QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DR JAMES WILLIAM GAFFIELD

1. I, **JAMES WILLIAM GAFFIELD,** Locum Surgeon, of c/- Bundaberg Hospital, Bourbong Street, Bundaberg, in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

Qualifications and Experience

3. I was awarded a Bachelor of Arts, majoring in Political Science, from the University of California, Los Angeles, in 1987. From 1988 to 1990, I was a Research Assistant at the University of California, Los Angeles in the School of Medicine, Neuropsychiatric Institute.

4. I was awarded a Doctor of Medicine degree from the Medical College of Pennsylvania in 1994. I subsequently undertook my internship in General Surgery at the Abington Memorial Hospital, Abington, Pennsylvania, from 1994-1995. I then undertook a residency in general surgery at the Abington Memorial Hospital from 1995 to 1999. I undertook a further residency in plastic surgery at the Milton S. Hershey Medical Centre of the Pennsylvania State University, Hershey, Pennsylvania, from 1999-2001.

5. I was awarded USA Board Certification with the American Board of Surgery in February 2000. I subsequently attained USA Board Certification from the American Board of Plastic Surgery in November 2004.

6. I was assessed by the Royal Australasian College of Surgeons and was awarded Fellowship of that College in November 2004, with specialist recognition in general surgery.

7. Attached and marked **JWG-1** is a copy of my curriculum vitae.

Employment at Bundaberg Base Hospital

8. In 2002, I became interested in working in Australia. I undertook an internet search and discovered the AMAQ website. I sent my CV and an expression of interest to that website and was subsequently informed that a surgical position was vacant at the Bundaberg Base Hospital (Hospital). I expressed interest in this position to AMAQ, who I believe submitted an application on my behalf to the Hospital. I was subsequently advised that my application had been unsuccessful.

9. A few weeks later, I was contacted by an AMAQ recruitment consultant, who informed me that another position had become vacant in the Department of Surgery at the Hospital. I was offered that position, which I accepted.

10. In February 2003, I came to Australia for a holiday (at my own expense) and travelled to Bundaberg, where I met with Dr Kees Nydam, Acting Director of Medical Services. I spent 2 hours meeting with Dr Nydam discussing the position.

11. I finished my private practice in Pennsylvania on 18 April 2003 and subsequently returned to Bundaberg and commenced employment at the Hospital as an SMO – Surgery on 28 April 2003.

12. I was initially registered with the Medical Board of Queensland as an overseas trained doctor in an area of need pursuant to section 135 of the *Medical Practitioners Registration Act*. All of the necessary documentation was completed by AMAQ and signed by me.

13. Prior to commencing my employment at the Hospital, I had started the process required to undertake the Australian Medical Council (AMC) exams. That is a fairly lengthy process, which I successfully completed in 2004.

Involvement with Dr Jayant Patel

14. Dr Patel had been appointed as Director of Surgery prior to my commencement at the Hospital. He was a more senior surgeon than I was and had more general surgery experience. My recent experience had been in the area of plastic and reconstructive surgery, whereas Dr Patel was more experienced in areas of general surgery.

15. Apart from the fact that I was one of two SMOs in surgery at the Hospital with Dr Patel, I did not have extensive involvement with him on a day to day basis. For example, we did not work together in theatre nor did we do rounds together. Ordinarily, what would happen is that if I was in theatre operating, Dr Patel was in the ward or in the clinic reviewing patients. I did not have any personal conflicts with Dr Patel and only limited involvement with him in respect of clinical issues.

16. There were occasions when Dr Patel would take vacation, and I would be required to continue the care of his patients. However, this only occurred on a couple of occasions. Dr Patel did not require me to do ward rounds on his patients during his weekends off as he would come into the Hospital and review his own patients over the weekend.

Desmond Bramich

17. Mr Bramich was admitted to the Hospital via the Department of Emergency Medicine (DEM) on 25 July 2004, following a blunt chest injury. The usual practice with trauma admissions is that switch contact a team of people, including the Surgical Consultant on call, the Principal House Officer (PHO), and the Intensive Care Consultant on call.

18. I attended the patient in DEM with my Surgical PHO. The patient had sustained a blunt chest trauma to the right side of his chest and had suffered multiple fractured ribs and possibly a haemopneumothorax. A right intercostal catheter (ICC) was inserted by my PHO under my supervision. The purpose of inserting the ICC was to drain fluid that was accumulating around the lung and to reinflate the lung. The patient was then sent to radiology for imaging, including a CT of his chest and abdomen. The patient was then transferred to the Intensive Care Unit (ICU) overnight for observation.

19. I attended with my PHO to review Mr Bramich the following morning. He had been complaining of pain on inspiration overnight, which is to be expected, given the patient had multiple fractured ribs. I noted his vital signs were within normal limits and his oxygen saturations were 94%. The ICC was draining, and the notes indicate there was approximately 150mls in the drain. The chest x-ray was again repeated that day.

20. The patient was reviewed by the ICU doctor later that morning, on 26 July 2004. The notes suggest 'pt feeling 100% better'. His vital signs remained within normal limits, and his oxygen saturations were 93% on room air. A decision was made to transfer the patient to the surgical ward for continued monitoring. A patient controlled analgesia (PCA) had been provided for management of his pain.

21. At this stage, it was my feeling that the patient was likely to remain in the ward for three to four days for pain management and then be discharged home. Pain management is one of the major issues for patients with fractured ribs as they experience quite significant levels of pain. They must also be monitored in the event of further bleeding.

22. The patient continued to have an uneventful course overnight on 26 January 2004. At around lunchtime on 27 July 2004, I was urgently called to review Mr Bramich. I recall I was in the operating theatre, in the middle of a surgical list, when I received the call. I attended the ward to review the patient, who I understood had recently undergone physiotherapy and had been eating lunch. It was apparent on visual observation that the patient was in excruciating pain. His vital signs were abnormal and his blood pressure had plummeted. The diastolyic blood pressure could not be heard. He had low oxygen saturations and was having trouble breathing.

23. I recall that Dr Younis, Anaesthetist, was contacted and attended the ward to review the patient. A decision was made to transfer the patient to ICU and he was intubated and ventilated in order to obtain control of his airway. Investigations were undertaken, including blood pathology, and imaging. I formed a provisional diagnosis that Mr Bramich was bleeding internally, but noticed that the ICC had only a limited amount of drainage.

24. Attempts were made to readjust the ICC and, given concerns as to the patency of the chest tube, a second ICC was inserted in ICU. Further drainage of 500-750mls of blood was noted following insertion of that drain. During this time, the patient was receiving a significant volume of packed cells and we continued investigations in order to identify the source of the apparent bleed. The patient remained in the ICU during this time and was medically unstable.

25. I recall Dr Martin Carter, Director of Anaesthetics and ICU, was present and had some involvement with Mr Bramich's care. Dr Patel also became involved. I was aware that Toni Hoffman, Nurse Unit Manager, ICU, felt that the patient needed to be transferred to Brisbane. However, I was of the opinion that the patient was simply too unstable and would not survive the transfer. At that stage, the patient was literally dying in front of our eyes. We were still trying to identify the source of the patient's bleed, and attempting to stabilise his quickly deteriorating condition. A decision was made for the patient to be transferred to radiology to undergo an urgent CT scan of the abdomen. At this stage, there was some thought that the patient may be bleeding from an abdominal organ, such as the liver, which may be amenable to repair and potentially life-saving surgery if it were able to be repaired quickly.

26. Dr Carter transferred the patient to radiology and I understand, remained with him during the course of the CT scan. The CT scan did not demonstrate any abdominal bleeding. After the CT scan was performed, Dr Patel assumed responsibility for the patient. Dr James Boyd, PHO, remained with Dr Patel to continue with the care of the patient. At approximately 6pm, I left the ICU.

27. I became aware the next day, following a discussion with Dr Boyd, that the patient had not survived. Dr Boyd also informed me that Dr Patel had attempted pericardiocentesis. I assume Dr Patel had formed the view that Mr Bramich may be bleeding around his heart which would be the reason for him undertaking this procedure. I am unsure of what occurred during the course of that procedure, as I was not present. However, I believe it was reasonable to suspect that the patient may have a pericardial effusion as a result of the blunt chest trauma he had sustained. On that basis, pericardiocentesis was an indicated procedure.

28. I cannot say whether Dr Patel had '50 attempts' at pericardiocentesis, as I was not present when that procedure was attempted. However, I believe the attempt by Dr Patel at pericardiocentesis was indicated in the circumstances. I also believe that it is not unreasonable to attempt the procedure on several occasions if there is minimal aspirate. I do not believe this procedure caused the patient's death. It is my belief that Mr Bramich had an unusual, devastating injury and that his death was a result of uncontrolled bleeding, likely from intercostal veins and/or arteries.

29. I cannot comment on the appropriateness or otherwise of transfer of the patient at or about 6pm that evening. I understand attempts were made to transfer the patient at some time in the evening, but that he deceased following arrival of the retrieval team.

P26

30. P26 was admitted to the Hospital under Dr Patel on 23 December 2004. I was on vacation during this time. I returned to the Hospital on 26 December 2004 and assumed care of the patient from Dr Patel, who left for an overseas holiday at that time. I received a handover from Dr Patel, including a handwritten note regarding the patient. Attached and marked **JWG-2** is a copy of Dr Patel's notes to me.

31. I recall Dr Patel informed me that the patient had been admitted with a traumatic injury, following a motorbike accident. He had been managed by Dr Patel and an

orthopaedic surgeon for a suspected hip fracture. The patient had been to theatre on three occasions for a laceration to his left groin. He had initially required surgery to repair a lacerated femoral vein and for debridement, washout and primary wound closure. He was transferred to ICU post-operatively. I was informed by Dr Patel that later that evening, on 23 December 2004, the patient returned to theatre as a result of developing compartment syndrome. Extensive upper and lower fasciotomies were performed to decompress the thigh and calf.

32. Dr Patel stated that the patient returned to theatre on a third occasion, again later that evening with acute left lower extremity ischaemia. An ultrasound duplex of the leg demonstrated no flow distal to the common femoral artery. P26 underwent exploration and arterial reconstruction with a goretex bypass graft which was performed by Dr Patel.

33. Dr Patel informed me that the patient had initially experienced some renal failure, but had responded quickly with fluid resuscitation. I was informed by Dr Patel that the patient was making a good recovery and that he would require skin grafts to the wounds created by the fasciotomies, which I was to perform once the swelling had lessened.

34. Dr Patel then went on vacation for two weeks. In addition, the surgical PHOs also changed over around this time.

35. I reviewed the patient on a daily basis with Dr David Risson, my surgical PHO and other junior doctors over the holiday period. I was present each day after the nursing staff had removed his dressings to examine the wounds. I recall initially observing that the leg had a mottled appearance just above the ankle, but that the colour appeared to improve in the leg over the course of the next few days. I recall that the toes appeared to be dead, which I attributed to vascular insufficiency following the initial injury. Distal foot necrosis was present on my first evaluation of the patient. I had formed the view that it was likely the patient would require a transmetatarsal amputation at some point.

36. In my opinion, the patient was making slow, but appropriate progress. His skin colour was improving and there was good capillary refill on the dorsum of his foot. The wounds from the fasciotomies appeared to be viable and were not infected.

37. On 27 December 2004, the patient was transferred from ICU to the surgical ward. The patient was having fourth hourly circulation observations, which were being undertaken by the nursing staff. He had a low grade temperature which was being monitored and treated with intravenous antibiotics.

38. On 30 December 2004, P26 spiked a temperature to 38° and became tachycardic. Up to that point, he had a normal white cell count. Blood cultures were undertaken and intravenous antibiotics were continued.

39. On 1 January 2005, I was called to review the patient as he had deteriorated. Upon attending the ward to examine the patient, it was apparent that he had rapidly deteriorated overnight. He was confused, not eating and one of his leg wounds had developed a superficial infection. I formed the view that the patient required transfer to Brisbane. Dr Risson made arrangements for transfer of the

patient to the Royal Brisbane Hospital. That transfer occurred early in the afternoon.

40. Following the patient's transfer, I was never contacted directly and informed of the patient's outcome.

41. I learnt that the patient had undergone further surgery at Royal Brisbane Hospital and ultimately a through-knee amputation. I was aware that it had been discovered that the femoral graft was infected and required removal. I believe the femoral vein had been found to be ligated, not repaired as I had been informed by Dr Patel.

42. At no stage, on transferring the patient to my care, had Dr Patel informed me that he had concerns regarding the viability of the femoral graft. I believe at the initial surgery that the vein had not been adequately repaired, given that it had been subsequently discovered to be ligated.

43. The subsequent anterial surgery was required as a result of the development of ischemia due to an intimal injury of the common femoral artery.

44. It is my view that the patient ultimately required through-knee amputation due to the inadequacy of the vascular repair performed by Dr Patel. However, the initial surgery undertaken by Dr Patel was, in my opinion, life-saving. The patient would not have been able to have been transferred, nor would he have survived the transfer prior to that surgery taking place.

P403

45. This patient was never seen by Dr Patel. She was referred to me by her general practitioner, with a breast lump for investigation. I examined the patient in outpatients on 24 July 2003. I noted an ultrasound scan and mammogram which had been undertaken were normal. Accordingly, I recommended the patient undergo surgical biopsy of the lump.

46. P403 was admitted to Day Surgery Unit on 21 August 2003 for a biopsy of the breast lump under general anaesthetic. That procedure was performed by me, with the assistance of my junior doctor.

47. Post-operatively, the patient developed a wound haematoma, which she subsequently attributed to post-operative nausea and vomiting. I became aware some months later that the nursing staff in the Day Surgery Unit had contacted my intern to inform her that the patient had been vomiting post-operatively. She was given an antiemetic and discharged home.

48. I became aware that the patient had been seen by her general practitioner on several occasions regarding development of a wound haematoma. Unfortunately, she did not return immediately to the Hospital for review. However, she subsequently sought a second opinion from a private surgeon, who I believe suggested she undergo physiotherapy. The wound haematoma was treated conservatively.

49. P403 subsequently came back into my care, and I examined her on numerous occasions over a period of two to three months. The haematoma did not require surgical intervention and resolved with conservative management.

50. I am aware that P403 commenced proceedings pursuant to the *Personal Injuries Proceedings Act 2002* in relation to development of a wound haematoma. I have been advised that those proceedings have been now been settled by the Hospital. The settlement was subject to a Deed of Settlement with a confidentiality clause.

P131

51. P131 was referred to Dr Patel from Breast Screen and attended upon him on 1 July 2003 complaining of an itchy nipple. I note from reviewing the medical record that she had an eczematous skin rash around the nipple and a normal mammogram. Dr Patel gave her steroid cream and recommended she return for further review in three months' time. The patient was to reattend the surgical outpatients department on 23 September 2003, but failed to do so.

52. On 27 October 2003, P131 presented to the Surgical Outpatients Department for recurrent haemorrhoids. She also was seen in relation to her itchy nipple, and informed staff that the cream Dr Patel had given her had not worked. She indicated she had been experiencing an itchy nipple for over two years. There was no pain or lump present. It was noted that she had no family history of breast lumps or breast cancer. P131 was referred to me for review.

53. P131 was seen again in the Surgical Outpatients Department on 9 February 2004 by my Surgical PHO, Dr Towsey. I believe that I was on vacation during this time. Dr Towsey examined the patient in respect of her complaint of haemorrhoids and the ongoing issue with her itchy nipple.

54. On 23 February 2004, I examined P131 in the Surgical Outpatients Department. I recommended she undergo a punch biopsy to exclude Pagets Disease, a rare and unusual form of breast cancer.

55. On 8 March 2004, the patient underwent a punch biopsy in the minor operations room. The pathology from that biopsy indicated abnormal cells or 'atypia'. I recommended to P131 that she undergo excision of the lesion and further assessment.

56. On 20 April 2004, P131 was admitted for excision of the lesion. This procedure was performed in theatre under general anaesthetic. An area measuring 12 x 10 x 5mm was excised and sent to pathology. That pathology report demonstrated the presence of ductal carcinoma insitu (DCIS). The tumour size was noted to be a minimum of 6mm and present at the resection margins. This procedure was intended to be diagnostic only and not therapeutic, hence the margins were inadequate.

57. On 14 May 2005, I informed P131 of the pathology results and discussed with her the options for treatment, including local excision with radiotherapy or mastectomy. The usual treatment of DCIS is local excision plus radiotherapy however, I recall Mrs Roach advised that she wished to undergo mastectomy. I

advised her to reconsider her options and return for a second appointment to discuss the treatment options further. I also put her in contact with the Breast Screen counsellors.

58. The patient again attended for discussion with Dr Towsey on 21 May 2005, at which time he again discussed her treatment options.

59. I again met with P131 on 28 May 2005, at which time she informed me she was adamant that she wished to undergo bilateral mastectomy. I recommended to her that she reconsider her decision and also advised her to discuss her decision with her general practitioner.

60. P131 elected to undergo bilateral mastectomy, which was performed on 22 June 2004. I was the surgeon at that procedure. P131 did not elect to undergo reconstruction.

61. I managed P131 in the post-operative period, and continued to see her on several occasions in outpatients department.

Insertion of Permacaths

62. Permacaths are catheters inserted into a central vein and used for haemodialysis for renal patients.

63. I became aware in 2004 of problems between Dr Patel and Dr Peter Miach, Director of Medicine, regarding permacath insertions performed by Dr Patel.

64. I assumed there had been some problem with the permacath's that had been inserted by Dr Patel, as Dr Miach began transferring his renal patient's who required permacath insertion to me. This historically, had been a procedure that Dr Patel had undertaken.

65. Dr Miach did not discuss with me any issues he had in relation to Dr Patel. However, he would come and see me personally to request permacath insertion for his patients. I did not ask Dr Miach why I was being requested to undertake this procedure when it had been previously performed by Dr Patel.

66. Dr Miach did not provide me with any information regarding concerns he had with Dr Patel's technique or any documentation regarding complication rates. Dr Miach simply began personally transferring a number of patients to me.

67. I estimate I performed 12 to 15 permacath insertions at Dr Miach's request.

68. I have become aware in the last few weeks that insertion of Peritoneal dialysis catheters was outsourced to Baxter, however, I had no involvement in this arrangement.

Other relevant Patel patients

- P38 – Removal of bowel cancer and subsequent bowel leakage requiring re-operation. Patient ended up with ileostomy and fistula, which eventually resolved.

- P50 – Morbidly obese, diabetic renal patient who developed necrotic tissue on a fatty abdominal flap. Initial debridement performed by Dr Patel and extensive apronectomy subsequently performed by Dr Gaffied. Patient ultimately required transfer to Brisbane for numerous complications.

Signed at **Bundaberg** on 1ST July ~~June~~ 2005.

James William Gaffield

JAMES WILLIAM GAFFIELD
Locum Surgeon
Bundaberg Base Hospital

JWG-1

CURRICULUM VITAE

James W. Gaffield, MD, FRACS

CURRENT POSITION

Private Practice
Pacific Plastic Surgery Pty Ltd
Bundaberg, QLD

ADDRESSES

Office: Friendly Society Private Hospital
19-23 Bingera St
Bundaberg QLD 4670
Australia
Ph (07) 4153 0795
Fax (07) 4153 0789

Mail: PO Box 1002
Bundaberg QLD 4670

Home:

HOSPITAL AFFILIATIONS

Friendly Society Private Hospital, Bundaberg
Mater Hospital, Bundaberg
Mater Hospital, Gladstone
Mater Hospital, Rockhampton

PREVIOUS POSITIONS

Staff Surgeon
Bundaberg Base Hospital
April 2003 – June 2005

Private Practice, Plastic Surgery
Abington, PA, USA
August 2001- April 2003

BORN

May 12, 1964
Berkeley, CA, USA

UNDERGRADUATE EDUCATION

B.A., 1987
Political Science
University of California, Los Angeles

POST-COLLEGIATE EXPERIENCE

1987-1988	Professional Distance Runner Los Angeles, CA
1988-1990	Research Assistant University of California, Los Angeles School of Medicine, Neuropsychiatric Institute

MEDICAL EDUCATION

M.D., 1994	Medical College of Pennsylvania

POSTGRADUATE TRAINING

INTERNSHIP	General Surgery Abington Memorial Hospital, Abington, PA, 1994-1995
RESIDENCY	General Surgery Abington Memorial Hospital, Abington, PA, 1995-1999
RESIDENCY	Plastic Surgery Milton S. Hershey Medical Center of the Pennsylvania State University, Hershey, PA, 1999-2001
COLLEGE FELLOWSHIP	Fellow, Royal Australasian College of Surgeons General Surgery; 2004
U.S.A. BOARD CERTIFICATION	American Board of Plastic Surgery November, 2004 Certificate #6727; exp 12/2014
	American Board of Surgery February, 2000 Certificate #44979; exp 07/2010
OTHER CERTIFICATION	Australian Medical Council, May 2004
REGISTRATION & LICENSURE	Queensland (General & Specialist Registration): 1030521 (current) New South Wales: 349275 (current) California: A77670 (current) Pennsylvania: MD-058515L (1994-2003)
ACADEMIC APPOINTMENTS	Senior Lecturer, 2004-current University of Queensland School of Medicine Rural Clinical Division – Central Queensland Region
	Clinical Assistant Professor of Surgery, 2002-2003

Temple University School of Medicine

Instructor in Surgery, 2000-2001
Penn State University College of Medicine

HONORS & AWARDS

Stephen H. Miller, M.D. Award, Outstanding Teaching by a Plastic Surgery Resident, Penn State University, 2001

Traveling Fellowship, Frederick A. Coller Surgical Society, 1999

1st Place, Surgical Research Day, Abington Memorial Hospital, 1998

Student Research Award, Association for Academic Surgery, 1994

Student Research Award, American Society for Clinical Nutrition, 1992

Student Research Award, New York Academy of Medicine, Regional Center for Clinical Nutrition Education, 1992

SOCIETIES

Royal Australasain College of Surgeons
American Society of Plastic Surgeons, Candidate
Australian Medical Association

COMMITTEES

Standards and Economies, Abington Memorial Hospital (2001-2003)
Impaired Physician, Abington Memorial Hospital (1996-1999)

COURSES

Advanced Pediatric Life Support (Australia), September 2004
Definitive Surgical Trauma Care (Australia), August 2004
AO/ASIF Maxillofacial Course (USA), July 2000
Advanced Trauma Life Support (USA), Feb 2000
Advanced Cardiac Life Support (USA), Feb 2000
ASMS Basic Maxillofacial Course (USA), August 1999

NATIONAL PRESENTATIONS

Topical Platelet-Derived Growth Factor Enhances Wound Closure in the Absence of Wound Contraction; An Experimental and Clinical Study. Robert H. Ivy Society, Pittsburgh, PA, June 2002.

Liposuction: Cosmetic or Therapeutic? Endocrine Surgery Symposium, St. John Hospital, Detroit, MI, March 2002.

The Microlift: Facial Rejuvenation via a Limited Incision. Northeastern Society of Plastic Surgeons, Philadelphia, October 2001.

Topical Platelet-Derived Growth Factor Enhances Wound Closure in the Absence of Wound Contraction; An Experimental and Clinical Study. Northeastern Society of Plastic Surgeons, Philadelphia, October 2001.

Digital Three-Dimensional Quantification of Breast Reduction Volumes. American Society for Aesthetic Plastic Surgery, Residents and Fellows Forum, New York, NY, May 2001.

Digital Three-Dimensional Quantification of Breast Reduction Volumes. Robert H. Ivy Society, Baltimore, MD, March 2001.

Sterilization of Contaminated Breast Implants with Povidone-Iodine. American Society for Aesthetic Plastic Surgery, Residents and Fellows Forum, Orlando, FL, May 2000.

Sterilization of Contaminated Breast Implants with Povidone-Iodine. North American Academy of Cosmetic and Restorative Surgery, Tucson, AZ, December 1998.

Serum Thyroid Stimulating Hormone (TSH) Falls in Response to Intake of a Mixed Meal. American Society for Clinical Nutrition, Baltimore, MD, April 1992.

Cerebrospinal Fluid (CSF) Biogenic Amines and Cortisol are Altered by Zidovudine (AZT) Therapy for the AIDS Dementia Complex (ADC). American Academy of Neurology, Miami, FL, April 1990.

LOCAL PRESENTATIONS

Evaluation of Neck Masses, Problem Based Learning Session, University of Queensland 3rd Year Medical Students, Quarterly from March, 2004.

Management of Facial Wounds. Medical Education Lecture Series, Bundaberg Base Hospital, Bundaberg, Australia, October 2003, March 2004.

Basic Suturing Techniques. University of Queensland Rural Medical Students, Bundaberg Base Hospital, Bundaberg, Australia, September 2003, June 2005.

Facial Trauma and Reconstruction. Surgical Grand Rounds. Bundaberg Base Hospital, Bundaberg, Australia, September 2003.

Breast Reconstruction: Plastic Surgery Options. Queensland Cancer Fund, Bundaberg Division, Bundaberg, Australia, August 2003.

Post-Oncologic Facial Reconstruction. Temple University, Division of Plastic Surgery Grand Rounds, Philadelphia, PA, USA, August 2002.

Plastic Surgery of the Breast. Quarterly Presentation to Temple University Medical Students, Philadelphia, PA, USA, 2001 - 2003.

Plastic Surgery Fundamentals: Flaps and Grafts. Quarterly Presentation to Temple University Medical Students, Philadelphia, PA, USA, 2001 - 2003.

Plastic Surgery Fundamentals: Flaps and Grafts. MCP-Hahnemann University, Department of Ophthalmology, Philadelphia, PA, USA, September 2001.

CLINICAL INVESTIGATIONS

Mentor Adjunct Study for Silicone Gel-Filled Mammary Prostheses. Abington Memorial Hospital IRB Approved.

Hyaluronidase: A comparison of its effect on the duration of lidocaine and bupivacaine anesthesia. Abington Memorial Hospital IRB Approved.

McGhan Medical Corporation Silicone-Filled Breast Implant Adjunct Clinical Study. Abington Memorial Hospital IRB Approved.

BIBLIOGRAPHY

1. Wilkins J, Singer E, Mitsuyasu R, Syndulko K, Setoda D, **Gaffield J**, et al: Cerebrospinal fluid (CSF) biogenic amines and cortisol are altered by zidovudine (AZT) therapy for the AIDS dementia complex (ADC).[Abstr] *Neurology* 1990;40:237.

2. **Gaffield JW**, Dratman MB: Serum thyroid stimulating hormone (TSH) falls in response to intake of a mixed meal.[Abstr] *Am J Clin Nutr* 1992;56:780.

3. **Gaffield JW**, McCombs PR: Assurance of thoracic duct ligation. *Contemporary Surgery* 1999;55:169.

4. **Gaffield JW**, Buinewicz BR: Sterilization of contaminated breast implants with povidone-iodine. *International Journal of Cosmetic Surgery* 1999;7:84-6.

5. **Gaffield JW**, Finlay DJ, Braun TI, Josloff RK: Group A streptococcal necrotizing fasciitis subsequent to pectoralis muscle strain. *J Trauma* 2000;48:538-40.

6. **Gaffield JW**, Mackay DR. A-3 pulley trigger finger. *Ann Plast Surg* 2001;46:352-353.

7. Dabb RW, **Gaffield JW**, Camp LK. Use of cyanoacrylate (superglue) for the fixation and prefabrication of nasal cartilage grafts. *Aesthetic Surg J* 2001;21:328-333.

8. **Gaffield JW,** Hall WW, Graham WP, Mackay DR. Gynecomastia: Surgical treatment and prevention of complications. *Surgical Rounds* 2001;24:453-456.

9. Saba, AA, Freedman BM, **Gaffield JW**, Mackay DR, Ehrlich HP. Topical Platelet-Derived Growth Factor Enhances Wound Closure in the Absence of Wound Contraction: An Experimental and Clinical Study. *Ann Plast Surg* 2002;49:62-66.

10. Crawford DL, Izes JK, **Gaffield JW**, McCombs PR. Arteriographic detection of renal cell carcinoma metastasis to thigh musculature. *BJU International* 2002;90(9cr):973.

11. Dabb RW, **Gaffield JW**, Saba AA, Al Shunnar B. The microlift: Facial rejuvenation via a limited incision. Submitted.

12. **Gaffield JW**, Lambert PA, Graham WP. Marginal resection after Mohs' micrographic surgery: Technique, implications, and outcome in patients with residual basal cell carcinoma. Submitted.

13. **Gaffield JW**, Saba AA. Contour deformities following radiation, mastectomy, and breast reconstruction: Correction with autologous fat grafting. Submitted.

14. Gray K, **Gaffield JW**. Perforated meckel's diverticulum with abdominal wall invasion; CT scan correlation with operative findings. Submitted.

15. **Gaffield JW**. Optimizing the wound environment for full thickness skin graft take to foot wounds with negative pressure dressings in patients with vasculitic ulcers. In preparation.

16. Mackay DR, **Gaffield JW**. Velopharyngeal insufficiency following cleft palate repair: A retrospective study of patients treated without intravelar veloplasty. In preparation.

17. **Gaffield JW**, Banducci DR, Saggers G, Mackay DR. Digital Three-Dimensional Quantification of Breast Reduction Volumes. In preparation.

18. Mackay DR, Saba AA, **Gaffield JW**. Dorsal nasal advancement flaps for nasal tip defects: Reconstruction with aesthetic tip rejuvenation. In preparation.

Ward Handover Sheet 07

Printed: 26/12/2004 04:19:29

Ward: Surgical

Shift: Day Shift, Sunday, 26 December 2004

Bed	WL	FR	Ur No.	Patient	Pat Type	Req Hrs (hh:mm)	Doctor	Age	Diagnosis	LOS	Notes
2.05	w01			P404	~~SUR~~	.1:55		43Y	URINARY RETENTION	1	
2.06	w01			P405	SUR	1:55	Gaffield	44Y	Cellulitis (R)lower leg graft 24/12	10	Skin Graft done on Friday- Vaccume dressing on
2.07											
2.08	w01			P406	SUR	0:55	Patel	47Y	Pancreatitis	3	Gall stone Pancreatitis Resolving
3.09											
3.10											
3.11											
3.12											
4.13	w02			P407	HDS	2:45	Robinson	91Y	#L NOF/NOF22/12	5	Dementia
4.14											
4.15											
4.16											
5.17	w02			P408	SUR	2:25	Robinson	23Y	# LT ANKLE ORIF 26/12		
5.18	w02			P409	SUR	2:25	Robinson	27Y	Mbal # tibial plateau	4	
~~5.19~~	~~w03~~			P410	~~SUR~~	~~0:55~~	~~Patel~~	~~17Y~~	~~PERI UMBILICAL PAIN~~	~~1~~	~~Homeward~~
5.20	w03			P411	SUR	1:55	Gaffield	39Y	MBA/ multiple grazes and lacerations-debridement Liver hematoma	6	Rt. Elbow wound ? may need Skin Graft Suction dressing on
5.21											
5.22											
~~6.23~~	~~w03~~			P412	~~SUR~~	~~1:55~~	~~Patel~~	~~45Y~~	~~SAH~~	~~12 Heparin Inf.~~	Home
6.24	w03			P266	SUR	2:25	Patel		Amputation R great toe	4	
6.25	w04			P413	SUR	1:55	Patel	68Y	Cellulitis left foot	2	+ve Blood Cultures

JWG-R

DON'T FORGET CLINIC WEDNESDAY MORNING

Ward Handover Sheet 07

Printed: 26/12/2004 04:19:30

Ward: Surgical

Shift: Day Shift, Sunday, 26 December 2004

Bed	WL	FR	Ur No.	Patient	Pat Type	Req Hrs (hh:mm)	Doctor	Age	Diagnosis	LOS	Notes
6.26	w04			P44	SUR	1:55	Gaffield	51Y	7/11 DiabUlcersl/ D'ment RHeel5,12,13/11&9/12/ free rectus flap stsg15/12	49	IDDM
6.27	w04			P45	SUR	1:55	Patel	77Y	SIGMOID COLECTOMY 21/12	6	Home ~~in day SX Today~~ Tomorrow
6.28											
29											
30	w05		035261	HALTER, Trevor	SUR	2:25	Patel	57Y	Rehab. Post Lap Chole. TF RBH. VRE. Isolation	2	- Subphrenic abscess - Transferred back from RBH
31	w05			P46	MED	1:55	Conradie	38Y	OD ON SEROQUEL	2	Monitored
32	w05			P251	PCU	1:55	Patel	78Y	Liver Bx 9/12. Colonoscopy 13/12-OGD13/12/ anterior colectomy 17.12	17	Palliative/ high ACAS high - Waiting for placement - Not a surgical candidate
33	w05			P47	SUR	1:55	Robinson	52Y	#(L)shaft femur at prosthesis	2	Diet controlled diabetic/AWS/osteoporosis/chronic alcoholic hepatitis/t/t Mater Public 26/12

ICU

Bundaberg Hospital SEX M UR NO

P26.

15 yr old - Med Bike Accident.

Thursday -

- Massive Blood loss from Fem. Vein Laceration - Repaired
- Post op compartment syndrome. Thigh & leg fasciotomy
- Femoral artery - occlusion secondary to intimal injure - 5 cm segment could not be repaired, Grafted c Gortex
- Graft open micro emboli to foot skin. Does not move foot - Probable sciatic nerve injury sec to ? Acetabular Fracture

- NEED closure of 3 loose wounds c skin Graft - This week.