QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DR MICHAEL IAN CLEARY

1. I, **DR MICHAEL IAN CLEARY,** Acting District Manager, The Prince Charles Hospital Health Service District, of c/-Building 14, The Prince Charles Hospital, Rode Road, Chermside in the State of Queensland, acknowledge that this written statement by me dated 23 August 2005 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.

Provision of cardiology services in Queensland

3. Cardiovascular disease is the major cause of morbidity and mortality in Australia. The most common forms of heart disease in Australia are coronary heart disease, acquired valve disease, conduction defects, congestive heart failure and congenital heart defects.

4. Cardiac services encompass a range of diagnostic, interventional, surgical and electrophysiological procedures. There are a wide range of treatments for heart disease including medical therapy, interventional procedures using catheterisation or electrophysiology and surgery.

5. There has been an increased and changing demand for cardiology services, particularly in relation to management of acute coronary syndrome and acute myocardial infarction.

6. Until 1996, cardiac surgical services were provided from only one state-wide service. In 1996, Queensland Health supported the development of two additional cardiac surgical units at Townsville and The Princess Alexandra Hospital Health Service District ('PAH'), to establish and develop zonal services.

7. Some of this increase in demand, related to changes in clinical practise following the release of the *'Australian Management of Unstable Angina Guidelines-2000'* by the National Heart Foundation ('NHF') and the Cardiac Society of Australia and New Zealand ('CSANZ'). A copy of the Guidelines are attached and marked **MIC-1.**

8 At the time the Guidelines were released, the Acting Director of Cardiology at The Prince Charles Hospital Health Service District ('TPCH') advised that he did not believe that the new Guidelines would result in an overall increase in activity, as patients would simply be receiving treatment at an earlier stage. However, the Acting Director of Cardiology indicated that he did expect a transient increase in activity as the Guidelines were adopted by referring hospitals.

9 Since the release of the Guidelines, the number of inter-hospital transfers to TPCH has increased as detailed below:

*Activity	2001	2002	2003	2004	2005
Inter-hospital transfer data for angiography and PCI (excluding cardiac surgery)	304	573	518	718	557
Emergency Department: Total attendances	9,106	10,152	11,190	11,366	11,722
Emergency Department: Patients waiting in department longer than 6 hours	134	231	570	1,124	1,392
Emergency Department: Admissions through ED	4,862	4,772	4,355	4,384	5,210

*Financial year data

10 The changes in activity occurred between 2001 and 2002. Emergency Department attendances and admissions also increased from 2001 to 2005. The number of patients waiting longer than 6 hours in the emergency department also increased. This is an indicator of reduced access to inpatient beds.

11 In September 2003, TPCH analysed interventional cardiology activity and identified an increased demand on the service that had resulted from increased referrals from peripheral centres.

12 A submission for funding outlining this analysis was prepared by TPCH and forwarded to Dr John Scott, then Acting General Manager Health Services via Central Zone Management Unit on 24 November 2003. This submission is attached to the undated and unsigned statement of Dr Con Aroney and marked 'CA4'.

Structure of Cardiology Service at TPCH

13 The Cardiology Service at TPCH provides comprehensive care to cardiac patients in Queensland. Flow charts detailing TPCH organisational structure are attached and marked **MIC-2**.

14 The current Director of Cardiology is Dr Darren Walters. He was appointed to this position on 24 February 2005. Dr Walters is also Director of the Cardiac Catheter Laboratory. Other Department Heads include Dr Darryl Burstow, Echocardiology; Dr Russell Denman, Electrophysiology; Dr Deborah Meyers,

Heart Failure and Heart Transplantation and Dr Rob Justo, Paediatric Cardiology. At present, TPCH is recruiting to the position of Director of the Coronary Care Unit.

15 Dr Con Aroney commenced at TPCH as a Staff Cardiologist on 11 February 1991. On 1 July 1994 he was appointed to Senior Staff Cardiologist and on 4 August 1994 Dr Aroney was appointed Clinical Director of the Coronary Care Unit at TPCH.

16. In his position as Clinical Director of the Coronary Care Unit, Dr Aroney did not have direct access to management information relating to cardiology funding and activity. This information would have been provided to the Director of Cardiology, who would have spoken with clinical unit directors about information relevant to their unit. I note that Dr Aroney was on leave for 2 years prior to his resignation. His absence would have also reduced his access to operational information.

17. Prior to taking up the position of Acting District Manager on 2 August 2005, I was Executive Director Medical Services ('EDMS') at TPCH, a position I held for approximately 5 years.

18. In my position as EDMS, I formed the view that Dr Aroney was a good clinician and someone who had contributed to the development of cardiology services in Queensland.

Historical funding and transfer of cardiac activity

19. In order to improve access to cardiac services in Queensland, PAH established its service in 1998-1999. TPCH was also funded to address the extensive waiting list which existed for cardiac surgery. TPCH was allocated elective surgery funding during the late 1990s. The funding was negotiated at a marginal cost, as the cost weights in the earlier casemix funding models in Queensland did not accurately reflect the real cost of cardiac surgery.

20. TPCH had been faced with significant cost pressures resulting from:

- Increased demand for interventional cardiology;
- Marginal cost funding of elective surgery;
- Growth in transplant services;
- Clinical supply cost increases which eventuated from the devaluation of the $A; and
- Increased clinical consumable costs related to single use items.

These demands resulted in the TPCH incurring a budget deficit in the 1999-2000, 2000-2001 and 2001-2002 financial years.

21. In February 2002, PAH prepared a submission to the Director General of Queensland Health, seeking funding to expand cardiac surgical services. I am not aware of the response provided. However, the submission was represented in

February 2003. The Director General, subsequently requested the issue be progressed.

22 Discussions took place between the Director General, General Manager Health Services and Zonal Managers, who provided 'in principle' support to the transfer of activity and resources.

23. Following these discussions, Queensland Health made a decision in early 2003, to expand cardiac services at PAH through the transfer of services from TPCH.

24 The Cardiac Surgery Services Working Party was commissioned and a project officer appointed to provide a detailed assessment of the recurrent and capital requirements of the service expansion.

25. A copy of the Cardiac Surgery Services Working Party Terms of Reference are attached and marked **MIC-3**.

26. In April and May 2003, both TPCH and PAH prepared Impact Analysis Reports based upon the transfer of 300 cardiac surgical procedures, 700 coronary angiograms and 233 coronary angioplasty procedures. Copies of those impact reports are attached and marked **MIC-4**.

27. Due to some disparities in the two reports, it was agreed at the May 2003 Cardiac Surgery Services Working Party meeting, that an external consultant would be appointed to review both business cases to determine the reasonableness of the assumptions and projections. Mr Jim Lowth, was appointed to undertake this process. Copies of the minutes of that meeting are attached and marked **MIC-5.**

28 On 30 July 2003, a meeting was held between myself, Mr Lowth, Graeme Kerridge, Manager Central Zone Management Unit and Dr Paul Garrahy, Director of Cardiology, PAH to finalise the cardiac services activity transfer.

29. It was agreed at that meeting that the final transfer numbers would be 300 cardiac surgical procedures, 500 coronary angiograms and 96 coronary angioplasty/stent procedures.

30 The transfer in cardiology activity was to commence in April 2004. The transfer in cardiac surgical activity was to commence in July 2004. Attached as a bundle and marked **MIC-6** is copies of memorandums from me to department heads regarding this transfer.

31. Despite the transfer of activity from TPCH to PAH, demand for cardiology and cardiac surgery continued to increase.

32. Submissions were made for additional funding for cardiac surgery by TPCH to Dr John Scott, Acting General Manager Health Services on 24 May 2004. Attached and marked **MIC-7** is a copy of that submission.

33. Additional funding in the sum of $2.4M was provided in the 2004-2005 financial year to undertake additional cardiac surgery at TPCH.

Internal memorandum

34. At paragraph 6 of his statement, Dr Aroney makes reference to an internal memorandum dated 8 January 2004 from me to Dr Andrew Gailbraith, then Director Cardiology, Jenny Walsh, then Nursing Director Cardiology and Hayley Middleton, Business Manager Cardiology. That memorandum is attached to Dr Aroney's statement and marked 'CA3'.

35. That memorandum was sent in response to advice from Queensland Health and the Executive and Director of Cardiology at PAH that:

- PAH had the capacity to undertake additional activity (in the order of 10-20 cases a week) effective immediately;
- That the waiting list at PAH (category 1 patients = 0; category 2 patients = 2) was dramatically lower than that at TPCH (category 1 patients = 229; category 2 = 79).

36. Based on this advice, plans were put in place for patients to be redirected from the TPCH waiting list to PAH. Following discussions with Dr Gailbraith, it was agreed to develop a procedure to redirect cases being transferred to TPCH from regional centres, to be referred over to PAH. The intention was to improve the access and timeliness of interventions through managing patients across the service.

37 In accordance with Dr Gailbraith's request, these arrangements were documented in my memo of 8 January 2004. Principles were based on:

- Continuity of care. All patients who presented to TPCH from the local community were to continue to be treated at TPCH as transfer to PAH would not be clinically appropriate;
- Patients in centres outside Brisbane who were being transferred to Brisbane, were able to be redirected to PAH without compromising their care. As such the arrangements where *'patients referred from within the Central Zone, but from outside the Brisbane north area are only to be accepted if they could be managed within our existing capacity'* were implemented.

38. The implementation of these arrangements meant that approximately 10 patients a week were receiving care earlier and that this in particular, related to patients in the Central Zone who appeared to have delayed access to services at TPCH.

39. The memorandum needs to be interpreted in the context of existing patient flows and in the context of what constitutes appropriate patient care. Clearly, if patients are able to access services at PAH sooner than at TPCH, patients should be referred to that facility.

40. The interpretation placed on this memorandum by Dr Aroney is incorrect, inconsistent with the management arrangements put in place and contrary to appropriate patient care.

41. Queensland Health has a standardised process to categorise patients on the waiting list. TPCH uses these categories. It was assumed by me that PAH also used the same categorisation process. However, on or about January 2005, I became aware that PAH had been using a different categorisation process in cardiology. This would have contributed to the significant difference in waiting list numbers between the two hospitals. Since this time, cardiology units have agreed on a standardised categorisation process across the state using the model that was already in place at TPCH.

42. I am unable to comment on the issues relating to patient P11, referred to in paragraph 6 of Dr Aroney's statement.

Correspondence from Dr Aroney and media release

43. On 16 December 2003, Dr Aroney wrote to the Premier detailing areas of concern relating to statewide cardiology services and in particular, the death of 3 cardiac patients on the waiting list.

44 I was Acting District Manager at TPCH during this period.

45. This correspondence was forwarded to Dr Phillips, then Executive Director Medical Services by the Central Zone Management Unit on 5 January 2004. I was subsequently provided with a copy of that correspondence by Dr Phillips.

46. On 5 January 2004 I cleared a briefing prepared for the Minister which provided a response to the matters raised by Dr Aroney in his correspondence. Attached and marked **MIC-8** is a copy of that briefing.

47. On 6 January 2004, comments made to the media by Dr Aroney were published in the Courier Mail. A meeting was held that morning between Dr Aroney, Dr Gailbraith, Dr Phillips and myself at which we discussed concerns raised by Dr Aroney in the media. Attached and marked **MIC-9** is a copy of an email dated 7 January 2004, detailing what was discussed at that meeting.

Thomas Ayre Investigation Report

48. In order to further investigate Dr Aroney's concerns, Dr Peter Thomas, Principal Clinical Co-ordinator, PAH and Dr Stephen Ayre, Deputy Executive Director Medical Services, Royal Brisbane Women's Health Service District, were appointed on 7 January 2004 pursuant to section 52 Health Services Act.

49 On 12 January 2004, the Thomas Ayre report was emailed to me by Dr Ayre. A copy of that report is attached and marked **MIC-10**.

50. The report contains 3 recommendations relating to the inter-hospital referral process; procedure bookings and the waiting lists for implantable cardioverter defibrillators ('ICD'). These recommendations were discussed with Dr Gailbraith, then Acting Director of Cardiology at TPCH, who reviewed the report and assisted in implementation of the recommendations.

51. On 15 January 2004 a briefing was prepared by Dr Phillips (and cleared by me) to Dr Scott, Acting General Manager Health Services. That briefing provided information regarding Dr Aroney's correspondence and comments made in the media. It also advised in relation to the recommendations made arising out of the Thomas Ayre Investigation Report. A copy of that briefing is attached and marked **MIC-11**.

52. On 22 January 2004, I received a memorandum from Dr Steve Buckland, Acting Director General, directing me to actively manage a range of issues relating to cardiac services. Attached and marked **MIC-12** is a copy of that memorandum.

53 At 11-19am on 23 January 2004, I sent an email to Mr Dan Bergin, Manager Central Zone, outlining the action I had taken in response to Dr Buckland's memorandum of 22 January 2004. Attached and marked **MIC-13** is a copy of that email.

54. On 27 January 2004, I prepared a memorandum to the Cardiology Department addressing the recommendations made in the Thomas Ayre Investigation Report and the matters raised by Dr Buckland in his memorandum. A copy of that memorandum is attached and marked **MIC-14.**

55. The plan outlined in my memo of 27 January 2004 was implemented by the Cardiology Department and activity was monitored weekly the District Executive.

56. Apart from distribution of the Investigation Report as outlined above, the Report was not further distributed or publicly released. The reasons were twofold. Firstly, I considered the responsibility for public release of the Report, lay with the then Director-General, Dr Buckland. Secondly, the Report was an investigation pursuant to the Health Services Act and in my experience, it was not usual practise for reports of that nature to be publicly released.

Mahar Johnson Investigation Report

57. On 29 August 2004, Dr Russell Denman, Director of Electrophysiology sent an email regarding the death of a patient awaiting ICD implantation. That email was sent to a number of medical staff including Dr Aroney in his capacity as Chair off the Queensland Branch of the Cardiac Society.

58. On 30 August 2004, Dr Darren Walters, then Deputy Director of Cardiology sent an email to a similar group of staff, regarding a case where an inpatient died awaiting cardiac surgery.

59 Following receipt of this correspondence and discussions with Mr Bergin, it was agreed that a further investigation needed to be undertaken.

60 On 6 September 2004 a briefing was provided to the Acting Senior Executive Director Health Services. This briefing advised of the intention to investigate the allegations and the appointment of investigators.

61. On 20 September 2004, Terms of Reference for the investigation were developed and I appointed Dr Andrew Johnson, Executive Director Medical Services, Townsville General Hospital and Dr Leo Mahar, Director Cardiology, Royal Adelaide Hospital were appointed as investigating officers.

62. On 21 September 2004, Gloria Wallace, District Manager advised Dr Walters and Dr Denman of the intention to investigate their concerns.

63. On 29 September 2004, the Terms of Reference were revised and finalised and the investigators formally met in Brisbane to commence their investigation on 12 October 2004.

64. On 24 February 2005, Gloria Wallace and I prepared a briefing to Mr Terry Mehan, Acting Senior Director Health Services regarding management of the Mahar Johnson report. A copy of that briefing is attached and marked **MIC-15.**

65. On 4 March 2005, following consultation with Drs Walters and Denman, the Mahar Johnson Investigation Report was circulated. A copy of that report is attached and marked **MIC-16**.

66. The Mahar Johnson Investigation Report contained 10 recommendations. In response to those recommendations, I prepared a document entitled *'Queensland Health Response to Recommendations Contained in Mahar Report'*. A copy of that document is attached and marked **MIC-17**.

Deaths on Waiting Lists

67. In paragraph 37 of his statement, Dr Aroney raises issues relating to the death of cardiac patients on the waiting list.

68. I recall there was a release of information by a Member of Parliament, regarding patients who were said to have died on a cardiac waiting list. This list was difficult to evaluate as it did not contain patient names of dates of birth.

69. A review of the procedural management of the patients was undertaken by me. A copy of my memorandum to Dr Scott regarding my review is attached and marked **MIC-17A**. I identify patient C in my memorandum, as being 'patient 9' as referred to in paragraph 37 of the statement of Dr Aroney.

70. I identified that the Cardiology and Cardiac Surgery Departments had, until this time, reviewed and monitored deaths on the waiting list. I established a process that would allow me to track and review deaths on the cardiology and cardiac surgery waiting lists. I subsequently transferred the monitoring of this area to the Patient Safety Committee.

71. TPCH also implemented a range of management strategies to manage the risk associated with Acute Coronary Syndrome including:

- Developing a standardised process for inter-hospital transfer including centralisation of the process;

- Standardisation of clinical risk assessment using TIMI score modified for age. This was the first time such a scoring system had been used for this purpose. It allows cases to be rated in terms of clinical priority;
- Development of a risk escalation process (outlined below) to allow coordination of services and to ensure that patients are able to access services equitably.

Cases Waiting	Action Required
0-5	Local management by waiting list coordinator
5-10	Escalation to Director of Cardiology
10-15	Escalation by Director to Directors at RBWH and PAH
15 -	Escalation by EDMS to EDMS at RBWH and PAH

72. A Clinical Decision Support System and Patient Management Database is currently being developed to assist in cross-hospital management of these cases that is in 'real time' and accessible by the referring hospital.

Drug-eluting stents

73. In paragraph 8 of his statement, Dr Aroney makes reference to a *'moratorium on the use of drug-eluting stents'*. I recall the situation to which Dr Aroney refers.

74. However, I do not recall, nor am I aware of any documentation that would or could be construed a threat of dismissal to the doctor involved. I am aware of a memorandum sent by Ms Deb Podbury, then District Manager, seeking an explanation for the use of a drug-eluting stent in circumstances where such stents had not been recommended for public use by the Commonwealth Medical Services Advisory Committee ('MSAC') except in specific circumstances.

75. At the time of the incident (late 2003), drug eluting stents were recommended for use by the MSAC in the context of clinical research. Staff were informed, through communications with the Director of Cardiology, that drug-eluting stents were not approved for use within Queensland Health.

76. I am aware that there was variation in how different States and Territories in Australia approached this matter with one State (Western Australia) approving their use.

77. Subsequent to this, Dr Walters, then Director of the Cardiac Catheter Laboratory, implanted a drug-eluting stent into a patient at TPCH. I understand he obtained the stent from a local private hospital. A memorandum was then sent by Ms Podbury, requesting an explanation for the use of the stent. A satisfactory explanation for the use of the stent was provided by the doctor involved and the matter was then closed. No disciplinary action was taken by TPCH over the incident. Attached as a bundle and marked **MIC-17B** is a copy of that correspondence.

78. In order to prepare this statement, I have also spoken to Ms Podbury, who informs me and I verily believe, that there was no 'petition of staff' as referred to by Dr Aroney in paragraph 8 of his statement. What Ms Podbury informs me did occur

was that she was approached by two doctors who expressed their concerns that Dr Walters had received correspondence regarding an alleged breach of the Code of Conduct and told her that Dr Walters was upset about that. Ms Podbury then immediately arranged a meeting with Dr Walters to discuss the issues.

79. In March 2004, a submission was made to Dr Scott, Acting General Manager Health Services, for interim funding pending publication of a second MSAC report into drug-eluting stents. Funding in the sum of $2.0M was provided by Queensland Health, for distribution across 4 districts. The second report was published in or about April 2005 which recommended public funding.

80. A copy of the MSAC Reports are available on the Internet at www.msac.gov.au

Paediatric cardiac services and ventricular assist devices

81. In paragraph 9 of Dr Aroney's statement he refers to the use of ventricular assist devices ('VAD') in cases involving two infants at TPCH. I recall the cases referred to by Dr Aroney.

82. TPCH has an outstanding VAD program in place for adults (defined as 17 or older). We implant approximately 4 of these devices a year as a bridge-to-transplantation (heart) and 2 as a bridge-to-recovery (short term 1-2 weeks).

83. The bridge-to-recovery program is less effective than the bridge-to-transplant program and uses different technology. The bridge-to-recovery program uses a Thoratec device and costs approximately $120,000 per patient to implant. The bridge-to- recovery program uses an Abiomed device and costs approximately $40,000 per patient to implant. The hospital does not have a VAD program for children or adolescents.

84. A paediatric VAD program is closely linked to paediatric heart transplantation. In Australia, because of the small numbers of paediatric heart transplants (approximately 6 per annum), all paediatric heart transplantation services are centralised in Melbourne. TPCH refers paediatric patients to this service.

85. In the most recent Commonwealth review of the Nationally Funded Centre for Paediatric Heart Transplantation, it was agreed that the current arrangements for the centre should continue. Dr Pohlner, Cardiac Surgeon, was a member of the review committee.

86. The device which Dr Pohlner proposed to use in the children described in Dr Aroney's statement is a Biomedicus device. This device had been used in adults but had been superseded by the Thoratec and Abiomed devices.

87. In relation to the use of the VAD (Biomedicus) in the first child referred to in Dr Aroney's statement, I became aware that its use was proposed when the child was in the operating theatre. I believe the clinicians involved in the surgery, felt that the child may need post-operative cardio-pulmonary support and therefore had proposed use of the VAD (Biomedicus).

88. I had discussions with the Director of Cardiac Surgery at TPCH and the Director of the National Unit in Melbourne. After extensive consultation, it was suggested that if the child required support that it could be maintained on cardiac bypass overnight and be reassessed the following morning. This approach was in line with previously accepted clinical practice.

89. In this instance the post-operative cardiac support was not required as the patient was able to be weaned from cardio-pulmonary bypass following surgery.

90. Following this case, I commissioned a team of clinical staff to prepare a business case in relation to the use of the VAD (Biomedicus) in paediatric patients.

91. In the interim, I became aware that Dr Pohlner had scheduled a child to undergo a cardiac procedure where the use of the VAD (Biomedicus) was anticipated. I discussed the surgery and use of the VAD (Biomedicus) with a number of key people. The consensus following those discussions was that child was unlikely to need a paediatric heart transplant and therefore, the surgery was considered not to be outside scope of practise of TPCH.

92. At the time that it was proposed to use the device, the state of the device was:

- It was technologically old and had not been used for 10 years;
- Staff (who would operate the device) thought it had been decommissioned or disposed of;
- The last time it had been used, it malfunctioned and no one knew if it had been repaired;
- The device had not been serviced by biomedical engineers and was out of service;
- Only one device could initially be found (two devices are needed because if the device fails it is imperative that a patient can be moved onto a second, back-up device immediately);
- There were no disposables items in stock at TPCH and none in Australia. Stock would have needed to be sourced from the USA;
- Only one member of the technical staff had been trained in the use of the equipment (minimum 4 staff required to operate it over 24 hours). This staff member had not used it in 10 years;
- No procedures were in place to guide the nursing staff in ICU in its use;
- Extensive staff training would be required if the device was to be used.

Use of the device in this situation would have been unsafe and gone beyond the role delineation of the service (now called Service Capability Framework) of TPCH.

93. I then had discussions with the Director of the National Unit in Melbourne regarding the procedure and in particular, the use of the VAD (Biomedicus). It was agreed that the procedure could be safely undertaken at TPCH however, it was apparent that there were a number of deficiencies (referred to in paragraph 89 above) that needed to be attended to before the procedure could take place. In particular, staff required training, a second VAD machine needed to be sourced and the disposable items for use of the machine needed to be purchased.

94. After an enormous effort, we were able to establish appropriate systems to support the use of the technology and the surgery was able to proceed.

95. Cost was not an issue in relation to either of these cases. Prior to this occasion we would generally maintain children on cardio-pulmonary bypass in the operating theatre

96. Dr Aroney was not involved in either of these cases and as such, would not have been aware of the facts surrounding them.

97. I do not recall, nor am I aware of, any documentation that would or could be construed as a threat of dismissal. I am however aware of correspondence between Ms Podbury to Dr Pohlner regarding a breach of a formal directive in relation to the second patient. A copy of that correspondence is attached as a bundle and marked **MIC-18.**

Cardiac Investigation Unit

98 In paragraphs 39-45, Dr Aroney particularises his concerns arising out what he refers to as the '3rd round of cuts' which occurred in September 2004.

99. A summary of activity and funding at TPCH between 2003 to 2005 is set out below:

*TPCH Cardiology	2003	2004	2005	Change
Budget	$25.44M	$29.04M	$30.95M	$5.5M
ICD	116	178	218	102
Angiogram	3,105	3,208	2,903	-202
PTCA/Stent	618	754	751	133
Admissions	6663	6914	7567	1304

*Financial year data

100. This table shows that between 2003 and 2005, the Cardiology Department had a funding increase of $5.5M. In terms of clinical activity, the Cardiology Department had an increase in ICDs and percutaneous angioplasty and stenting procedures and a small decrease in angiograms. Overall access to beds also increased both in terms of admissions and bed days used. An additional 1304 patients were treated in 2005. This data would not support the assertion that there were budget reductions.

101. During this period, there had been an increase in activity at other Queensland public hospitals. The table below shows the increase in cardiac surgical and cardiology activity across PAH and TPCH and the increase for specialised cardiology activity at PAH, RBWH, Townsville and TPCH:

	2004	2005	Change
Cardiac Surgery	1,890	2,160	270
ICD	211	290	79
Angiogram	5982	6129	147
PTCA/Stent	1662	2047	385

102. This table shows that across the State that cardiac activity increased. The last column in the table details the level of activity growth. This data would not support the assertion that there was restricted activity.

103. Around this time, activity at the Cardiac Investigation Unit ('CIU') was reviewed in light of increasing clinical demand, the impact of new technology and the changes in practise in light of the overall resource allocation:

- Clinical Demands: after hours emergency cases remained at approximately 5 per week;
- Impact of Technology: the new cardiac MRI has meant that the number of children requiring angiography has reduced by half. As such the continued, routine scheduling of 8 paediatric angiograms a week, in circumstances where 4 angiograms were not being performed, was replaced by adult cases. This was discussed and agreed by paediatric cardiologists subject to additional cases being able to be booked if required;
- Clinical practice had changed with an increase in the number of patients referred for acute intervention increased to 25 per week. There was also an increase in angioplasty and stenting activity and a decrease in angiography;
- Resource issues were considered including the additional funding for cardiac procedures.

104. Concerns had been raised within the Cardiology Department regarding the level of planned activity to be performed in the CIU in the 2004-2005 financial year.

105. By this time, activity levels had been redefined, based on the impact of the activity transfer to PAH. As stated in the briefing, funding at that time allowed for a weekly schedule of 57 funded acute and elective catheter laboratory procedures to be performed (excluding after hours emergencies).

106. I recall and was present at the staff meeting on 24 September 2004, referred to by Dr Aroney. There are handwritten minutes of that meeting which were taken by Dr Radford. I do not recall, nor do the minutes reflect that Ms Wallace stated that she had *'a list of foreign graduates who were prepared to step in and take our positions'*. At this time, Dr Aroney was on extended leave and plans needed to be made to identify additional staff. The minutes reflect a comment to the effect that we had *'been told about possible locums from an agency in South Africa'*.

107 Attached and marked **MIC-19** is a copy of Dr Radford's handwritten minutes.

108. A further meeting took place on 3 November 2004 between myself, Ms Wallace, Dr Aroney and Dr Peter Tesar, Cardiac Surgeon regarding cardiac activity. A copy of the minutes of that meeting are attached and marked **MIC-20**.

109. On 12 October 2004, I prepared a briefing to Dr Scott, Acting Senior Executive Director Health Services in relation to these issues. A copy of that briefing is attached and marked **MIC-21**.

110. In response to this briefing, Queensland Health provided additional funding as follows:

- October 2004 $1.07M (used for additional angiography and ICD activity);
- December 2004 $1.4M (allocated to ICD, ASD closures and angiography);
- April 2005 $3M (used to support ICU, transplants - heart and lung, and oncology).

111. The cumulative effect of the additional funding allocations referred to above has been that, since February 2005 (the date from which reliable data on this topic is available to me):

- The angiography waiting list reduced from 192 to 99 cases;
- The angioplasty waiting list reduced from 52 to 48 cases;
- Currently only 7% of Category 1 angioplasty cases are waiting longer than their recommended 30 days compared to January 2005 when 30% of such cases waited longer than 30 days;
- The waiting list for defibrillators has reduced from 68 (February 2005) to 55 (current). Of these current cases, over 70% are facing a wait longer than their recommended 30 days. However, only last week I submitted a funding request for an additional $2.1M to address their wait. I am optimistic of a favourable outcome to my funding request;
- Currently the cardiac waiting list for new patients is 575 cases compared to 745 such cases in October 2004.

112. Attached and marked **MIC-21A** are true copies of the statistical data on average waiting times for cardiology services (other than out-patients)

Resignation of Aroney and credentialing/privileging issues

113. By letter dated 9 March 2005 addressed to Ms Wallace, Dr Aroney gave written notice of his resignation from TPCH. In that correspondence, Dr Aroney requested ongoing privileges at TPCH. By letter dated 21 March 2005, I advised Dr Aroney that *'if the need arises, the process for considering and awarding privileges will be awarded through Medical Administration'* A copy of that correspondence is attached and marked **MIC-22**.

114. I note in paragraph 58 of his statement, Dr Aroney states that his offer to provide services was *'effectively refused'* and that it was treated *'as a request for privileges rather than an offer of voluntary service'*.

115. I refer to my previous statement to the Commission of Inquiry, regarding the role of the EDMS signed 23 August 2005. In paragraph 6 (e) and (f) I have provided information regarding the way in which clinical privileges are awarded. For any person who is not a member of staff at TPCH, privileges are granted on a case-by-case basis for each procedure undertaken. This is a very simple process and is approved by the EDMS or the EDMS on-call.

Comments in relation to Chronology provided by Dr Aroney

116. Jan-July 2004: During this period additional funding was provided for elective surgery support post election. TPCH received additional funding that was directed towards medical procedures such as atrial-septal defect ('ASD') closures, angiography and related procedures.

Communication with staff at TPCH

117. At paragraph 7 of his statement, Dr Aroney states that *'PCH executive administrators... were usually too busy to meet staff, would only speak to cardiologists briefly and ... virtually never visited the wards'*. I believe this to be an incorrect portrayal of the situation based on:

- Until November 2002 I and the Executive Director Nursing Services conducted regular clinical rounds of the hospital;
- Although the formal rounds no longer occur, I meet with and move through the hospital on a regular basis;
- There were regular formal and informal meetings with clinical staff including Directors and senior staff. This included the Hospital Executive which has representation from 3 members of the Cardiology Department;
- The previous Deputy Director Medical Services (who has recently taken up a more senior position) and I regularly arranged for joint visits to clinical areas including our 'Christmas Rounds' where we provided small gifts (paid for personally) to all the junior medical staff and major operational units within the hospital. This 'Round' usually took all day and provided an opportunity to recognise the support that staff had shown to TPCH during the year;
- In conjunction with the District Executive, I arranged similar facility visits at Christmas for all the major services in the District.

I provide this information by way of example, of some of the many ways in which the executive team maintained a presence in the organisation

118. I note Dr Aroney also states at paragraph 7, that a meeting was scheduled with me and that he was *'kept waiting 2 hours'* before being told that I was *'too busy to meet with'* him. I recall the meeting to which he refers.

119. In order to respond to this comment, I have had my executive diary restored from an archive file. My diary does not does not record a meeting with Dr Aroney in the timeframe he describes.

120. I recall that I was advised that Dr Aroney was waiting to see me, but that there was no appointment in my diary. I could only assume that there had been an administrative error in organising the meeting by staff who worked in my office. I made every attempt to meet with Dr Aroney and provided an apology and an explanation to him about the error in the booking.

121. I recall that at the time Dr Aroney attended my office to meet with me that I was meeting with a patient's family about a serious clinical issue and was unavoidably detained. It is likely that upon receiving notification about my

meeting with Dr Aroney, that I would have balanced the need to continue my meeting with the patient's family against meeting senior staff. I understand that an alternative meeting time for the meeting with Dr Aroney was offered.

122. I always aim to be very accessible to staff. I believe that, on the whole, I am successful in meeting this aim. In achieving this I meet with new medical staff on their appointment, regularly meet with the Directors of Clinical Units, have an 'open door' policy and spend up to an hour a day discussing management issues with the Chair of our Medical Advisory Committee. This is in addition to meeting with staff at formal meetings or informal functions such as the medical staff dinners.

Minimal Activity over Christmas Period

123. It is the usual practice at TPCH and other major hospitals, to have a period over Christmas during which minimal activity is undertaken. During this period emergency and acute services are maintained. Elective services are generally not scheduled during the period.

124. This allows the hospital to meet a number of objectives such as reducing activity during periods when patients and staff would like to spend time with their families and providing staff with an opportunity to take leave.

125. The reduction in elective services which occurs over the Christmas period requires detailed planned which starts in July each year. At the conclusion of Christmas period a formal evaluation of the impact of the minimal activity is undertaken.

126. Cost cutting is not the goal of the systematised management of the minimal activity period however, if activity is to be reduced it needs to be done in the most efficient manner so that we do not waste funds by operating inefficient services. If this can be achieved, it allows maximal funding to be available during the remainder of the year to treat patients.

Signed at **Brisbane** on **23 August 2005**.

Dr Michael Cleary
Acting District Manager
The Prince Charles Hospital Health Service District
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