BUNDABERG HOSPITAL *Commission of Inquiry*

STATEMENT OF Jonathan JOINER

Jonathan JOINER makes oath and says as follows

1. I obtained a degree in medicine in 1983 from the University of London. I obtained a diploma in anaesthetics in the UK in 1990. I registered to practice in Australia as a general practitioner in 1989 and, since then, I have practised with a special interest in anaesthetics.

2. I am a visiting medical officer at the Bundaberg Base Hospital performing five (5) sessions per week in theatre in anaesthetics. I have been employed at the Hospital for about eleven (11) years. Dr Martin Carter who is the Director Anaesthetics at the Hospital is my immediate line Manager.

3. I know Dr Jayant PATEL who was engaged at the Hospital as a surgeon. I would work with him once every second week. I found Dr Patel to be forceful person and, at times, intimidating. He would shout at staff and threaten to resign if he did not get his way. I recall a particular example. I cancelled a procedure arranged by Dr Patel because of staffing issues and time constraints. Dr Patel did not speak to me for 2 to 3 days following the cancellation, and ignored me in the corridor.

4. In or about April or May 2003 I became aware that Dr Patel was proposing to perform an oesophagectomy which is a significant surgical procedure. I recall having a meeting with Dr Darren Keating, who was at the time the Director of Medical Services, after I had had discussion with Toni Hoffmann about that issue. I told Dr Keating that the patient should be transferred to Brisbane.

Signed: ..... Deponent

Taken by: ..... Solicitor/Barrister/~~Justice of the Peace/ Commissioner for Declarations~~

5. I was concerned about that type of procedure being performed at the Hospital because the Director of Anaesthetics was on holidays, the Hospital only had a level one intensive care unit, and recent studies had shown that this type of operation has a better outcome in a tertiary centre. Level one ICU have limited ventilated beds. Longer term ventilated patients with complications stretch ICU resources.

6. It is my recollection that Dr Keating agreed the operation should be conducted in Brisbane. I do not remember the name of the patient. ICU staff told me that Dr Patel then threatened to resign if he was not allowed to perform the procedure. In any case, the operation proceeded in Bundaberg. I did not assist but, instead, I believe a Canadian was involved.

7. I recall a patient undergoing an oesophagectomy in June 2003. Dr Patel was the surgeon. I do not recall that male patient's name. The patient had two (2) leaks from the oesophagectomy site and returned twice to theatre. On the second occasion the patient remained ventilated. I was in charge of ICU on that morning and made a decision that the patient should be transferred to Brisbane. I arranged an intensive care bed for him in Brisbane. However when Dr Patel became aware of the arrangements, he immediately threatened to resign.

8. In the event, Brisbane would not accept a patient without receiving a surgical referral from Dr Patel. He declined to give that referral and I arranged a further meeting with Dr Keating at which Dr Patel was also present. Dr Keating decided to keep the patient in Bundaberg for another two days. The patient's condition did not improve, and by the Friday it was decided to transfer the patient to Brisbane. By that time however the Brisbane ICU bed was no longer available. I believe the patient was kept at Bundaberg for a few more days following which he was transferred to Brisbane where he died.

Signed: . . . . . Taken by: . . . . . .

Deponent Solicitor/Barrister/~~Justice of the Peace~~/

9. I knew P 44 She was a patient of Dr Patel's in ICU. I recall receiving a telephone call on a Sunday evening on a weekend on which I was on call for the ICU. The call was from a nurse whose first name is Lyn. She asked me to attend the ICU and turn off the patient's ventilator. I refused to do so for a number of reasons. In particular, I had not dealt with the patient and no formal brain death tests had been conducted.

10. Brain death tests are conducted by two specialists. They work together to run a series of tests (which would take 30 to 60 minutes) and they then conduct certain discussions with relatives of the patient. At that point, they make a decision about whether to turn off the ventilator. The tests are prescribed by our professional body.

11. The following day I had discussions with Dr Dieter Berens about the need to conduct brain death tests. He stated that brain death tests should be performed prior to switching off a ventilator. In further discussions also on the following day with Dr Carter, Director Intensive Care, he indicated that the CT scan clearly showed the patient was brain dead and that brain death tests were not necessary. I did not see the CT scan and I was reticent, in any case, to take such a dramatic step without complying with the protocol on the night in question.

12. I heard later from theatre staff that Dr Patel was making disparaging comments about me and was furious with me because I didn't attend at the Hospital and turn off the ventilator.

13. I know Dr Peter Miach who is the Director of Medicine at the Hospital. I am aware that Dr Miach had a practice of not sending his patients to Dr Patel because he questioned Dr Patel's clinical competence.

Signed: . . . . . Taken by: . . . . .

Deponent Solicitor/Barrister/Justice of the Peace/

Affidavit Sworn on the 24th day of June 2005

at Bubdaberg in the State of Queensland in the presence of:

. . . .

Deponent

Solicitor/Barrister/Justice of the Peace/
Commissioner for Declarations

Signed: . . . .
Deponent

Taken by: . . . .
Solicitor/Barrister/Justice of the Peace/