queensland Clinician Scientists Association which consists in the main of staff doctors and VMOs, but particularly staff doctors who wish to and do do research?-- Mmm.

So the particular area to which I want to take you now is research. Do you agree that there is a failure in Queensland Health to establish and have implemented a coherent research policy for Queensland Health medical practitioners?-- I believe that to be true. Ms Kelly, I will help you and answer your questions as much as I can. This is an area that my depth of knowledge is reasonably poor in terms of, for example, the amount of funding that Queensland Health puts in and things like that, so my detail, you know, my opinion is that research has always been a very low priority in the Queensland Health sector, public health sector. That's been true for 20 or 30 years as we've run a public health sector on the cheap and, you know, based at the lowest denominator of basic care. We have had individually, you know, high quality research units, but the number of high quality research units in Queensland compared to, perhaps, southern states has always been very poor and research and time off for research is a very, very poor priority in Queensland Health.

Yes, and on Tuesday night you referred to the failure to provide sufficient teaching time?-- That's correct, and that's getting tighter and tighter. We have constant

correspondence and minuted meetings where teaching - sorry, teaching has - the constriction of teaching time is now becoming a really major concern. That's at two levels, firstly, it's a concern for the medical school, but also it's a concern for the junior doctors. Our junior doctor groups that are very active complain constantly about a constriction of teaching time, they get very poor time off to study. The senior staff, whom you represent, are getting very, very pushed to find any teaching time and, also, that impacts on the overseas trained doctor and our - in that our senior staff were reporting back to us early about the overseas trained doctor problem, with the promotion above level of competence, the supervision and teaching that was needed to bring some doctors up to speed, just the time was never made in Queensland Health. That actually is an important issue, Commissioner.

COMMISSIONER: Thank you.

MS KELLY: And just as the frustration over failure to provide adequate teaching time is making itself felt on senior staff, is it also, in your experience, a failure to provide proper research time a source of frustration and, indeed, exodus by Queensland Health staff?-- We have said publicly, and I think I have said in this Commission, I believe Queensland Health is a poor employer of staff specialists. We presented evidence that they have the lowest salaries in the country. They also get, to my knowledge, the least time off for research and teaching and the intellectual satisfaction and the intellectual desire that will keep them in the job in Queensland is very poor, and that's one of the reasons that the health system in this state is so poorly resourced in terms of workforce.

Thank you. I want to take you then to some evidence you gave on Tuesday night in relation to the Queensland Health pathology service. I don't need to refer you to the transcript, but for anyone who has the transcript it's at page 585 and following. Now, in that evidence you were responding to questions by the Commissioner about different types of bullying and you referred, in particular, to a couple of events that happened in Queensland Pathology. Do you recall that?-- Yes.

Now, just to clarify, we're talking here about anatomical pathology, aren't we?-- Yes.

Now, the chronology to which you took the Commissioner at the top of page 585-----

COMMISSIONER: I'm sorry, Ms Kelly, you're way ahead of me. What do you mean by anatomical pathology as opposed to any other kind?-- There are four branch - sub-branches of pathology, possibly more. The most important is anatomical or histopathology. That's where you look at pieces of tissue under slides to make diagnoses of cancer, et cetera, under a microscope, et cetera, Commissioner.

Does that include blood samples and other?-- No, blood samples would be - are divided into two branches of pathology, haematology, that's looking at the cells.

Yes?-- And the fluid in the blood is usually biochemistry, Commissioner, and that's another sub-branch of pathology. The vast majority - because of all the automation that's occurred in pathology the vast majority of pathologists that come through are anatomical and histopathologic because looking at tissue down a microscope is done manually. They have machines that can do 40,000 blood samples an hour, and you only need one biochemical pathologist to supervise a whole lab.

MS KELLY: You referred in commencing to discuss this issue that there had been an area of need at Royal Brisbane?-- That was my understanding.

Yes. Do you understand that that area of need was occasioned by the resignation of numerous staff specialists?-- I was aware that many staff specialists had left Royal Brisbane.

In fact, eight over a four, five year period?-- I didn't know the exact number, Ms Kelly.

All right. Did you know - was it within the knowledge to which you referred on Tuesday the effect that that exodus had on the training, both of medical students and Registrars in pathology?-- Yes, that was very important because the College of Pathologists, I think, disaccredited Royal Brisbane Hospital as a training post for Registrars. My recollection is that they left the Registrars that were currently in training, had jobs there, they left those posts accredited, but refused to allow any Registrars to staff training at Royal Brisbane because of loss of staff.

So there was an immediate requirement, if you like, by Queensland Health to acquire sufficiently senior staff pathologists, specialists, to train the Registrars coming through-----?-- That's correct.

-----to meet the need and that's why there was a need for three FTEs or Full-Time Equivalent pathologists?-- That is also what I have been told.

Do you understand what the chronology was in relation to the employment of those pathologists in terms of when they were registered by the Medical Board?-- No, I don't. My brief was a fairly broad one when I was asked by the College of Pathologists to assist them in representations to the Minister and the Premier, and when the matter - you know, when the college was referred to the ACCC and, you know - which, as I said I thought was a very poor act and I, sort of - I guess the function of an AMA President is a bit like to act as a barrister for medical groups, because of your medicolegal contacts and your supposed knowledge of the system you go along and represent a medical group and what you get given is - you get given a short-term brief to understand the issues, so that you can present them and help them present their case,

so I'm not aware of the minor detail.

Dr Molloy, is it your understanding that Queensland Health might well have employed certain pathologists to fill these FTE positions in order to satisfy the college prior to being - it being satisfied that these were properly accredited pathologists?-- I think the imperative to employ more histopathologists was two-fold: one, that they needed the work done. I think at the time they were outsourcing work to the private pathology companies and also - I mean, yes, there was a level of political embarrassment in terms of the state's biggest hospital not being able to train histopathologists.

So there was then something of a struggle, wasn't there, about the nonaccreditation by the college of persons either employed or proposed to be employed to fill these FTEs?-- That's my understanding, is that the - the brief that I got from the Pathology College is that they - that Queensland Health put them to up to be - I guess it must have been specialist deeming - as I explained on Tuesday, deemed specialists. The college weren't happy. I don't know the detail of what went on between Queensland Health and the college pathologists. I was told that the college put a special exam on in Sydney for two of them, and I was told that they didn't come close to passing.

But notwithstanding that one remains - at least one remains employed?-- I don't know. I understand there were three. I don't know if the one that remains is one of the two that failed the exam or not. I know that three were put up. I don't know the detail of the doctor who is still there, whether they were one of the two failures because I know all three didn't sit the exam.

What-----?-- That's my recollection of it, anyway.

What proper work could that person be lawfully doing in the position of pathologist when not accredited?-- Well, I think that would depend entirely on the - can we break - can I break that into two parts?

Sure?-- One is what work could they be doing and the answer is under the auspices of Queensland Health virtually anything it would seem from, you know, a junior Registrar's job to a director's job. What they lawfully could be doing, I actually don't know. I don't know the answer as to what the law is in terms of what you are allowed to do.

But much as - this is a similar situation, is it not, to that of Dr Patel, not a surgeon, but practicing as one?-- Yes, that's correct.

Now, you were asked by the Commissioner before dinner about whether - about a drop in staff, clinical staff, at Royal Brisbane and the Commissioner asked you had there been a commensurate drop in numbers of administrators; do you recall that?-- Yes.

And you said you didn't know?-- That's correct.

Are you aware of a program called Inov8?-- No.

Are you aware of a proposal within Royal Brisbane to introduce 17 new AO7 positions, which proposal was announced in March?-- I think so, in that I did some media work with the Government Gazette of the 8th of April when there were 27 new positions for AO7 and AO8 administration officers announced and I actually did present that to the Premier. I - there was a very significant amount of political activity occurring at that time and when that was pointed out to me I - I - there are small things sometimes where straws break camels backs and that was one of them, I think.

Are you aware of the budget of 1.7 million for that new - that range of new AO7 positions?-- Yes, I was. I actually used that with the press because it approximated to the amount of money that we were looking for cardiac - for expanded cardiac services or some similar service. I don't remember the total context.

Yes, thank you. Are you - you said there was actually quite a controversy about it. Do you recall the launch of that program whereby an actor was hired to wear a Superman costume?-- No, I didn't.

Okay?-- No, I didn't know about that.

All right.

COMMISSIONER: By Queensland Health?

MS KELLY: Pardon?

COMMISSIONER: By Queensland Health.

MS KELLY: Yes.

COMMISSIONER: What's this to celebrate the-----

MS KELLY: 17 new AO7's at the cost of 1.7 million in March of 2005. Dr Molloy, I want to take you to the evidence that you gave at the same section of the transcript on Tuesday night about bullying. I want to make sure that we traverse the range of your knowledge about bullying. As I understood it you gave examples of bullying, that - of various types. The first was in relation to the college for sticking its neck out and being seen as this is the College of Pathologists?-- That's correct.

And that there was a public spin campaign which accompanied that-----?-- Yes.

-----to the effect that the colleges were a cartel?-- Yes, and then I was then verbally told that when the Minister and the DG - the Deputy Minister then was asked to speak as the new Minister at various college functions. For example, the

College of Surgeons had a meeting at the Gold Coast. He made a point of including this in his speech, you know, colleges have got very, very good control of standards, but they're fundamentally academic organisations and you start waving things like ACCCs at colleges they get very, very nervous. They're not tough like us.

In fact, that brings me to the next type which you identified and that is the effect of that action on the other colleges?-- That's correct.

You said this is an experience which will stay with you for your life to have 35 heads of college apparently intimidated by this action?-- It wasn't so much particularly by that action. All of them - many - not all of them, but most of them at various positions had visiting doctors or staff doctors of Queensland Health and all were concerned about personal acts. I really felt they were concerned about personal acts of intimidation or acts of intimidation to their members that they were representing who might come forward to represent to either the Forster Inquiry or to this inquiry.

And that brings me to the third category, at least, that I discern from your evidence and that is the Cartmill example, the personal vilification and threats of defamation and in other circumstances gaol; in other circumstances in relation to, I think, Dr John Blackford was threatened with dismissal for asking for conference leave, that type of personal intimidation is the third type which you have already identified, and I suggest to you in relation to the third type there is a consequential type, that is, where doctors witnessing such behaviour on the part of Queensland Health in relation to their colleagues are similarly intimidated?-- Yes. I - you know - as I said, there is clearly a very significant impact on doctors working in Queensland Health in terms of the culture of working there. I was really very surprised at - at this heads of college meeting to have such a - such a response.

You referred to Dr Con Aroney - as you know for whom I act?-- Yes.

And Dr Con Aroney was a very public example of the bullying to which you referred on Tuesday night. Are you able to estimate the degree of knowledge of the events which were visited upon Dr Aroney amongst your members? Is it a well understood, well-known set of happenings, or is it simply lost in the media dross?-- I - can I ask - can I clarify your question? Are you asking do my colleagues understand what Con went through?

Yes?-- Is that what you are asking? I think they do. You know, most of my colleagues are well read. I think that they understand and it has been very well publicised. Of course, with the release of the Maher report, which we then responded to, with Con Aroney as part of the panel, I think it had a very high level of publicity and, you know, his stand has fundamentally been vindicated.

COMMISSIONER: I think Ms Kelly's point is simply this: that if your members are aware of what that doctor was put through by Queensland Health despite the fact that he was subsequently largely vindicated, is that likely to have an impact on other medical practitioners?-- Thank you, Commissioner, I had misunderstood the sense of the question. Yes, I am sure that's true.

MS KELLY: And now is there a fifth type of this bullying to which you haven't referred: are you aware of a practice in Queensland Health of threatening a troublesome doctor, as I think you referred to as VMOs sometimes being a troublesome doctor, with a risk to the welfare of their patients?-- I don't think so. I - I am struggling to think of an example.

Can I clarify my question - I am content with your answer, if that's your answer, but I perhaps need to clarify the withdrawal of a service, the closure of a service?-- Oh, yes, I have heard - I have heard anecdotal level evidence where, you know, "If you keep pushing this, we will do away"-----

Close you down?-- That's correct, yes. I have heard anecdotal evidence of that.

So, in effect, the doctor is placed in the position of having to be quiet-----?-- Yes.

-----in order to protect the welfare of current and future patients?-- That's correct.

Is that right?-- Mmm.

Thank you. Finally, Dr Molloy, there was suggestion at the commencement of the controversy of Dr Patel that there was - this was one bad apple, a case of one bad apple in the health system. Do you recall that?-- Did I say that or-----

No, no, there was suggestions by those-----?-- That's a

relief.

-----defending Queensland Health's record-----?-- Right.

-----to that effect. Do you recall this or not?-- I don't particularly recall it but I could completely accept it was said.

Do you accept that this is a case of a rogue doctor going bad within a region, and therefore remote from Brisbane - in a geographic and functional sense in a remote area?-- Well, Bundaberg isn't a remote area. Bundaberg has 78,000 people and is very near to other major population centres of Hervey Bay and Maryborough. No, I can't accept that as - you know, at that level of simplicity. Look, the vast majority of doctors who work in both the private and public sectors in this State are good doctors. But, you know, there must be doctors out there - there are something like 14,000 doctors registered in the State, about 10,000 practising - even if .1 per cent of those doctors are not good doctors, that's still a very substantial number of doctors that can do harm. So, you know, I suspect that Dr Patel was one of our worst, but there probably are a couple of other doctors out there who may be right down at the bottom end of the spectrum. But, I would feel confident speaking of our standards for the vast majority of our doctors.

COMMISSIONER: I think, Dr Molloy - obviously I am not expressing a concluded view on this - but I think the way the evidence is tending to go, it suggests not so much that Dr Patel was a totally incompetent doctor, but rather that he practised beyond his level of competence. That he could perform competent surgery on an ingrown toenail, or possibly an appendix, or something like that, but he was just doing work that was out of his league. Do you have any basis for supposing that there are other doctors, particularly foreign-trained doctors around Queensland in a similar situation?-- Well, I guess to a certain extent that was the case at Hervey Bay, both in the orthopaedic department and you are aware that the zone manager in the central zone had limited scope of surgery at Hervey Bay. So I think there are doctors - there has been evidence of other doctors other than Dr Patel that work beyond their scope of competence or the hospital's scope of competence.

Has your attention been drawn to other cases around the State? One that's been mentioned a couple of times is an anaesthetist at Charters Towers. Is that-----?-- No I am not aware of the details there, Commissioner.

Or an ear, nose and throat doctor at Townsville?-- I am again uncertain of Townsville. I was actually - I was actually doing some research on Townsville and I am just not sure if that's the case, or that was potentially the case in terms of a very controversial appointment which I understand has now been stopped.

Right. And, similarly, with a controversial appointment that

didn't go ahead in the - as regards an intensivist in Central Queensland, Rockhampton, I think?-- Yes, I am very aware of that one because, you know, I helped - after the college of physicians stepped in and stopped that one, I actually drew a number of people's attention to it. I thought that that was substandard conduct.

Well, perhaps it would assist if you give us a thumbnail sketch, anyway, of what you thought was substandard conduct there?-- Well, the intensive care department at Rockhampton Hospital has been a very significant problem, and without the ICU beds the surgery department will collapse, in terms of scope of practice. There is a competent surgery department, in my opinion, at Rockhampton Hospital. This became a very significant political issue. Rockhampton Hospital has some fairly major management problems and the anaesthetists were helping out intensive care, but really the workload was just too substantial. There were a number of threatened closures. Rockhampton Hospital finally found an anaesthetist, who I understand is extremely competent - finally found an intensivist, I am sorry, who I understand is a very competent intensivist, and she is from Germany, I understand. May I ask, Mr Gallagher has been heavily involved in trying to reconcile problems in Rockhampton. Could he intervene if I give you a wrong fact during my briefing?

I have no difficulty with that.

MS KELLY: No.

COMMISSIONER: If no-one else has any objection?-- Anyway, but this lady has been working basically one-in-one ever since she arrived. A number of promises were also made to her, in terms of helping her out, that have not been met by Queensland Health. She then - Rockhampton Hospital advertised for an intensivist. They came up - the recruitment agency, I understand, came up with an Indian lady who had actually had a good Indian degree from Bombay, had a sort of physician's degree from Bombay that you do by thesis about three years after you get out of medical school - it is not like our physician's degree - then had spent something like, I understand, three or four years working as a senior Registrar in intensive care at Royal Melbourne Hospital - that's actually, of course, a very good intensive care unit - but had not sat her exams, and it would seem was not able to get a very good reference from anybody who had worked with her at Royal Melbourne Hospital. The - she was put up to be a deemed specialist to the joint faculty. Intensive care doctors are registered by a joint faculty of the Anaesthetic College and the Physicians College. You can enter intensive care through either stream and they have a joint faculty. The joint faculty said she could work in an intensive care unit but not supervise one alone, which meant she would not be useful for covering this doctor who would be out of Rockhampton on her time off. The - having had that application to be a deemed specialist knocked back, the hospital and the recruiting company - and I am not sure totally of the detail there, as to who actually signed it off - readvertised the position as

instead of an intensive care doctor, as a physician, a general physician with some duties in intensive care, and put the application up to the physician's college to see if they would tick her off. And, fortunately, the physician college spoke to the joint faculty and realised the deception that was occurring and the application was knocked back a second time.

I just want to make sure I understand this entirely. Someone - and you are not sure who, whether it was the hospital administration or it might have been the recruiting firm - but someone tried to, as it were, go behind the decision of the faculty that this person wasn't fit to be a deemed intensivist by simply recategorising the position-----?-- That's correct.

-----as a physician's position rather than intensivist position?-- A physician with some intensive care duties.

Are there any other specific examples you can bring to our attention of overseas-trained doctors either having been appointed in a situation where they are beyond their competence, or threatened appointments that through the intervention of the AMA or some other body have been prevented?-- Not that immediately spring to mind, Commissioner. I suspect there probably are others, but it is really only since Dr Patel that I have actually been more researching this area. And as these things gather momentum, people come to you with stories and people give you papers from meetings and things like that.

Yes, thank you, Ms Kelly.

MS KELLY: Thank you, Commissioner. Dr Molloy, thank you for that. In respect of the one bad apple question to which I drew your attention, is it the case that your evidence suggests that there are dysfunctions in cardiology, pathology, orthopaedics, medical education and training, the employment and deployment of VMOs, the jurisdictional gaps between the Medical Board, Queensland Health and the Health Rights Commission, and that these dysfunctions occur across the regions and in the tertiary hospitals?-- Yes. You know, our criticism of shortfalls in the system have been consistently a matter of public record.

So is it fair to say that notwithstanding the best efforts of the health practitioners who have remained in the system, the system is riddled with crisis?-- Yes. There are - there are areas of serious shortages in the public health sector and there are significant disparities of care within the sector, from hospital to hospital, and there is significant disparities between the system as a whole and the private health system.

Thank you. Nothing further.

COMMISSIONER: Thank you, Ms Kelly. Anyone else before Mr Farr? You have the floor.

MR FARR: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Dr Molloy, my name is Farr. I appear for Queensland Health and some of their staff. Can I take you back to a point you were questioned about earlier this evening by the Commissioner. It is accepted, it would seem, that there is a shortage of medical practitioners in Queensland, in Australia, and, for that matter, internationally?-- That's correct.

All right. That shortage overall has caused, if I understood things correctly, a jockeying, if you like, for the services of doctors around the world, countries might be bidding against each other, that's correct?-- That's correct.

And for those doctors that do come to Australia, States would be competing against each other for the services of those people?-- That's correct.

All right. The shortage of doctors is not something that has just developed overnight, obviously. I take it this is something that has occurred over a period of time?-- That's correct.

And if I understand the submission of the AMA correctly, at least part of the reason for that is a Federal government decision back, I think, in the early to mid-1990s regarding the restriction of the number of medical student places, and that position then being maintained for quite a number of years?-- That's correct.

The effect of that decision, just focussing on that, as I understand it, is that as the years passed and populations increased, the number of medical graduates that this country was producing remained by and large the same, or perhaps even dropped slightly?-- That's correct.

It would be, I take it, the view of the AMA that the rate of graduates should increase commensurate with at least population increase?-- That would be eminently sensible.

Now, by way of an example, in 2004 - I am advised that there were 226 medical graduates in Queensland. Would that accord with your knowledge of that topic, approximately?-- Yes, approximately, yes.

Can I put this to you, too, and just ask you if you can comment upon it: I am also advised that in 1976 there were 226 medical graduates in Queensland. Is that something about which you are aware?-- That would be about right. I graduated in 1978.

Right?-- And I graduated in a year of about 220.

So that's approximately-----?-- They would be approximate figures.

Sound about right?-- Yes.

Now, that lack of increase over what would seem to be a substantial period of time must have a significant impact upon the ability to provide health care?-- Yes.

It seems, as I understand things, that that has been recognised as a problem some time past now, and the Federal Government's decision in restricting those numbers has been rescinded and, in fact, additional places have been created for medical students around the country?-- That's also correct.

Okay. And I am assuming - and please correct me if I'm wrong - but the intention of that is obviously to ultimately have more Australian-trained medical graduates hopefully entering the Australian medical workforce-----?-- Yes.

-----for a start, and, secondly, hopefully by the method of that occurring as time progresses, improving the standard of health care year after year?-- That's correct.

And I take it that the AMA is most supportive of that in fact continuing?-- Yes, very much so.

And being given whatever assistance is needed to ensure that it works properly?-- We were one of the primary organisations that lobbied for it and brought it both to the government and the public's attention.

Right. And I think the effect of it all is that in around about 2010/2011 we should expect about twice as many medical graduates for that year as, for instance, we might have this year?-- That's correct.

And then that increase in number should continue then for each year thereafter?-- That's also correct.

Perhaps even more, depending upon how these schools go?-- Yes.

In Queensland we have three new medical - reasonably new medical schools who are yet to produce their first graduates. That's Bond, James Cook, and Griffith?-- Yes.

Okay. And is it the case that as those places establish themselves, that there is a hope that they might be able to increase the number of graduates that they produce as time passes?-- Yes.

So one would reasonably hope and have reason to hope that once the graduate staff in those places and the increase in graduates from Queensland Uni, that it will provide some impetus for even more graduates in the years that follow and

thus reduce the burden on those already in the system?-- Yes.

Okay. It would seem, from the issues that have been so far identified in this inquiry, that we could look at the problems facing the provision of public health services in this State in the context of short term, mid-term and long-term?-- That would be a reasonable classification, although, to be fair, I suspect one of many.

I appreciate that. It is perhaps a simple approach, but can we, on the topic that we have been discussing so far, the improvement that one would expect and hope in the system, simply by virtue of having more medical graduates coming into the workforce would be something that would be considered, I think by everyone working in the system, as a long-term goal?-- That's fair.

All right. And, as I understand from speaking to various people involved in the health business, there is an expectation that as things improve in that regard, that will also have a flow-on effect in other areas, so that the number of doctors start to increase, the number of nurses will necessarily need to improve, the facilities that are provided might necessarily improve. That is the hope of many people?-- Yes.

If that all occurred, it would be something that might provide some reasonable expectation of having a good health structure in the long-term?-- Yes.

Given that, might it be of particular importance, perhaps for the purposes of this inquiry, to focus predominantly on the short to mid-term problems, because part of the exercise will be to establish the basis for that long-term future?-- Yes, I think that's a reasonable view, too.

So if we have the right systems in place in the short to mid-term, hopefully that will give the long-term potential solution its best opportunity of working as best as it possibly can?-- That sounds very logical.

All right.

COMMISSIONER: The only difficulty I have with that, Mr Farr, and perhaps Dr Molloy you could comment on this, is that long-term solution sounds very attractive if there is a commitment to the funding that will be necessary to employ those extra doctors and those extra nurses and to provide those extra facilities, in whatever we're talking about, as a long-term, 10 years or 15 years, or something like that. One of the difficulties is that we're really working in the dark. We don't know what additional funding there may be in that many years' time, so I don't think we can simply say it will all be fixed up in a decade's time and, therefore, we only need concentrate on the next 10 years.

MR FARR: No, no, definitely not?-- I agree that's eminently sensible, Commissioner. I mean, the fact is even if we've got

more doctors, if we have a poor system, you know, we just won't have - we will never have good doctors prepared to work in a bad system.

COMMISSIONER: Well, you made the point yourself that there are surgeons and other specialists available to perform elective surgery in the major public hospitals here in Brisbane, but unless you have got the intensive care facilities or the critical care facilities, unless you have got the theatre staff to open up the closed theatre at Royal Brisbane, you can have as many surgeons as you like, you are still not going to get more operations done?-- Mmm.

MR FARR: Flowing on from the comments of the Commissioner, is it your view and your association's view that what we should really be focussing upon is the improvements that can be made in the system within the budgetary constraints that do exist, whatever they might be, trying to make the most of the dollar, as it were?-- Yes. I think there are - there are two aspects to that. One, you know, we are - many of us are convinced that within the current budgetary constraints, that dollars could be more wisely used in Queensland Health than they currently are. But, you know, I remind you of the initial evidence that I presented on Tuesday, that we have a $700 million funding shortfall in the current spending every year to meet the average spending on a public patient per head of population that exists in other States.

All right. And that, in fact, brings me to the next point that I was going to make - and I appreciate that the comment that the Commissioner made on Tuesday night about part of the function of this inquiry is not to go and say we just need a bigger cheque - but as I understand your position and the position of the AMA, is that what you are hoping and striving to ultimately achieve is the best value for the dollar, for whatever number of dollars might exist in the system, but the association's of the view that there in fact needs to be a lot more dollars to make it work to its maximum potential?-- That's right. At least as much is spent in other States.

All right. You will have had, over the years, obviously, some considerable contact with the various people that work in administrative positions in Queensland Health, and I take it that you would have and would appreciate that the budget that is supplied is something that they have to work with as well. I think the point that you make is that you think they are too budget focussed?-- Yes. I think that the - your point about the budget that they are given is what they have to work with is, I think, a fair one, and because the primary method of assessing the competence of an administrator is their level of budget compliance, that becomes a mechanism by which they are either - you know, they pass or they fail.

Yes?-- They are promoted or they are demoted or perhaps sacked. That the - basically the budget compliance has become the core business focus of administrators.

And that's the opinion that you have formed from a number of

the things you have spoken about over the past couple of days?-- That's correct.

All right. Now, we might-----

COMMISSIONER: I might interrupt at that point. I think, though, from your earlier evidence you are actually making two points. One of them was about being budget focussed but the other is about budget allocation between different - you know, getting more bang for the buck, as it were, and Ms Kelly gave us an extreme example of money spent on a superman costume, or an actor to launch a program for having a couple of dozen more bureaucrats, which might or may not be true, and we will probably hear about that later. But were you also making a point about better use of the available money, not just being budget driven?-- Oh, yes, Commissioner. Yes, I thought I had made that point.

Thank you, Mr Farr.

MR FARR: Thank you, Commissioner. If we can just come back to the short to mid-term future, one of the pieces of evidence that the AMA has I think referred to and commended is what's been generally referred to as the Lennox Report. And the Lennox Report, if I can use that term, is a document that has - well, it was specifically in relation to the potential problems and potential solutions in relation to overseas-trained doctors. That's correct?-- Yes.

And one of its principal focuses was a centre for overseas-trained doctors that might provide assistance, support training, so on and so forth?-- Yes.

Now, can I just ask, if you are able to - and please tell me if you can't, during this - I'd like to run through some features relevant to that topic arising from that report. Can I ask you, firstly, have you met Dr Lennox?-- No.

You did mention on Tuesday that you didn't know what became of him? I take it from your last answer you have never met him, never spoken to him?-- No, that's correct.

One of his key recommendations related to the establishment/funding, if you like, of a centre for overseas-trained doctors and such a centre was in existence at the time at the Queensland - on the campus of the Queensland University?-- That's correct.

Is it your understanding that in early 2003 Federal funding for that centre at that time ended?-- Yes.

And as a consequence of that funding ending, the centre management applied to Queensland Health for funding from that organisation?-- That's correct, and at a meeting with Wendy Edmonds and a meeting with the then Director-General, we lobbied conceptually on behalf of the centre. That was my preceding President but I do remember attending a meeting where lobbying was placed for that funding.

And in fact, can I suggest to you that in early April 2003 - I'll just get my wording correct here - the funding was granted by the then General Manager of Health Services, Steve Buckland, and now Director General? On an interim basis, I should add?-- I don't know the exact date, but I knew that the State Government had helped the centre.

And that the funding was for a 12 month interim period until arrangements could be made to transfer the centre to the Queensland Health Skills Development Centre based at the Herston campus of the Royal Brisbane and Womens Hospitals?-- Yes, that was my understanding. Again, I wasn't aware of all the terms, but conceptually I was aware of that.

That's fine. Can I suggest to you then, just following the chronology, in July 2004 formal responsibility and management for the centre of overseas trained doctors passed to Queensland Health. Are you able to comment upon that?-- Again, I was aware that there'd been a transfer. I'm not aware of the dates.

All right. That's fine. I'm not expecting that you would remember this, but this roughly sounds correct to you. Then can I suggest in September 2004 the centre physically transferred to the Herston campus?-- That's correct.

Where it was renamed the Centre for International Medical Graduates?-- I understand that that happened around that time.

All right. Now, can I also ask you then, in relation to this organisation - this place, that at the same time as it transferred to Herston, there was an approval for funding by Queensland Health for an assessment, training and support project specifically for overseas trained doctors to be run through that centre?-- There may have been. I mean, again I'm not cognisant of all the detail, but I completely accept that this is part - consistent with the general intent and the briefings that we had.

Okay. Putting aside dates and that sort of thing, are you aware of such a program? And just to assist you, the program, I'm instructed, is called Recruitment, Assessment, Placement, Training and Support Program?-- Yes, I have had a briefing on that.

All right. And is it your understanding that that project is aimed at both permanent resident doctors and temporary resident doctors who are overseas trained and who are to enter the public health system?-- Yes. My initial understanding of the briefing that I had was that particularly the intent was screening as doctors entered the system, screening to assess best assessment of skill levels.

Right?-- That was my initial briefing of what the intent was.

I might be able to assist you in that regard. Is your understanding this: that that centre is still to reach its

maximum operating potential-----?-- Yes. That is our understanding. We have a number of concerns about the centre, but also have - you know, we view the skills centre at the Royal Brisbane Hospital as an excellent facility. It has some of the staffing and funding features that we've come to know and love with Queensland Health in that the funding model is rather problematic and depends on aggressively the centre selling its programs, particularly within the group of client hospitals and those hospitals paying for the use of the centre, and also various training programs, perhaps the colleges purchasing time at the centre.

Right?-- The financial model may turn out to be troubled. The second thing is that one of my platforms or planks, I guess, has been a demedicalisation of the health system. The skills centre still hasn't got reputable academic doctors on staff and associated with it and setting up the teaching curricula for doctors who are going to be its primary focus. It has junior doctors working in an assistant capacity paid at four hours a week. But, you know, the intent of the facility is noble. The facility is simply excellent, but again, the funding and staffing model may be falling into an all too familiar Queensland Health pattern.

Can we just look at the intent of the place to start with? Is it your understanding that if it achieves its intended purpose in operation, that all overseas trained doctors would pass through the centre before they get to a hospital?-- That's my understanding, or within a very short time of them arriving in a hospital.

Is it also your understanding that it is intending to adopt, and has adopted in some cases, the sensible approach of subjectively looking at individual people so that they're not just giving them one course, a one-size-fits-all approach?-- Yes, I understand there is going to be a level of individuality and, yes, I think that is sensible.

Is it the case that the AMAQ is in fact very supportive of the full and proper establishment of that centre and its efficient running and management?-- Yes.

If it does achieve those things - and do you understand it's hoped to have it running to full capacity by the end of this year?-- I was aware that that's the hopeful timeline, that's right.

If it manages to achieve what it hopes to achieve, will it be a centre that will play a very important role in the provision of quality health care for the public of Queensland?-- Yes, it will.

That centre, as you've indicated at the beginning of my questions on the topic, if not started as a result of the Lennox report, certainly is in existence consistent with recommendations of the report?-- Yes, that's correct, although plans for the centre were not - the centre was not initially conceived of or set up as a centre for international

medical graduates. That grew as part of it.

Right?-- Really it followed the line of setting up a skills laboratory, particularly a surgical skills laboratory along the lines of the excellent one in Western Australia, which is simply too far to go, and the fact that teaching had to move to a certain extent from patients to various modules, various machines and things like that, and also both at an early post-graduate and a senior post-graduate level. The intent of the centre was one more of facilitating genuine post-graduate education in the Queensland public centre. The add on of the international medical graduates centre was just that, an add on. It's a very good one, but it wouldn't be fair to suggest that that was the original intent of the centre.

I'm not suggesting that to be the case?-- That's fine.

However it came to be in existence in its present and anticipated form, it is something that would seem to have at least in part - is in part responsible - has a responsibility from the recommendations of the Lennox report?-- Yes, that may - well no, actually, look, I can't say that. I don't know what the thinking was in Queensland Health in terms of the chain of decision making or thought taking the Lennox report to the involvement of IMGs at that centre. I don't know what intellectual lobbying or decision-making processes - and whether the Lennox report was involved in that at all. It would be consistent with a recommendation in the Lennox report, but I truly don't know whoever decided that ever read the Lennox report.

Ultimately your evidence on that point is you just can't say one way or the other?-- Yes, that's right.

COMMISSIONER: Mr Farr, on the subject - as I understand it, you're putting to Dr Molloy that there were some benefits that came out of the Lennox report. I'm just having some difficulty in understanding the basis of your instructions to put that, because I have in front of me a media statement issued by Queensland Health - and I can't say whether it was Dr Stable or Dr Buckland who issued it - saying, "Overseas trained doctors report this report has no official status and was not accepted or endorsed by Queensland Health Executive." Are your instructions from the Director General that it is a Queensland Health report that does have an official status, or is he maintaining the line that was published in October 2003 that the Lennox report's a nothing?

MR FARR: Neither of those two, in effect. My instructions are that it was a document that was not commissioned by Queensland Health, but that it was a document which has been referred-----

COMMISSIONER: Not commissioned.

MR FARR: That's the term that's been used earlier in the course of evidence. But that it was a document that was generated by Dr Lennox, as I understand it, had amendments

made to it as time passed, and contained features which I think were recognised as being of some benefit.

COMMISSIONER: Well, if it was recognised as having some benefit, why would either the present or the preceding Director General be telling the media that it's got "no official status and was not accepted or endorsed by Queensland Health"?

MR FARR: I'm not quite sure. I don't know what they mean by the term "endorsed or accepted". My questions really are there is some reference in it to this centre that I have been questioning about.

COMMISSIONER: Yes.

MR FARR: And I'd like to have before the Commission the fact that this centre exists in its form and its anticipated format.

COMMISSIONER: Okay, thank you.

MR FARR: Thank you. That centre, if it is to and does in fact function in the manner hoped for, would be, I understand, an important feature in the Queensland public health system to assist these overseas trained doctors and to provide pathways for that good platform for the future?-- That's correct.

The overseas trained doctors - or I think "international medical graduates" is the current term - there is a high reliance upon them, as you've indicated, in Queensland, but it is, as I understand it, the case that there is a high reliance on such people in all states of Australia and in many western countries, for example?-- I understand that our reliance in Queensland is greater than in other states.

Right. Your understanding is also that there are many western countries that also utilise the services of internationally trained doctors?-- Well, that's correct, and in fact there is a global medical market, and also, you know, it's a positive educational experience for doctors to move between countries and experience other health systems.

You accept, do you, that overseas trained doctors form an integral part of the medical workforce in Queensland?-- Yes, I do.

And that they provide many valuable functions?-- Yes, I do.

And there are a high proportion of many highly skilled people providing high quality care?-- Yes.

If I can just use the term "IMGs" rather than repeating the term?-- Yes, please.

IMGs are utilised not only in the public system, but they're also utilised in the private system, aren't they?-- Yes, that's correct. I mean - yes, that's correct. In the private

system there are a large number, I suspect, of international medical graduates who have fulfilled full college qualification and maybe are in private practice, and particularly, of course, in general practice there are very significant numbers of IMGs.

All right.

COMMISSIONER: Are there any in private practice who are operating in a position equivalent to a Director of Surgery when they're not surgeons?-- That would be impossible in the private sector, Commissioner, because in the private sector you can't operate without a Medicare number, you can't get a Medicare number without a proper specialty qualification, and you can't get a proper specialty qualification unless you're a proper specialist.

MR FARR: The fact that there are IMGs used in the private sector would tend to suggest that the private sector is in need of them?-- Yes.

Obviously. So there is a workforce shortage in the private sector as well as the public sector?-- Yes. There are areas of distinct workforce shortage in the private sector. Measuring what a workforce shortage is in the private sector is a little bit more problematic in some areas, you know, whether you work it on appointment times or you do a mathematical calculation, things like that.

Do you know what the proportion of IMGs that were recruited into the Queensland private workforce last year - 2004 - is compared to those recruited into the public workforce?-- No, I don't. No, I don't know what that proportion is.

If I were to suggest it's roughly in the rate of one-third to two-thirds of the total number that come here-----

COMMISSIONER: Two-thirds public to one-third private?

MR FARR: Yes, two-thirds public to one-third private. Are you able to comment upon that at all? If you can't, please say so?-- That's sort of what I would have expected if you'd asked me to guess. I would have said around the 40 per cent mark, because I understand that general practice very actively recruits into the private sector IMGs.

Can I just ask you-----?-- Could I just add something there?

Certainly?-- Those figures also maybe a little bit biased for that year because there was the government strengthening Medicare program, remember, where Mr Abbott wanted to specifically employ and put aside Commonwealth money to bring new doctors in. So last year's figures and the proportions of last year's figures may not be representative of every year. I'm not trying to disagree with you, I just thought that point of clarification was important.

COMMISSIONER: Dr Molloy, I notice it's 9 o'clock. I'm quite happy to continue sitting for as long as it takes to finish your evidence. I don't want to put you to the difficulty of coming back on a third occasion, but I also appreciate that you've got to see patients in the morning, and I imagine you start fairly early and so on. Are you happy to continue with your evidence?-- You're considerate as always, Commissioner. I'd much prefer to finish tonight. Obstetricians aren't total strangers to late nights. I'm very happy to finish, if you're comfortable with that, and the rest of the people can take that.

I will ask around the room as well, because it's unusual for lawyers to find themselves working at this time of night - in public anyway.

MR FARR: Yes, in Court.

COMMISSIONER: Does anyone have any difficulty if we continue for the time being?

MS KELLY: Commissioner, I need to excuse myself shortly, but there's no problem with continuing in my absence.

COMMISSIONER: All right. Will there be someone here to represent your client's interests?

MS KELLY: I'll rely on the transcript.

COMMISSIONER: Anyone in that situation should feel free to go, but otherwise we'll continue. We might just take a five minute comfort stop, though, for everyone concerned and resume in five minutes, if that's convenient, Mr Farr.

MR FARR: Certainly.

THE COMMISSION ADJOURNED AT 9.03 P.M.

THE COMMISSION RESUMED AT 9.09 P.M.

DAVID MOLLOY, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: While we're waiting for everyone to come in, the Secretary, with his usual efficiency, has pointed out to me something that I should confirm on the record. Earlier today - I think it was when Dr Bethell was giving evidence - someone asked Dr Bethell a question - I think it might have been you, Mr Morzone, but someone asked a question which referred to the statement of Dr Kees Nydam. I had made a note at that time to give that statement an exhibit number so that

the transcript makes sense when one looks at that passage of the evidence, but I had forgotten to say on the record the exhibit number which it's been given. So in case anyone wondered why there's no Exhibit 51, that is the number which I attributed to the statement of Dr Nydam dated 31 May 2005. That should, I hope, keep the record straight.

ADMITTED AND MARKED "EXHIBIT 51"

COMMISSIONER: Mr Farr?

MR FARR: Thank you, Mr Commissioner. Doctor, is there a different vetting process at all for those IMGs who come into the private system as opposed to the public system?-- Not to my knowledge. I mean, except that the vetting system for the private sector is probably more complete in that you really can't enter the private sector without a full fellowship of the relevant Australian college. So that really is a very, very complete vetting system where - and, you know, I'm not now having a go at your client, but I mean, you can work in the public sector, as Dr Patel did, without getting ticked off by the appropriate college. I guess the answer must be yes to your question, in that in a theoretical sense there shouldn't be, but in a practical sense there is because of the need to own a full fellowship.

An important issue - and probably maybe the most important issue for IMGs is the quality of the person's qualifications and skills?-- Yes.

You spoke on Tuesday of there perhaps being a need for some equivalence tables, if you like, between medical schools around the world so that someone can sensibly look at the level of the qualification that a person holds and have some knowledge of what in fact it means?-- That's correct.

In fact I understand that there are some studies being conducted in the United States at the moment on that very topic?-- Yes, I understand also that's true.

I take it from that fact that this is a world-wide problem that needs to be addressed by a number of - any countries that use internationally trained doctor?-- Yes, that's correct, but it also depends on the entry restrictions. For example, it's my understanding - and again I'd be happy to be corrected - that it's impossible almost to practise in the United States without first passing the ECFMG entrance exam, whereas it's very possible to practice in this country without first passing the AMC exam.

But the fact that the States, for instance, are conducting such studies would tend to suggest it's an issue to which they've been alerted and are trying to do something about it to assist?-- I think that's fair comment.

Is there any studies of that nature in Australia, for instance?-- I understand that there's a federal program - I'm not sure who controls it, but I think it's controlled by the AMC and funded by the federal government - to look at fast entry medical schools. In other words, trying to assess medical schools and get a list of medical schools that have effectively equivalent qualifications, and if graduates come from that school they can be fast-tracked into the Australian system.

I see. So if there was - whatever the systems might be, but if there's a good vetting system, if you like, there's an equivalency system in place, that might be the sorts of things that one would hope to see in the issue of qualification and what the qualifications themselves mean?-- Yes.

Another issue would be training and support of an international doctor-----?-- Yes.

-----upon arrival in the country because of cultural differences, that type of thing?-- Yes.

Again these are things that are, I understand, hoped to be addressed in the centre for IMGs?-- That's right. I understand that there's going to be better assessment of the skill level of the IMG. I think that is different, though, in that the skills centre will not be then offering - will offer some training, but, you know, the training and mentoring will actually be out in practice, is my understanding.

All right. I think I understood you to say on Tuesday that there might be some benefit in training for the local staff to better work with the international staff, to have them have some education as to what to expect, the culture of the person that's going to be coming, that type of thing?-- Yes. I think under ideal circumstances that would occur.

Then, of course, there is the supervision of the IMG on placement, if you like, in a hospital situation, and supervision can be a varying problem, as I understand it, depending upon the location and the nature of the work?-- Yes.

Some locations - and I think you agree with this - are notoriously difficult to attract and keep staff?-- Yes, that's true.

And they provide perhaps the greatest challenges for the level of supervision that one would hope to have?-- Yes.

You spoke in your evidence on Tuesday of a policy that you believe exists where there is the approach of appointing people to SMO positions rather than a deemed position because that would avoid the supervision aspect. Did I understand your evidence correctly?-- No, I didn't say that. I said I believed that policy existed, but not for that reason. I believed the reasons to be, one, they were cheaper to employ.

Right?-- Two, it avoided the deeming process which can be time-consuming, and the colleges do knock people back. So you get a more guaranteed workforce at a cheaper price if you avoid the deeming process.

Okay. Now, can I ask you firstly, do you have any actual evidence - documentary evidence - that you can rely upon in support of that contention or is that your opinion, the opinion of the AMA from information you've received?-- That's the opinion of the AMA from information that has been received.

I see. I take it that you would be more than happy if you were proved to be wrong in that opinion?-- Oh, yes. I just don't expect to be proved wrong.

Can I ask you this - just for the purposes of this question could you accept that my figures are right. They will no doubt be proved to be or not in the future, but if last year there were about 130 IMGs appointed to an SMO position in Queensland and about 111 appointed to specialist positions - and I can't distinguish between deemed or registered - would that be a figure that sounds about right to you?-- I'm happy to accept those figures.

Would we expect in the ordinary course of events that there would be more SMOs than deemed specialists and more deemed specialists than registered specialists?-- Those figures would disturb me in that the majority of people are still coming in as SMOs to do specialist work.

Right?-- And I think, therefore, I feel very comfortable with the AMA's proposition.

Right?-- I really have very little about deemed specialists versus registered specialists. I would imagine the majority would come in as deemed specialists.

All right. I'm not-----?-- We support the deeming process, so it doesn't really matter because those people are coming in with the intention of becoming full specialists. We don't really see a big difference.

We'll just use the generic term "specialist", if you like. My question was would you expect there would in fact be more positions as SMOs than as specialists in Queensland Health?-- I don't really think that the position's terribly important. I mean, really the classification of the position seems to be who they can get to fill it and the position is interchangeable. If you could find a deemed or registered specialist to do the work in any of the jobs that would be an SMO, they'd just change the job classification to a staff specialist. But, you know, I don't really see - I think that the classification is to a certain extent opportunistic and would reflect what was available, who was available to fill those positions. But you know, certainly the evidence that we have is that Queensland Health would seem to have a preference for using SMOs because of price and availability.

Are you suggesting that if someone is eligible for appointment as an SMO they would necessarily be eligible for appointment as a deemed specialist?-- No, quite the opposite. I - all I'm saying is that if someone is eligible for an appointment as an SMO, but they could be - you know, but they have a deeming qualification or a full registration, they would naturally want to have the - the more defined status and the higher pay rate.

I understand. So if we take it back a step then. If a person is appointed to an SMO position that doesn't necessarily mean that that person has sufficient qualifications to be a deemed specialist; you would agree with that?-- It would almost certainly be that they didn't.

That being the case, the position of an SMO might be the appropriate position for that person, depending upon the individual circumstances; do you agree with that?-- No, I wouldn't. You know, the position of SMO is created, in my understanding, to - particularly in regional areas to allow someone to come in and do specialist level work without having specialist qualifications. If they have specialist qualifications they're appointed as a staff specialist. If they don't have Australian specialist qualifications, but they can operate - act as a physician, put someone to sleep, then they're given SMO work in that particular specialty area.

What if there's someone who doesn't have sufficient qualifications to be properly qualified as a deemed specialist, what position should they be appointed to? Is there a position?-- Well, that's what we've been saying, an SMOs position. You know, if they have competence in anaesthesia, but not a degree in anaesthesia they will get an SMO job in anaesthetics.

Is that what you are saying should happen or does happen?-- I'm saying that's what does happen.

What are you saying should happen?-- I think, one, Queensland Health should appoint people who are fit for the deeming process whose qualifications are suitable. They can be a deemed specialist or they can have a full certificate registration, that way there is a guaranteed quality that anyone who works in a Queensland public hospital will have the same qualifications as anybody working in the private sector.

COMMISSIONER: We've heard from a number of sources over the last couple of days that the concept of an SMO, a Senior Medical Officer, is assumed to imply that that person will be acting under the supervision of a fully qualified specialist. If things are run on that basis - if, for example, Dr Patel is appointed as an SMO at Bundaberg to operate only under the supervision of a fully qualified surgeon, is that something you have a problem with?-- No, I - no, Commissioner, I don't have a problem with that, but - you know, I'm - I thought I was being asked what's the ideal circumstance.

Yes?-- The ideal circumstance is that everybody gets an

Australian qualification; you know, that we have a stamp of quality that is the same as the rest of the country.

But I think, and Mr Farr will no doubt correct me if I'm wrong, I think he was really saying to you is there scope within the public health system for people who are SMOs rather than staff specialists, and do I take it from your answer that, yes, you accept there is scope to have SMOs in the public system, if they are experienced practitioners in a particular area of specialty, but not fully qualified as specialists who will be working under the immediate supervision of an appropriate specialist?-- I think that's very well put Commissioner.

MR FARR: Thank you, Commissioner. Is there also a position below SMO that's available for international medical graduates?-- Well, international medical graduates can work anywhere in the health system from being, you know, a junior house officer to a principal house officer, which is the equivalent of a Registrar.

And they should be, in an ideal situation, appointed to the position that their skills and qualifications are commensurate to?-- Yes.

And if a person had skills and qualifications, for instance, commensurate to a Junior House Officer or a PHO, Principal House Officer-----?-- Yes.

-----that would be a person whose skills and qualifications were not of such a nature that would qualify them for SMO or beyond?-- That's right. An SMO classification is really meant to do - to say that you can do specialist work and whilst the - a supervisory component must be there, that supervisory component doesn't necessarily mean to be on site, like for a Registrar.

I see. And a Junior House Officer, Principal House Officer, I take it, would be positions that are paid less than a Senior Medical Officer?-- That's correct.

If a person who only had skills good enough for PHO, was appointed to an SMO, Queensland Health would be paying that person too much?-- Yes, that's correct.

Thank you. Can I ask you now some questions about VMOs, changing the categories?-- Just in relation to your last question, they would be paying them too much, but only by about 20 or $30,000, which is a good investment, rather than Queensland Health or the - or, you know, the Government saying to the electorate there's nobody. So it's a good buy at that price.

But they're getting paid more than they should be?-- They're getting paid more than their skill level; that's exactly right.

Now-----

COMMISSIONER: But you might also say by the pay scales in other states they're getting paid what they're worth, even if it's 20 or 30,000 more with the pay scales in Queensland?-- Yes, that's also true, Commissioner.

MR FARR: And I take the Commissioner's point, but you understand my question, I'm referring to the pay structure within Queensland?-- Yes, I do understand that.

Now, in the course of your evidence and your submission and statement you have, when speaking of VMOs, said that you believe that there is a policy to reduce VMO numbers?-- Yes.

In the course of your evidence or your statement you have said things such as "it's the AMAs view" or "we believe" or "there is no doubt in my mind" or "we feel", using some of the terms that you have adopted?-- Yes.

Can I take it from the use of those terms that this is another situation where you do not refer to any particular documentation in support of your allegation of this policy, but it is an opinion you have formed from information you have received?-- Oh, well, I mean, within the AMA, within the minutes, for example, of the combined colleges meetings with the heads of all the colleges, we have had that documented at Council meetings, at the Combined College Chairs meetings, at numerous other workforce meetings, the Public Hospital Working Party meetings, this policy of Queensland Health. It is not just an opinion that you have taken out of thin air. You know, I beg you not to ask us to do it, but I'm sure we can produce 20 pieces of paper over the last couple of years where that has been minuted at meetings.

What I'm interested in now is one piece of paper from Queensland Health that supports it. Do you have that?-- No. Well, actually-----

COMMISSIONER: Mr Farr-----

WITNESS: Please, can I-----

COMMISSIONER: Yes, please?-- It's just the figures that I gave you, where there was a 50 - 50 full-time equivalent drop in the VMO numbers, I did not look that up, myself, but I got that from the President of ASMOFQ, which is the union representing salary doctors, and he got those figures, he told me, from the Queensland Health annual report.

MR FARR: I understand that. The situation with VMOs, if I can just ask you to explain it a little better for us - as I understand it, there is negotiations which take place periodically to determine the various conditions that people would work under if they are holding the position of VMO?-- That's correct.

As I understand it those negotiations take place, perhaps, every few years, two or three years, something like that?--

Yes, I think it's every three years.

It can vary, I understand?-- That's correct.

Okay. And, in fact-----?-- Well, it's not supposed to.

All right?-- But the Government does vary it, yes.

And do I understand that, in fact, such negotiations are part way through at the moment?-- That's correct.

The negotiations in relation to VMO conditions is something that's been going on now for a very long time. It's been happening, I think, at least 20 years, I think you mentioned in your evidence on Tuesday?-- Well, longer, I think.

Longer than that?-- Yeah.

And is it fair to say that in these negotiations it is usually the case that there is a dispute in conditions or pay or that type of thing?-- I understand it to be. I'd like to make it perfectly clear I've been very careful to distance myself from the VMO negotiations. They are part of the AMA.

Right?-- But I have been continually out there fighting for an improvement in the standards of the system, and I was very careful that I didn't want to sully an argument that I was presenting for an improvement and improve patient care with an industrial negotiation, even on behalf of my members and-----

I see?-- -----I have not handled any aspect of the VMO negotiations and only have the most superficial brief on the details because I really didn't want to mix the issues.

I understand. I won't ask you questions that might in some way be relevant to those negotiations.

COMMISSIONER: Did I rightly understand what I thought you said on Tuesday that VMO negotiations, to the extent of your superficial knowledge, are really focussed on how much it is necessary to reimburse VMOs to cover the costs of running their private practice while they're at the - at the public hospital, that it is not - does not proceed on the footing that a VMO actually receives any profit, any income, any revenue from doing VMO work?-- Well, that's - my understanding is that basically it's supposed to - the VMOs tell me that basically is a line ball call on that and that that sort of forms the basis of the revenue - of the remuneration negotiations, Commissioner.

And I guess these things are always variable if you have a VMO who is a specialist with rooms on the Terrace, he or she is likely to be paying more rent than a specialist with rooms in Bundaberg and so-----?-- -----that's probably-----

-----the Bundaberg specialist might make marginally more money out of it than the Wickham Terrace specialist, but the overall idea is compensation for expenses rather than out of pocket?--

Yes, that's right.

MR FARR: Ultimately every few years or so there is this dispute, which I take it, starts off with two parties at varying degrees apart and ultimately an agreement being reached?-- That's certainly happened, yes.

It is, at least when dealing with the issue of the remuneration - it really gets down to an industrial - I don't know that dispute is the correct term, but an industrial dispute?-- It's an industrial negotiation, yes.

The other matter that I wanted to ask you about specifically on the issue of VMOs and people wanting to be VMOs is you speak in your statement of doctors wishing to be treated with respect, and I'm not suggesting they should be treated in any other way. In the private hospital system there is a - somewhat of a different culture, if you like, between it and the public system, I would suggest to you and can I clarify that for you? The primary client of a public hospital - of a private hospital is often said to be the doctor because it's the doctor that brings in the patients. Would you - have you heard that said before?-- Yes, I have heard that said, not so much use of the word "primary" but an important client.

All right, an important part?-- Yes, there is a view that doctors are important in private hospitals.

And that is not the view in relation to public hospitals, obviously?-- No.

The patient should be the more important, if you like?-- Yes. I'm not totally convinced, though, that that's the focus in public hospitals either.

In any event, though, public hospitals do, to a certain degree, and I'm in no way wishing to denigrate this, but woo or shmooze doctors to use their hospital facilities?-- No, because patients go to public hospitals because they need to go to public hospitals. Doctors don't bring patients to public hospitals, though, they - of course, GPs refer patients to public hospitals.

I may have said public, if I made a mistake I meant private, private hospitals?-- Can you say that again, I'm sorry?

Private hospitals to some degree try to woo doctors to use them?-- Yes, private hospitals do actively market, particularly to young doctors and they say, look, you know we have operating time, we have rooms, or whatever.

And is it the consequence of that difference that - and I'm not suggesting this is the only reason, but is it a reason that the perception or the treatment or the respect that doctors are held in in a private hospital can differ to a public hospital?-- It's not just that, it's really that you are the arbiter of the standards.

I'm not suggesting that it is only just that, but does that play a role?-- It only plays a small role. The most important thing is that in our private hospital we get to be the arbiter of the standards. We get a say.

COMMISSIONER: How does that compare with public hospitals?-- Well, remembering I don't work in a public hospital, but my understanding is that the view is that the - that the doctors are being disempowered in public hospitals and have very little say, not no say, but very little say in the standards of care of patients. You know, in a private hospital if your patient is not being well treated you go and see the administration, there's one layer of administration, and you say something and, you know, if the case is fair, something will happen. I will give you an example. During the school holidays the private hospital that I admit patients to - I was operating. They closed a ward on the weekends, and patients were shifted from a private room into a communal ward where there were six bed cubicles. Two of my patients were recovering from surgery. They were offended they were moved three floors and shifted from a private room to a six bed cubicle. I felt the case was very fair. I saw the administration and as a result of that the policy of the hospital has changed. I had to deal with one level of administration and patients would not be moved around in such a way as to save the hospital money again. That took me one letter and 30 minutes negotiation with the administration to improve patients care in that area.

COMMISSIONER: And it was successful?-- Completely successful, and a major hospital policy changed as a result of that. Now, I don't - I don't think you could achieve that in the public hospital in a month of Sundays.

D COMMISSIONER EDWARDS: Because of the decision making process?-- I just - I wrote a letter to the administration and then I had a discussion with the DON who was excellent. In fact, I didn't have to seek her out when I was operating. She made it her business to come and see me. She agreed that what had happened was not good policy for a private hospital, apologised, ensured me that she was taking steps that it didn't happen again in the future, and they would be planning their bed allocation and things more carefully in the future. It was done under the nicest possible way.

COMMISSIONER: I think, Dr Molloy, that you and Dr Edwards were at cross purposes. His question was: is the reason you can't do that at public hospital because of the layers of administration?-- Oh, I see, yes. I think there's layers of administration and there would be, you know, a - you know, a person's back would be up because of the doctor interfering in the administration of the system and also, you know, there's an attitude, well, we saved money, so whatever.

And there's no incentive either to please the doctors or to please the patients?-- No. I mean, the - the primary goal of doing that was to maximise bed to staff ratio, and the patients were inconvenienced. I don't believe that that would

factor very much in a public hospital.

MR FARR: Can I suggest to you, Dr Molloy, that there are in addition to the features of the matters that you have spoken of in your evidence some other considerations for doctors acting as disincentives to take on VMO positions. The first is, I would suggest, the fact that there is an ever increasing gap between the income in the private profession and that in the public profession; do you agree with that?-- No, I don't. You know, it - you know, money when I was working a VMO was - was irrelevant to me and it really is - you know, you are talking six hours a week, and it's true that you - if you work that six hours in private you would earn more. I am absolutely convinced that doctors don't work in the private system - don't consider the income aspects as particularly important. You know, it's an opportunity to give something back. It's where they trained. There is a really strong commitment to doctors in an academic sense to nurture their profession. I absolutely believe in that. I didn't - I was a little cynical about it, but all my political experience in the last 20 years has proved time and time again that that's the case. The most classic example of that is that if we put a political meeting on about conditions we hardly ever have any doctors come to it, we put a scientific meeting on it's booked out, and I have proven that time and time again over the last 20 years.

Do you-----?-- So, I really do believe that remuneration is a relatively minor factor. What is more important, you know, is being able to get a car park and to get from your rooms to your ward quickly. You know if we gave VMOs the choice between an extra $10 an hour and a decent car park, the way they used to have, not because of the status simply because they didn't waste half hour to getting to their ward round or operating list, that would mean more to most of them.

Do you agree that there is at the moment the largest gap between private income and public income, relatively speaking, that has existed in Australia?-- I don't know the answer to that. I suspect it's likely, but I don't know the answer.

COMMISSIONER: Just following up on Mr Farr's question, do you know of any instances whatsoever where Queensland Health has sought specialists in a locale where there are specialists in private practice to act as VMOs and that the specialists have simply refused to participate?-- We have evidence, for example, in Rockhampton which is a city in crisis that it was considered an absolute last resort in the hospitals to bring in - bring in the specialists - bring in a VMO workforce. We have very good evidence in Bundaberg that VMO surgeons were simply not welcome in the department. The - you know, there was an active policy, it was spoken to me by an anaesthetist at the last Directorate of Anaesthetics that is now working in Melbourne that VMOs were not welcome in the department. I am not aware - I suspect somewhere in Queensland, Commissioner, there is probably some example where we have to dredge up - a VMO workforce is being actively encouraged. I am not aware of it.

Mr Farr seems to be suggesting that the reason that Queensland Health has problems attracting VMOs is because of this huge differential between public pay and private pay scales, but is there any actual evidence of that in the sense that private specialists are knocking back offers of VMO positions because they prefer to make more money in private practice?-- I don't think so. It's really all about the conditions of work. You know, I - I have spoken to anaesthetists. You know, there's this shortage that we keep talking about at Royal - at Royal Brisbane I have spoken to the anaesthetists because they put a list of sessions that are available each week, but the reason the anaesthetists don't go it's not really the pay. They would - they don't mind helping out. Their complaint is they no longer are getting a Registrar to teach. They're just used to do volume work and, you know, the staff doctors get the - get the Registrars to help out on the list and to teach. So they're just used to do low - volume and the other reason they go to the public is you get, you know, the difficult anaesthetic cases, you don't get the high volume Cat 3 work that you often see in the private sector and so they get to anaesthetise some very difficult or sick patients and have their skills challenged, and they don't get those lists either, and so the quality of the lists and the fact they don't have a Registrar to teach and interact with they say, look, if I'm going to do some high volume just simple work that a Registrar could do I may as well do it in the private sector. But it's really the fact that they feel insulted about going there and if they're going to do equal - exactly the same work and not go for the public for things that they want to do they don't go.

Well, my impression and it's no more than that, is that some of the state's most highly respected specialists in a whole range of fields, from psychiatry to orthopaedics, to general surgery, to ear, nose and throat, to neurosurgery and so on, cardiac surgeons, are still fulfilling VMO positions in public hospitals, is there really any truth in the suggestion that's being put to you by Mr Farr that it's the pay scales that are - are any disincentive to private specialists to make themselves available?-- I think it's only a very, very small part of the VMO equation. You know, it's - you know, I - I mean, you know, it's - I mean, it's hard when there's an industrial negotiation. If I say it's no part, well, sort of next time Dr Cartmill goes to negotiate with Queensland Health he will say, "Dr Molloy said under oath in the commission you don't care about money. Here's the offer."

But realistically, you know, everything we get from the VMOs is a complex range of reasons, they will and won't work in the public sector, but the pay is well down - well down the list.

Thank you, Mr Farr.

MR FARR: Thank you, Commissioner. Doctor, are you aware that all available potential VMOs in Mackay, for instance, have been personally approached and asked if they would be interested in a position?-- I am not aware of that.

You don't know, for instance, that three doctors were approached in obstetrics and three rejected?-- That wouldn't surprise me.

COMMISSIONER: Why do you say that?-- Well, they're ticked off with the public hospital. All of them - you know, many of the doctors, as I spoke to you on Tuesday, you know with the previous time I had had in Mackay, also I did a visit up there last year and had dinner with the local doctors, as well as visiting both the private and public hospitals, the message that I got was that they're all so ticked off with the policies of the public hospital over the last couple of years that they're angry with it, and they may well have been asked to go back again in recent times, but they're all disenchanted with the public - not all, but many of them are disenchanted with the public system and wouldn't consider it.

And what's the source of that disenchantment; is it monetary or something else?-- No, no, it was the hospital policy. I mean, it was the hospital policies of, you know, basically making them feel unwanted, replacing them with staff specialists in the first place, and also putting into place policies they felt were designed to drive them out of the public sector.

Can you give examples of the sorts of policies? Is it scheduling times?-- I think, as I alluded to on Tuesday, scheduling times for operating theatres, changing of sessions, cancellation of sessions, a whole lot of ways you can get rid of a VMO just by being a little bit difficult.

D COMMISSIONER VIDER: Dr Molloy, at the time of the VMO's resignation from a position, does the VMO enter into any discussion with the hospital to name what his disturbance is and why he is leaving?-- I think that does happen. You know, they say, "I am resigning for this reason.", and there is often sometimes a paper trail before when they voice a number of grievances to the public - to the system and the administration.

And are you aware, because you have spent a lot of time tonight talking about this particular issue, and I am wondering if you are aware of any instances where collectively these doctors have come together in the public system and gone to the administration with a prepared list of issues?-- Yes. I mean, the most recent example of that - and the letter was partly referred to in a Courier-Mail article - was the

orthopaedic division at Royal Brisbane Hospital, where they approached the administration as a very much united and very concerned force, concerned about the loss of operating time, the number of lists had been halved, the mix of trauma, the lack of elective surgery, the failure to appoint two doctors as VMOs, the resistance by the administration to actually appoint two doctors as VMOs, and a number of other issues relating to the workload of registrars and safe hours.

And once they have raised those issues, do they get followed through, and a response come back to them, either to say, "There is nothing we can do about it.", or-----?-- I think that generally happens eventually, but, you know, my impression is that until you push very hard - I know how hard the orthopods pushed at Royal Brisbane and they were getting nowhere and I eventually - I did press about it, simultaneously with running the problem into the D-G and also directly to the Minister. I actually phoned the Minister about it.

Thank you.

COMMISSIONER: Mr Farr, you were putting to Dr Molloy instances, as I understand it, of VMO or specialists who had been offered VMO positions and declined or refused the positions. Are you able to put any specific instances of VMOs who have declined - sorry, are you able to put any specific instances of specialists who have declined VMO positions because the money was inadequate or for other reasons?

MR FARR: I don't have specific instructions on that topic.

COMMISSIONER: I understand.

MR FARR: If something is supplied, the Commission will be provided. Doctor, just for the purposes of this question, could I ask you to accept these figures - I will need to read this into the record - and I am still dealing with Mackay hospital. I will start from the beginning: Obstetrics, three approached, three rejected - three rejected, one agreed to limited gyno work; general surgery, four approached, four rejected; orthopaedics, four approached, one accepted, one expression of interest not yet finalised to reject it, some further discussions are being held; medicine, approached two, both accepted; anaesthetics approached group practice of six, one accepted, five rejected; ED/FACEM, approached one but due to private GP workload, unable to continue; ENT, one approached and he rejected it; urology, one recently resigned but continues VMO sessions; paediatrics, approached two, both accepted; psychiatrics, two approached, two rejected; and radiologist, two were employed but recently resigned. Just from those figures, can I suggest to you that they, as an example, are inconsistent, just from the fact that that number of doctors are approached, with Queensland Health having a policy of reducing VMO numbers?-- When were they approached?

Look, I can't give you the exact time. I understand this is a recent document but I can't-----?-- This is not since Tuesday

when I brought it up in the Commission?

I don't believe so, no. I wouldn't stoop to that level, doctor?-- Sorry, Commissioner.

COMMISSIONER: No, no?-- I am-----

MR FARR: Can I ask it this way: if those figures are correct - and I am not asking you to accept that because I know you don't know - but if they are, would that be some indication, if you like, that there might not be such a policy?-- No, no. You know, those number of VMOs have dropped, that's incontrovertible evidence. I have very, very clear evidence from the large number of senior doctors that I have spoken to in the State that we firmly believe policies exist, and if the hospital administration is starting to turn around in Mackay, I don't accept that as evidence that a Statewide policy didn't exist under any circumstances.

Right, okay. Do you know of any studies that suggest that doctors - your new doctors, young doctors are the first generation that place lifestyle, financial considerations, shorter hours to the forefront considerations for themselves?-- Yes, I can't name specific studies but I have had extensive readings in understanding the emerging medical workforce where there are changes in the career aspirations of our younger generation.

And can I ask you this: a medical practitioner upon qualification will in most cases these days have a HECS debt?-- On a medical - yes, as they become an intern, that's correct.

Do you know what generally that level of debt would be?-- I understand it is around about 25 to $30,000.

All right. Can I put to you the figures that I have been provided with and ask you to comment upon them, somewhere between 43 and $52,000?-- That may be correct.

That again - assuming whatever the figure might be, it is a lot of money - but it means that doctors are starting out with a debt these days that might not have been the position some years ago, that's correct?-- That's possible.

And if I have understood the time-frames involved in qualifications, a lot of doctors essentially hit the workforce at a time in their life when they might also be starting young families or thinking of doing so?-- That's very likely.

Perhaps getting a home, that type of thing?-- That's correct.

Financial pressures on doctors perhaps are greater now than they have been. Would you agree with that?-- I don't think that they are probably greater than they have been. I mean, they're substantial, but, you know, I think we can all remember back over the generations. I never remember feeling particularly wealthy as a first or second or third year

graduate as I was trying to pay off a home.

I appreciate that. The HECS debt itself, could it have any role in young doctors, young new specialists, for instance, taking a different attitude?-- Look, it may have. The repayment schedule for HECS debts I am not totally familiar with. I understand it is a reasonable - it is not an onerous one - I guess there is - but medical students also have a wide range of how they finance that, and quite a significant number of them are not without parental help. Not always, but, you know, come from professional families and families who have some substantial financial backing.

COMMISSIONER: But if Mr Farr's argument is right, that today the differential between public and private sector is greater than it has ever been, surely that just suggests that those coming into specialist practice are able to make more money the four or four and a half days a week they are in private practice to subsidise themselves for the session a week they do in public practice?-- Yes, yes, that's also true, Commissioner.

Yes, Mr Farr.

MR FARR: That's assuming, of course, that one can make good money when you first start out, or is it a case in the medical profession, as it is in the legal profession, you have to build yourself up?-- I didn't catch the last bit, I am sorry.

Do you have to build your practice up?-- You have to build your practice up, but the work is available. What changes really is the mix of work.

Sure?-- You know, a young surgeon might start off doing more assisting, but then - I guess like being a junior barrister - and then work up to having lists that are entirely of their own.

All right. Can we change the topic now to something which we might try and clarify, areas of need. There have been submissions made by Queensland Health and I think also by the AMA, that all of Queensland is declared an Area of Need. Can I suggest to you that that in fact is wrong and that the correct position is that all of Queensland is an area that can have areas of need declared within it. Do you understand that to be the case, in fact, the correct position?

COMMISSIONER: That anywhere in Queensland can be declared an Area of Need?

MR FARR: Yes.

COMMISSIONER: But declaration also made on a position-by-position basis.

MR FARR: Or location by location basis.

COMMISSIONER: I think that's consistent with the evidence we

have heard from other people, isn't it?

MR FARR: I just wasn't sure.

WITNESS: I must say, I wasn't totally sure, Commissioner. The Queensland Health submission does say all of Queensland is an Area of Need, like the Minister's gazetted the whole area as an Area of Need.

COMMISSIONER: I think Mr Farr is now telling us, in effect, if that's how we're reading the Queensland Health submission, we have misread it, and that it is intended to say that the whole of Queensland is eligible for declarations of need rather than being the subject-----?-- That was my understanding, Commissioner. It is only since reading that submission by Queensland Health that I had actually thought that.

I am glad we've got that cleared up.

MR FARR: Thank you. Can I move on now to - and you might - can I just be of some assistance here - I don't expect that I will necessarily be very much longer. Can I move on to some brief questions in relation to Dr Patel and Bundaberg? The first thing I wanted to ask you is this: you have given evidence that the first person to bring Dr Patel to anyone's attention in Queensland Health was Dr Peter Cook two months after Patel starts?-- Yes, but I did - yes, that's correct.

In fact, it is the case, is it not, that Dr Cook wrote to the Chief Executive Officer of the Mater Hospital, Jenny Skinner, I think her name was?-- That was a copy of the letter I was sent, that's correct.

Is it the case that you are assuming that that letter was passed on to someone in Queensland Health?-- That's correct.

COMMISSIONER: Is that an assumption or is that what you have been told?-- Actually, that's what I have been told, Commissioner.

By?-- Dr Cook. In discussing the matter with me, as you are aware, he asked my advice on what to do. I advised him that the evidence must be passed on to the Commission, and he was of the view that in his discussions with Dr Skinner at the time that further action had been taken. I guess that may be somewhat presumptive evidence, though.

Yes?-- Dr Cook, of course, will discuss - perhaps discuss this with you further, if you are going to call him as a witness.

Well, Mr Farr, we can probably leave it at that, can't we, that Dr Molloy is saying he has no direct knowledge of the matter and we will no doubt hear from Dr Cook what he did with his complaint.

MR FARR: That might be so. I don't know that Dr Cook will be

able to answer it because it will be a letter he has provided to the Chief Executive Officer for that person to then hand on but I am sure we can provide some evidence to clarify that issue.

COMMISSIONER: Yes. I think the real point is that Dr Cook had an understanding that when he handed it to the Chief Executive, it would be taken further and he may be able to say that he was told it was going to be dealt with in a particular way. I think Dr Molloy's point is simply that in terms of whistleblowers, Dr Cook was the first one to blow the whistle. Perhaps he didn't blow it loud enough and perhaps it wasn't heard in the places it should have been heard, but he was the first one to raise the problem.

WITNESS: Commissioner, just while we're talking about whistleblowers, I was asked what the AMA's policy on whistleblowers is and we do have, actually, an AMA guideline on public comment from hospital doctors from 2002. "In general, the AMA takes the view that the public interest would be better served by ensuring that the public is well informed and that health and medical treatment issues are subject to open debate. Doctors are often well placed to inform the public on health and treatment matters on which others remain silent. They are encouraged to consider their professional obligation to be advocates of the health interests of their patients and the community." Now, that's designed to encourage doctors to speak but they are constrained by the Code of Queensland Health and their employment conditions.

COMMISSIONER: In fact, since you have raised that, there was a letter to the editor of The Courier-Mail I think yesterday - sorry, with these late sittings I lose track of what day it is - but I think yesterday there was a doctor making the point that public health doctors are required to sign to a Code of Conduct that prevents them from speaking publicly on any issue?-- That's right. The AMA has intervened on a large number of occasions for doctors that have been threatened under the code for, you know, drawing interest - matters of public health to the public's attention. You know, examples being anaesthetics, the emergency centre doctors, et cetera.

I can understand why it would be an important part of a public health system's Code of Conduct that doctors shouldn't make public statements that interfere with patient confidentiality, or issues of that nature, but can you see any reason, from an ethical or professional viewpoint, why if a doctor, say, at the Gold Coast feels that the accident and emergency department is insufficient over the Christmas period, he should be prevented from going to the local newspaper and raising that matter in the interests of the patients?-- I don't. Queensland Health has put most forcefully to me on a number of occasions when I have advanced that view that - that they are a corporation, that in the private sector MIM would immediately, or AXA or BHP would immediately sack an employee who went public and complained about management fiddling the books, or, you know, safety conditions at one of their plants, and they expect the same standard of behaviour of their

employees in terms of protecting the reputation of the organisation as would perhaps be evinced by private sector companies.

So maybe someone - and maybe it is us - is going to have to remind Queensland Health at some stage that they are not a profit making private sector corporation; they are supposed to be a service to the ill and disadvantaged people of Queensland?-- And also, Commissioner, answerable to the people in this State.

Yes. Yes, Mr Farr?

MR FARR: Thank you, Commissioner. Just before I move finally from the Dr Cook issue, can I ask you this, Dr Molloy: do you agree that the Mater Hospital is not administered by Queensland Health?-- Yes, I understand that there is a complex interrelationship with the Mater in terms of administration and its status as a public hospital - as a quasi public hospital.

D COMMISSIONER EDWARDS: It is funded on the basis of State hospitals?-- That's exactly right, and the awards and all of those sorts of things.

MR FARR: It is funded but not administered by Queensland Health. That's it in a nutshell?-- Yep.

All right. Now, as I understand the AMA submission, it is said that the potential problems that might arise from inadequately trained IMGs is something that has been concerning members of the AMA for some time?-- Yes.

And you have been attempting to alert people to those concerns?-- Yes.

I take it, therefore, you would have alerted your own members to those concerns?-- I would assume so. How that has happened, I am not sure. Some of this preceded my time in the AMA, as either President or President elect.

You haven't checked?-- No, I haven't.

It has been said in evidence, and you have heard it and said it, in fact, in part at least, that no member of the AMA came to you or to the executive to complain about Dr Patel. The first you knew of it, for instance, was when it hit the newspapers?-- May have been the newspapers or certainly hit the press. I am not sure of the mode of press.

All right, the press?-- Yeah.

You would expect, would you not, that if the AMA has concerns about a particular system, that they would alert their members to be on the lookout for problems in that particular area?-- I think the work that was done by the AMA between 2001 and 2004, certainly after the release of the Lennox Report, I know that the AMA was involved in a lot of media. You know, one of

the values of our good relationship with the media is, of course, our members read the newspapers and get information about what the AMA is doing as well. I know that after the leak of the Lennox Report, that there was a lot of consistent publicity about the AMA's concerns in relation to IMGs. I would be amazed if we had a major working party, major lobbying effort in the Queensland Government which ended up with the Lennox Report being commissioned, if the majority of members didn't know about that through articles in our magazine or whatever. I just can't attest to it. I would be amazed if it wasn't the case, but I just can't tell you, you know, I know it has happened on these occasions.

And you would assume that members would know that if an issue arose in an area that is of a concern to the association, that they should alert the association to that issue?-- Well, that may or may not be the case. Yes, they may alert the association there is a particular problem. It may be as a result of one of our executives visiting in the area or not. It is not an invariable case, though. It really may be more a generic concern than a specific concern relating to one person. We do - you know, we're a large policy-based organisation, so the number of generic concerns we have - you know, we do handle a large number of generic concerns rather than he did or she did. It is a message.

The fact is that you didn't even hear a whisper, did you?-- No.

It is not like the gossip mill was running overtime?-- No.

COMMISSIONER: It is after 10 o'clock. I don't want to say out of grumpiness something I shouldn't say, but if your instructions from Dr Buckland are to challenge the AMA because Dr Buckland's organisation was employing an incompetent doctor killing patients but it was the AMA's fault for not revealing the fact after Dr Miach brought it to the attention of his immediate superiors, I think you are wasting your time.

MR FARR: And that's not what I am intending to do at all. What I am intending to show is there might be the potential that doctors didn't realise the difficulties as they were occurring.

COMMISSIONER: Yes.

MR FARR: Assuming they were occurring, and I don't know that I need to take that any further.

You spoke of the Royal Brisbane Hospital and its problems on a couple of occasions. Can I just ask if you would agree with this - and it will be brief - you spoke on Tuesday of a new building at the Royal Brisbane Hospital you think now contained seven floors of administrators. Can I suggest to you that in fact you were wrong in that regard and that it contains many floors of many people other than administrators. Could that be-----?-- I understand it is actually five floors of administrators and two of the floors that I thought were

there are actually in the building across the road in the - on the corner of Campbell Street and that they got moved for the pathology department to go there.

Right. Can I suggest to you that the number of beds that have been in place with the Princess Alexandra Hospital and the new Royal Brisbane and Women's Hospitals have not dropped 650, as you have suggested. Can I suggest that as at July of 1999 there was about 1,800 beds between the two hospitals and that as at May of 2005 there were 187 less beds in total, is that correct?

COMMISSIONER: Is that open beds or is that the "yes, Minister" wards?

MR FARR: These are open beds, on my instructions.

COMMISSIONER: Open beds.

MR FARR: Could that be correct? Could you be wrong in that regard?-- I have been consistently briefed on a number of occasions by a large number of people that that was the loss in beds. I have been told that by the highest levels of Queensland Health that was the bed change.

COMMISSIONER: When you say the highest levels, who are you talking about?-- Well, I've been told at levels around DG level that that was the proximate bed loss in informal conversations. Now, counting beds in Queensland Health is not easy. Commissioner made the point of commissioned beds, non-commissioned beds and sometimes, for example, at Caloundra Hospital, when we were doing our audit we found that some short-stay beds for day theatre, which are really just trolleys for people to recover on for a few hours, were counted as beds. So, you know, we have this constant grapple when we're trying to come to grips with Queensland Health of dispute over figures because they own the data and they don't publish much of the data. So I'm prepared to stand by - if there is incontrovertible evidence that it's a smaller bed loss than I've been told on a large number of occasions and have used, I'd be happy to retract that. I would argue though, that with an increasing population, very few new hospitals, and the largest growing population in Australia in South-East Queensland, to loose 187 beds is pretty disastrous policy planning, and I wouldn't be particularly proud of presenting that on behalf of my instructors.

Really. Well, can I present the rest of my instructions to you so I can finish my question? Do you know how many new beds that were placed into the Redcliffe Hospital, Prince Charles Hospital and other central zone hospitals during that time?-- No.

If I suggest to you that those places - and I can't give you the numbers, but all had an increase in numbers, could that be correct?-- I do truly believe that those are your instructions. I don't necessarily believe it's correct. In fact, one of the things that's begun in the last couple of months is the fact that Redcliffe, for example, is closing its paediatric unit. So there's actually been a reduction in services at those hospitals, and there's also been a reduction in other specialty services in those hospitals. So I think you will have to accept that we will dispute the level of services in those centres.

You said earlier in your evidence that - and correct me if I've misunderstood this, but one third of operating theatres at the Royal Brisbane and Womens Hospitals have closed?-- Or have been inactive, that's correct.

Is that a situation that you say varies, or is this the constant theme?-- I understand that that is more often than not.

Can I suggest to you that the usual reason for theatres not operating is the lack of anaesthetists? You'd agree with that?-- I think that's a very likely root cause.

And frequently and often you have perhaps 20 out of the 24 theatres operating?-- I have no idea what that means, okay? You could have 20 out of the 24 theatres operating, but only have one case scheduled in half of them. I mean, really these sort of snapshots by the administration, we've learnt in the

political debate, really mean very little.

I'm using your snapshot, you see. You're the one that talks about one-third?-- The one-third that I have been given has been advice from the anaesthetists, and also advice from the orthopaedic surgeons.

You've also said in your evidence, if I've understood it correctly, that the Royal Australian College of Surgeons were considering whether to reaccredit the Royal Brisbane and Womens Hospitals as a training facility in surgery positions?-- For a number of surgery positions they actually are accredited at the moment, but a number - what they've done has been calling in the candidates' log books and they have a particular watching breaching on neurosurgery, ENT and some concern about orthopaedics because of the case mix.

If you don't know, please say so, but the Royal Australian College of Surgeons has confirmed the Royal's accreditation as a provider of surgical training for general surgery which is the major volume of surgery?-- Yes, they've done that for general surgery, but that doesn't change my statement, the fact that they are concerned about those training posts, and have said so publicly.

Do you also agree that that college has confirmed the status for maxillofacial surgery?-- I truly wouldn't know.

Do you accept that the Royal Brisbane has high acuity surgery?-- You mean acute surgery - emergency surgery?

Yes?-- Yes, that's correct.

And are you aware of a system that's being put, or has been put into place where the lower level surgery can be conducted at other places allowing registrars to accompany that surgery to another place, thus facilitating training?-- Yes, I know that the Royal is taking some steps in that direction.

All right. You gave some evidence of readmission rates on Tuesday afternoon, and can I just confirm your evidence in a nutshell was that Queensland has the highest readmission rates, and the reason for that is that it has lower rehabilitation centres, and that if a person needs to go back for some sort of treatment in other states, they may go to a rehabilitation centre rather than to a hospital?-- Well, they're more likely to be in a rehabilitation unit and therefore not - one, they're less likely to relapse and, two, they're in a bed.

All right. So if, for instance though, interstate a person goes to a rehabilitation centre after release from a hospital, that would not be considered a readmission?-- No, that's right.

If a person in Queensland with exactly the same problem goes back to a hospital, that would be a readmission?-- Yes. It's readmissions to an acute bed.

And do you agree also that the study from which you obtained that information had a caveat attached to the study qualifying those figures referring to the small base sample and the fact that it didn't refer to the particular health problems that certain health areas will have greater readmission rates than others and so on and so forth?-- I think those caveats are general across a whole lot of data relating to those sort of public health reports.

But the caveat in fact did say, didn't it, that it might be difficult to place very much reliance on such figures given these features?-- Except that it's consistent with the rest of the data I presented, which is the lowest number of beds, the lowest number of specialists, and the lowest numbers of trainees in rehabilitation and the fact that we know the services don't exist.

Can I ask you this: you said on Tuesday - you were asked some questions about Cuba, but I'm not interested in that, but you did make the comment about some countries requiring a return of service from their doctors. In other words, that they have to stay within that country to provide a service for a certain period of time before they could be eligible to move on?-- Mmm hmm.

Were you suggesting that that might be a position that Queensland could adopt?-- No.

Or consider?-- No, I was not suggesting that. We have a very clear policy that we're not in favour of bonding doctors, that we believe in a freedom of our professionals to be able to move between jobs, sectors and countries, the same as any other Australian citizen.

Well, you know - you may not know - pilots, for instance, who train in the airforce, they have to give a return of service commitment. It's not something that you're advocating?-- I thought that they joined the airforce and signed up. I didn't realise that that was a return of service commitment.

Bullying. You would agree with me, would you, that bullying can be a very subjective thing?-- I think that's fair.

And what may seem to be bullying to a person who is bullied, might not seem to be bullying to the person doing whatever the action might be-----

COMMISSIONER: Mr Farr, before Dr Molloy answers that, I've expressed on several occasions my concern about the way in which you're getting your instructions - and of course that's not aimed at you, but I've received amongst Exhibit 52 a letter just today from the Premier which includes, amongst other things, a copy of a media statement by the Health Minister, Gordon Nuttall, to the effect that "Health Minister Gordon Nuttall accepts the State's health system is racked by the culture of intimidation and secrecy", and goes on, "Bundaberg Hospital nurses have alleged bullying and

intimidation...Mr Nuttall yesterday conceded perceptions about secrecy had been part of the Health Department's image for a long, long time. He said it was a culture that could not be changed overnight. Mr Nuttall said that he feared that now the truth about Dr Patel was known the trail of deaths would be confirmed by investigations" and "This business about bullying and intimidation and people not coming forward with their concerns, we have to change it, Mr Nuttall said."

Being as tolerant as I think I can, I just don't see how you can represent Queensland Health and put to this witness a view which contradicts that published within the last month by the Minister for Health and forwarded to me today by the Premier of Queensland. How can that possibly be the position of Queensland Health at odds with its own minister?

MR FARR: I don't know that I can take my cross-examination any further. I can indicate, of course, that I knew nothing of that letter until this very second.

COMMISSIONER: Yes.

MR FARR: And given the contents of that letter, then I am of the view that I should not proceed with my cross-examination on that topic.

COMMISSIONER: All right.

MR FARR: Unless I'm instructed to the contrary at some future stage.

COMMISSIONER: There are a couple of other things. I guess we had the discussion about Brown v. Dunne the other day. Dr Molloy has given evidence about excessive management layers, how it's six or seven or eight layers up to a decision and six or seven down again. That's the sort of specific thing that I would have thought, unless it's challenged, we'll have little alternative but to accept everything that Dr Molloy has said.

A similar example, cultural budget compliance, a similar example where he says that the pay scales are significantly below that in other states and that they're dressed up with packages that really aren't worth what they claim to be. Those sort of specifics - I find it very difficult - unless Dr Molloy's evidence is challenged and a positive case is put to him - how we can ultimately do anything but accept his evidence as totally reliable.

MR FARR: I have cross-examined Dr Molloy on my instructions and-----

COMMISSIONER: That's all I need to hear, and if you don't have any instructions to challenge any of that, the evidence will stand as it does.

MR FARR: I can't take it any further.

COMMISSIONER: Thank you.

MR FARR: I was on what I think was the final point that I wished to raise, but would you just excuse me for one moment?

COMMISSIONER: Certainly, Mr Farr.

MR FARR: That's all I have. Thank you.

MS McMILLAN: Mr Commissioner, I had three questions. I'm sorry, I know the time of night, but I can say they're on notice. Mr Tait generously allowed me to speak to Mr Molloy briefly in the break.

COMMISSIONER: Please go ahead.

MS McMILLAN: They are three, and Dr Molloy knows exactly what they are, so with your leave - I know Mr Devlin cross-examined the other night, but these arise out of matters Mr Molloy-----

COMMISSIONER: No further explanation is needed.

MS McMILLAN: Thank you.

FURTHER CROSS-EXAMINATION:

MS McMILLAN: You're aware, are you not, that the only states which have specialist registration or specialist titles recognised under the legislation are Queensland and South Australia?-- That's correct

And are you aware that the fellowship of particular colleges such as your own is recognised as the basis for specialist registration under the Medical Practitioners Registration Act-----?-- That's correct.

-----in their regulation. Now, the Commissioner asked you some questions earlier about, for instance, recognition of, say, a fellow of the Canadian college of, say, your own college of obstetricians and gynaecologists and how, for instance - whether it was possible in the future that, say, the Medical Board may be able to effectively recognise a similar sort of fellowship such as your own. Would your reservations still hold if, for instance, the AMC conducted an accreditation of overseas colleges such as Canada and it approved it so that there was an equivalence there in terms of fellowship of both the Australasian college, as you say such as your own, using that example, and say Canada, very like system for instance et cetera, and eventually maybe putting it in as under one of the regulations such as exists under our Act?-- The AMC is a reputable organisation. I suspect that we would only have no concern if that was done only with the full consultation, cooperation and agreement with the colleges, and I repeat where we started earlier today. We see the colleges as the arbiters of standards of medical care for

specialists in Australia.

That might, if it were, for instance, to further address the - some ideas of more transparency, if you like, looking at equivalence issues, but also transparency and that issue in terms of being able to look at regulations under our Act?-- Look, if the colleges and the AMC can come to accordance on equivalent overseas specialist degrees, the AMA would have no problem with that.

Thank you, Mr Commissioner.

COMMISSIONER: Thank you for that. Just before re-examination, I have a few things I'd like to clarify arising out of Mr Farr's questions. Mr Farr began by suggesting to you that the shortage of doctors had not occurred overnight. Are you aware of any circumstances, either domestically in Australia or internationally, that has exacerbated the problem over recent years?-- Yes. The lifestyle changes and desire to work long hours have changed, and the other impact - the other major impact is feminisation. For a significant number of years 50 per cent of our workforce, or slightly more, have been female graduates, and with time out to have children and also differing lifestyle patterns, the workforce hours have diminished in the medical profession.

Mr Farr suggested to you, and you agreed with him, that apart from the AMA's position that the total budget pie - this is my version of it rather than his, but the total budget pie should be increased by $700 million. Putting that to one side, he suggested to you that the AMA's position was that reforms should be adopted to make the most of the available health dollars. Can you summarise for us what sort of reforms you have in mind that would make the most of the available health dollars?-- Administrative reform, a decrease in the number of bureaucrats, resultant savings going across to clinical care, better organisation of clinical care and the removal of programs within Queensland Health and projects at hospital level that we think consume resources. In other words, the core focus on clinical care and, for the time being, other projects being extraneous to budget.

Essentially spending a larger share of that existing pie on actually providing clinical services?-- That's right. Nurses, doctors, beds, operating theatres.

Mr Farr told us that the Lennox report was not commissioned by Queensland Health, and then after the break you came back and you talked about the commissioning of the Lennox report. Do you have any personal knowledge as to whether or not the Lennox report was in fact commissioned by Queensland Health?-- No, Commissioner, I don't. It was just before my time.

Right. Finally, Mr Farr put it to you that overseas trained doctors should be appointed to a position that their skills and qualifications are commensurate to. In Dr Patel's case, would you agree, firstly, that his skills and qualifications

were commensurate to a Senior Medical Officer position under the supervision of a qualified general surgeon?-- Yes. I'm sure that that was the case. I mean, by most IMG standards Dr Patel was very attractive. He was American Board certified and he spoke excellent English, and I'm sure that he would have met the criteria for an SMO's job under supervision.

Applying again Mr Farr's test, did he have skills and qualifications commensurate to the position which he in fact held that a Director of Surgery or indeed a Senior Medical Officer without supervision-----?-- Well no, I would argue not, and perhaps to a certain extent that argument is in hindsight, but I would be disturbed that a hospital of that size with the history of the Surgery Department there that there would be a Director of Surgery without a ticked Australian qualification.

Before re-examination, Sir Llew, do you have any questions?

D COMMISSIONER EDWARDS: No, I don't. Mr Tait?

RE-EXAMINATION:

MR TAIT: You didn't ever meet Dr Patel?-- No.

So you're talking of whether his suitability for an SMO position - that's how he appeared on paper?-- Yes.

Next, the feminisation of the medical workforce, that's been occurring for many years now. For at least 10 or 15 years 50 per cent of graduates have been females?-- Yes.

It's hardly snuck up on us?-- No.

And finally, you were asked by Mr Farr about whether the readmission rates were perhaps high because they didn't provide much rehabilitation, so therefore they had to go back as readmissions. Is readmission rate an accepted benchmark of a standard of care, just the same way infection rates are?-- Yes.

Thank you.

COMMISSIONER: Thank you, Mr Tait. Mr Andrews?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: It's been a long evening. I really want to thank everyone involved, everyone at the Bar table, for their cooperation in concluding Dr Molloy's evidence, and can I single out particularly you, Mr Farr, for conducting your cross-examination so efficiently and succinctly, as, of course, you always do.

Dr Molloy, we do appreciate not only your coming to give evidence, but the fact that you've been prepared to give evidence at this unpleasant time of night. Thank you very much for your assistance. You're excused from further attendance, although I should say that there is the possibility that we may be in touch through your learned counsel and solicitors if the inquiry wishes to have your further input in an informal way in writing or some other way on any issues which may arise?-- Thank you, Commissioner. I'd like to thank you for the courtesy and the good manners with which I've been treated, and also pledge that the AMA in Queensland will do everything it can to help the course of this inquiry.

Thanks you. Finally, before Dr Molloy leaves the witness box, there's something I should mention. I circulated a note yesterday to counsel and solicitors at the Bar table just mentioning that my wife happens to be a patient of one of the colleagues of Dr Molloy in his medical practice. I understand that no-one wishes to raise anything about that, but I thought it should be clearly on the record that there is that slightly tenuous connection. Thank you, Dr Molloy?-- Thank you.

You're excused.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen, I think we're advertised in The Courier-Mail to resume at 10 o'clock tomorrow. Does that suit everyone? I know we're not going to get a lot of sleep, but is 10 o'clock all right?

MR ANDREWS: Yes, thank you.

MR TAIT: That's fine.

COMMISSIONER: I'm happy to make it 10.30 if that would make it more comfortable.

MR TAIT: Immaterial to us.

COMMISSIONER: 10 o'clock it is then.

THE COMMISSION ADJOURNED AT 10.32 P.M. TILL 10 A.M. THE FOLLOWING DAY