INVESTIGATION REPORT REGARDING ALLEGATIONS OF CARELESS, INCOMPETENT OR INEFFICIENT CONDUCT BY DR IZAK MAREE

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Period of Investigation: Wednesday 20 December 2000 –
Monday 29 January 2001

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1 BACKGROUND TO INVESTIGATION

1.1 Events Leading to Investigation

Dr Izak Maree commenced duties as Medical Superintendent of Charters Towers Hospital on 4 September 2000 (Appendix 1). Between 4 September 2000 and 17 December 2000, Dr Maree provided clinical and administrative services to Charters Towers Health Services District.

On 17 December 2000, Dr David Row, Senior Medical Officer Charters Towers Hospital, wrote to Mr Peter Sladden, District Manager Charters Towers to express his concerns about the clinical competence of the Medical Superintendent, Dr Izak Maree (Appendix 2). Dr Row's allegations followed the day after a fatal event in operating theatres at Charters Towers Hospital.

The gravity of the concerns expressed were such that the District Manager sought advice from the Manager, Northern Zone Queensland Health, and an investigation was subsequently commissioned to examine that allegations made by Dr Row on 20 December 2000. Terms of Reference were established in consultation with Human Resources Officers (Appendix 3) and the Investigation Officers were appointed from within the Northern Zone Queensland Health. Dr Maree was suspended from duty on full pay.

1.2 Key Dates

19 May 2000	Dr Maree interviewed by telephone from South Africa
22 May 2000	Dr Maree offered position as Medical Superintendent Charters Towers Hospital
25 May 2000	Dr Maree accepts position as Medical Superintendent Charters Towers Hospital
28 August 2000	Dr Maree arrives in Townsville for one-week orientation
4 September 2000	Dr Maree commences duty Charters Towers Hospital
31 October 2000	Dr Row departs Charters Towers for study leave and locum service in Beaudesert.
17 December 2000	Dr Row returns from Beaudesert and writes letter to Mr Sladden.
17 December 2000	Fatal event in operating theatres
18 December 2000	Letter handed to Mr Peter Sladden, District Manager Charters Towers, copy to Medical Board of Queensland.
20 December 2000	Investigation Officers commissioned by Zonal Manager
20 December 2000	Investigation Commences
February 2001	Investigation concludes

1.3 Key People

Dr David Row, Senior Medical Officer, Charters Towers Hospital
Dr Izak Maree, Medical Superintendent, Charters Towers Hospital
Mr Peter Sladden, District Manager, Charters Towers Health Services District
Dr Derek Manderson, Principal House Officer, Charters Towers Hospital

1.4 Investigation Terms of Reference

The Manager, Northern Zone Queensland Health, Mr Terry Mehan commissioned the Investigation Officers, Dr Andrew Johnson and Dr David Farlow, and provided terms of reference (Appendix 3) on 20 December 2000

2 PROCESS OF INVESTIGATION AND EVIDENCE

2.1 Key Dates

20 December 2000

Investigation Officers Appointed

20 – 22 December 2000
collecting evidence and interviewing witnesses in Charters Towers

28 - 30 December 2000
collection of evidence in Townsville

4 – 5 January 2001
interviewing witnesses in Townsville

8 - 12 January 2001
collection of evidence in Townsville

15 – 19 January 2001
interviewing witnesses and collection of evidence in Charters Towers

22 January – 9 February 2001
drafting report for Decision Maker

2.2 Summary of Allegations / Alleged Incidents

The allegations listed by Dr Row in his original letter to Mr Peter Sladden were examined in depth and broken into eleven (11) key issues, these were clarified with Dr Row at his first interview. They were defined as follows:

2.2.1 Dr Marec is unwilling to assume clinical duties.

2.2.2 Dr Maree misdiagnosed a patient with a perforated gut, which may have contributed to the death of a patient.

2.2.3 Dr Maree did not handle a difference of clinical opinion appropriately.

2.2.4 Dr Maree failed to demonstrate appropriate concern over the death of a patient.

2.2.5 Dr Maree mismanaged a patient with a perforated eardrum and acted dishonestly with the patient's family.

2.2.6 Dr Maree commenced patients on anti-tuberculosis treatment against Queensland Health policy and specialist advice.

2.2.7 Dr Maree has an unacceptable level of skills in interpreting Chest X-rays and ECGs.

2.2.8 Dr Maree demonstrates a lack of commitment to clinical duties, including after hours.

2.2.9 Dr Maree is not entitled to the clinical privileges that have been granted to him.

2.2.10 Dr Maree misled the interview panel during his selection process.

2.2.11 Dr Maree may have acted incompetently in a fatal event in operating theatres on 17 December 2000.

2.3 People Interviewed

Witnesses were interviewed and provided input into allegations as indicated in the table below. The level of evidence provided by witnesses was weighed on three levels and scored as such in the table:

1. Soft. Usually hearsay or indirect evidence
2. Medium. Usually direct observation of behaviours of other parties to an issue.
3. Hard. Direct involvement or observation of an issue.

Witnesses		Role	Issue 1	Issue 2	Issue 3	Issue 4	Issue 5	Issue 6	Issue 7	Issue 8	Issue 9	Issue 10	Issue 11
1	Dr David Row	SMO	3	3	3	3	3	3	1	1	3	1	1
2	Ms Elspeth MacDonald	RN 4	3			1		1		3			2
3	Ms Rosalie Willshire	RN1 ward	2	1									
4	Ms Ann Nielson	RN1 Ward	3		3	3				3			
5	Dr Derek Manderson	PHO	3	3	3	3	3	3	3		3		3
6	Dr Bashir Ahmed	SMO	3	3	3	3	3	3	3		3	3	
7	Dr Rob Norton	S/S Micro-biology						3					
8	Pr Michael Humphries	Prof Obstetrics									3		

	Witnesses	Role	Issue 1	Issue 2	Issue 3	Issue 4	Issue 5	Issue 6	Issue 7	Issue 8	Issue 9	Issue 10	Issue 11
9	Dr Vic Callanan	S/S Anaes									3		3
10	Dr Scott Simpson	S/S Anaes									3		3
11	Dr Yayah Kiwan	VMO Cardiology							3				
12	Dr Sarah Kirkham	PHO	3										
13	Dr Peter Keary	VMO physician						3			3		
14	Dr Guan Koh	S/S Neonatal						3			3		
15	Mr Peter Sladden	District Manager	3								3	3	2
16	Ms Andrea Wade	RN1 ward							3		3		3
17	Mr Peter Kelly	RN1 ward											3
	Ms Criena Preston	RN2 OT									3		
19	Dr John Lingard	Dental											3
20	Ms Carmel Davoren	SW	3										2
21	Ms Irene Luxmoore	RN5	3										
22	Ms Kay Lowe	RN1 Cardiac							3				
23	Ms Christine Butler	RN2 Maternity									3		
24	Ms Alicia Horrocks	RN2 ED	3						3				
25	Ms Bev Guy	RN1 Diabetes									3		
26	Ms Kathleen Chandler	EN											3
27	Ms Win Edwards	RN1 Pharmacy	3										
28	P81	Patient Parent					3						
	Dr Bruce Cameron	VMO expert									3		
30	Dr Lloyd Green	Reference									3	3	
31	Dr Johan Wolfhaad	Referee									3	3	
32	Ms Judy Eddison	RN1 Ward							3				
33	Dr Michael Stander	Referee									3	3	
34	Dr Andrew Swanston	S/S ENT Surgeon					3						
35	Dr Niall Small	S/S ED Physician									3		
36	Dr Grant McBride	S/S Pathology									3		
37	Dr Izak Maree	Med Super CTH	3	3	3	3	3	3	3	3	3	3	3

2.4 Techniques Used During Investigation

Interviews with witnesses were tape-recorded. Both interviewers took handwritten notes during the course of the interview, which were then compared, and a record of interview was generated immediately on completion of the interview. Both interviewers and the interviewee then checked this record. Where the interviewee was satisfied that the record of interview was a true and accurate record of their interview, they signed and returned the original which was then stored on the "parent file". Where the interviewee made minor changes to the record, these changes were incorporated into the electronic record, and the original corrected and signed paper copy was placed on the parent file, together with the corrected version.

Interviews tended to be free flowing, witnesses being given the terms of reference for the investigation, and being encouraged to provide narrative accounts of their perceptions with respect to the allegations made by Dr Row, where they had direct personal knowledge. Where issues in dispute were identified, clarification from the witness was sought and specific questions were asked. Where the investigation officers identified that a witness potentially had relevant information, direct questions were asked of the witness.

All information considered to the investigation officers to be credible, relevant and significant to the complaints under investigation was provided to Dr Maree either during the course of the investigation; or during interview with Dr Maree. Where specific issues arose regarding the treatment of patients under Dr Maree's care, Dr Maree was provided with access to the medical records in order to refresh his memory of the cases.

Dr Maree was strongly advised to consider obtaining legal advice before speaking with the investigation officers.

3 OUTCOME REQUESTED BY AGGRIEVED

Dr Row indicated in his letter of complaint that he sought to identify an approach to allow Dr Maree to improve his level of clinical skills.

4 FINDINGS AND REASONS

4.1 Standard of Proof Applied

The Terms of Reference specified that the standard of proof required was "on the balance of probabilities".

4.2 Relevant Policy and / or Legislative Provisions

In considering the information available to the investigation officers consideration has been given to the relevant sections of the Queensland Health Code of Conduct, the Health Practitioners Professional Standards Act 1999 and the Medical Act 1939.

4.3 Allegations

4.3.1 Allegation 1
Dr Maree is Unwilling to Assume Clinical Duties

Findings

Dr Maree's primary role is the provision of medical services to the district of Charter's Towers. On his arrival he identified there was a significant backlog of administrative duties and there was an "extra" doctor at the Charters Towers Hospital; this enabled him to focus on non-clinical duties without detracting from the provision of clinical services. There is insufficient evidence to suggest that Dr Maree is unwilling to assume clinical duties.

Reasons for Findings

Dr Row (Witness 1) was concerned that Dr Maree was not assisting the other doctors in managing the clinical workload. Dr Row indicates that he understood that at the time of Dr Maree's arrival in Charters Towers Hospital, there was an extra doctor and Dr Maree would initially focus on administrative duties. Dr Row further accepted there was a significant backlog of administrative duties due to hospital accreditation and the significant delay in appointing a Medical Superintendent.

Dr Row states that he assumed this focus would change when the number of doctors reverted back to normal establishment. Dr Row had leave from Charter's Towers Hospital and during this time expected Dr Maree to increase his clinical load. On returning from leave Dr Row indicated that it was his understanding that this did not occur.

Dr Ahmed, Senior Medical Officer (SMO) at Charter's Towers Hospital, indicated (Witness 6)

"That he was never concerned about Dr Maree's availability and that he had no need to contact him for clinical matters. He was unaware of any problems with accessing Dr Maree."

Mr Peter Sladden (Witness 15) [District Manager, Charter's Towers] also indicated:

"That he had concerns expressed to him by Dr Row on or around the 30 October, 2000 regarding the clinical load that Dr Maree was undertaking. Mr Sladden stated that Dr Row had indicated that Dr Maree was failing to provide support to the SMO and PHO particularly on a Friday when there was only one doctor performing the outpatient role. Mr Sladden had indicated that he had raised these issues with Dr Maree on the 29th November, 2000 during his performance appraisal and had reinforced with Dr Maree that his primary role was one that provided clinical services."

Mr Sladden indicated that in his perception, the Medical Superintendent's clinical role was more of a "sweeper" position that responded to the clinical demand according to the number of doctors available and the patient demand. Mr Sladden indicated that Dr Maree appeared to respond appropriately to this guidance.

Dr Maree has indicated in his written response to allegations (Appendix 4) that:

"I feel it relevant to bring to the enquiring officers' attention the ***administrative backlog*** *that existed upon my arrival at Charters Towers Hospital. It also was imperative that a large amount of issues be addressed as soon as possible as the District has applied for* ***accreditation,*** *which will take place during March of 2001. I shall shortly supply a summary of issues that needed to be addressed urgently, as the Acting Medical Superintendent prior to my arrival (Dr Row), did not address it. As this was a period in which 4 doctors instead of the usual 3 staffed the hospital I saw it fit to speedily address administrative matters before we return to the usual complement of 3 doctors, on 03/11/00.*

Firstly: ***No performance appraisals*** *had been performed on any staff member falling under the supervision of the Medical Superintendent for at least the past five years. The fact can be verified with Mr James Healy, the Human Resources Manager. This process is crucial before accreditation can be achieved and I still feel the accreditation officers will be surprised to learn that no such procedures were done prior to my arrival. The process took at least 4 weeks of my time given about 2 hours daily spent on staff interviews. All performance appraisals are now up to date and ready for the accreditation process.*

A ***Business Plan*** *had to be drawn up by the Medical Superintendent, which includes all departments under his control The due date was 01/06/00. On my arrival this was more than 3 months overdue, as the Acting Medical Superintendent has not given any attention to it. I had to draw up not only the business plan of my own Department but also assist in the drawing up of the plans for Allied Health, Pharmacy, Radiology and Dental Departments. I am happy to report that the business plans have been completed prior to 03/11/00, discussed with the District Manager and implemented. Needless to say, the process took a huge amount of time and effort. The business plan includes the drawing up of a* ***working roster.*** *The business plan was forwarded to Dr Row for his comments and input. He did not give any input; nor did he mention any existing working arrangements.*

A ***Medical Records Integration project*** *is underway to integrate medical records of the facilities of Queensland Health in Charters Towers, thereby enhancing service delivery and saving a huge amount of time for all clinical staff, as entries in files will no longer need to be duplicated into more than one file. The process started before my arrival, but no chairman of the committee existed and the members felt unsure as to what was expected. I was offered chairmanship of the committee (by the committee members) and am happy to report that integration of files on the Hospital Campus is very near completion, resulting in a huge productivity increase.*

The ***Radiology Department*** *used a different numbering system from the UR System employed in the rest of the facility. As it was a manual system it meant that a few minutes had to be spent upon every request for an X-Ray before retrieval was possible. With the help of the Radiology Department this system was changed to a computerised system employing the UR Numbering system. This process is complete and results in an enhanced service delivery and increased productivity. It took planning, though and that took time.*

Prior to my arrival the ***Allied Health Department*** *was so unhappy with the lack of input they received from the Acting Medical Superintendent (Dr Row) that they considered requesting another supervisor. Ms Carmel Davoren was the Allied Health Team leader at the time, and can be questioned about this fact."*

It would appear from the depth of support outlined to the investigation officers (Appendix 5) from witnesses, that Dr Maree's attention to the administrative and management side of his duties, was appreciated by many of his subordinates.

There has clearly been a perception amongst many staff that Dr Maree favoured the administrative side of his duties over the clinical, this is characterised by the Director of Nursing Ms Irene Luxmoore (Witness 21)

"Dr Maree was "very good at calling meetings". Mrs Luxmoore indicated that Dr Maree had called significantly more meetings than were required to get things done."

Despite this perception, there is clear evidence that Dr Maree applied himself willingly and with some dedication and skill to administrative areas of his work, as he saw that this was a significant priority for service provision. There is insufficient evidence to suggest that he was unwilling to attend to clinical duties in general.

4.3.2 Allegation 2

Dr Maree misdiagnosed a patient with a perforated gut, which may have contributed to the death of a patient.

Findings

There is insufficient evidence to establish that Dr Maree missed clinical signs that would have led to the earlier diagnosis of this patient's condition. The nature of the disease process is such that a sudden deterioration may have occurred after Dr Maree's assessment of the patient.

Reasons for Findings

P67 precented to Charters Towers Hospital within hours of his earlier discharge. His previous admission had been for the care of muskulo-skeletal injury, during which he had received non-steroidal anti-inflammatory medication. Upon re-presentation, he complained of abdominal pain, which is a known side effect of such medication. Dr Derek Manderson admitted him with a provisional diagnosis of gastritis. He was commenced on appropriate therapy for this condition and was reviewed by Dr Maree and Dr Manderson on a ward round some hours later. Dr Maree examined the patient and observes as follows in his written statement:

*"The **nursing notes** that follow are very important to show that the patient responded well to treatment, slept well overnight and was in a much better clinical condition the following morning on ward round (28/09/00) when Dr Manderson, Dr Ahmed and myself saw the patient.*
These nursing notes read as follow:

19.15 P67 s settled down to sleep. Pain responding very well to pain relief.
21.23 Oxygen saturation 91%-94% on Room Air. Feels much better.
06.0 Slept well most of the night. Given Mylanta for his reflux.

It is clear from these entries that when the three doctors saw the patient on the morning of 28/09/00 at approximately 08.30, he was very far from the "perilous state" Dr Row claims he was in when I examined him. The patient also had 400ml of tea at 10.00 on 28/09/00, without any vomiting resulting. Bowel obstruction at this stage is thus highly unlikely.

I also include his observations for the 14 hours prior to my assessment of the patient, again confirming that the patient was not in a "perilous state" at the time of my examination: 27/09/00: 18:00 BP 150/80

21:00 BP 150/90
28/09/00: 05:00 BP 120/70
09:00 BP 110/70

I remember examining the patient on 28/09/00 at about 08.30, as we start ward rounds at 08.00. As already stated, Dr Manderson and Dr Ahmed accompanied me. I remember examining the abdomen and my findings were consistent of those of Dr Manderson the previous evening, being diffuse tenderness but definitely no Rebound Tenderness. Dr Bashir Ahmed also examined the patient during this ward round and his findings were consistent with my own. Seeing that the pain had responded so well overnight to treatment, we decided to add Lactulose for constipation and Aspirin 150mg daily to lower the risk of DVT whilst he was not fully mobilized.

Now more than 2 hours elapse before a nursing staff member makes the next entry at 11.05.
The entry notes:

" Pain ++ mostly below his rib. Pale, sweating, short of breath. Given Morphine 7,5 mg IM and took effect slowly. ECG shows ST depression in the chest leads. Doesn't feel like Angina pain, he says".

An assessment of the patient is again made at 11.45 on 28/09/00, by Dr Manderson. I find no entry in the file made by Dr Row indicating that he assessed the patient at any stage on 28/09/00 Dr Row's very important finding of a "rigid abdomen" (his own words) are not documented anywhere. The assessment by Dr Manderson at this time states "tender, distended abdomen with guarding" (although the handwriting is difficult to read.) An abdominal X-Ray was ordered by Dr Manderson, the patient to be kept nil by mouth and IV fluids to be commenced. The decision to transfer the patient was made at a later stage, although it is unclear who made this decision.

To return to the allegation: it is stated that the life could have been saved if I started effective fluid resuscitation. At the stage when I saw the patient at 08.30 on 28/09/00 there was no need for fluid resuscitation as evidenced by a normal Blood pressure, a patient that responded well to treatment overnight and no rebound tenderness. It cannot be expected that fluid resuscitation must be started when presented with such a clinical picture on a routine ward round. It would imply that most patients seen on ward rounds would be started on fluid resuscitation!

No other evidence obtained contradicts Dr Maree's assertion that the patient suffered some form of acute event subsequent to the ward round at which the patient was examined by Dr Maree which led to his death. There can be no conclusion that Dr Maree misdiagnosed the perforated viscus in this context.

4.3.3 Allegation 3

Dr Maree did not handle a difference of clinical opinion appropriately.

Findings

Dr Maree ordered the removal of a nasogastric tube from a patient after it had been ordered or inserted by Dr David Row the preceding day. Dr Maree did not seek to

establish from Dr Row the reasons for his having established the nasogastric feeding prior to ordering the removal of the tube. This would appear to represent a lack of professional courtesy.

Reasons for Findings

Dr Row, in his interview (Witness 1) stated that:

"This difference of opinion resulted from assessment of a patient by the name of P68 *D.O.B. 24th September, 1963. He stated that* P68 *had been admitted to hospital recently with a urinary tract infection and subsequently a respiratory tract infection and had an episode of unexplained vomiting. Dr Row stated that* P68 *has Systemic Lupus Erythematosis. He stated she had a low body weight (approximately 42.6 kilograms) and had recently been losing weight. There had been some discussion with the nursing staff regarding the appropriate treatment for* P68 *and that Dr Row had believed that she should be receiving nasogastric feeding to try and effect some weight gain.*

Dr Maree comments in his written statement as follows:

"Dr Manderson, Dr Ahmed and myself conducted a ward round on 02/11/00.
The entry made during the round reads:
" Feeling much better; No vomiting; Afebrile; Pulse is regular; Looks better;"
The treatment plan was as follows:
1. Discuss the case with the medical Doctors at Townsville General Hospital.
2. Remove the NG Tube.
The entry is in the handwriting of Dr Manderson. The observations show she was ***afebrile*** *from 21.00 on 01/11/00 until the time of discharge on 06/11/00. The patient was on an* ***intravenous infusion*** *of fluids at this stage.*

Directly following this entry an entry is made by Dr Row: ***"Continue NG tube feeds"*** *as well as a single illegible entry.*

Dr Row states in his interview with the investigating officers that the patient was on Nasogastric feeding ***to effect weight gain*** *and that this was discussed with the nursing staff (at which stage, is unclear). No entry as to this being the reason for the nasogastric feeds can be found in the file. It is thus fair to assume that the three doctors attending to the patient on 02/11/00 were unaware that the nasogastric feedings were administered to effect weight gain. As the patient* ***vomited the day before*** *and could not keep food down the reasonable assumption when confronted with the case would be that she was on nasogastric feeds* ***due to her vomiting.***

The question that needs answering is: was it a fair decision by the three doctors attending the patient on 02/11/00 to remove the nasogastric tube? The facts indicate the ***observations were all normal*** *the patient* ***felt much better*** *and there was* ***NO vomiting.*** *Presented with these facts I think the decision to remove the NG Tube was fair, especially seen in the light of the fact that the patient also had an* ***IV infusion running*** *and was receiving fluids, and taking in consideration the absence of knowledge as to the reason for the NG feeds. If it would be assumed that when presented with this clinical picture a patient should receive nasogastric feeds, it would mean that most patients seen on routine ward round will qualify for NG feeds.*

The use of NG Feed to effect weight gain is unknown to me in a patient that can tolerate food, does not vomit and has no gastrointestinal contraindication to oral feeds. The patient had no swallowing disorder either.

Shortly after giving an order to remove the NG tube an order was then given by Dr Row to reinsert the NG tube. Presumably he visited the patient later the same morning after the ward round of the three doctors mentioned. The reason for his visit is unclear, as the patient had already been seen and assessed by three doctors.

Inserting and removing a NG tube is traumatic to any patient. I can only guess at the confusion in the patient's mind about her treatment plan when a group of doctors visit her, makes a decision and then shortly afterwards another doctor overrides this decision.

Dr Manderson observed that the nasogastric tube had been removed on the instruction of Dr Maree in his interview (Witness 5):

"Dr Manderson recalled the case of P68 and states that he felt he was "in the middle" of this situation. Dr Manderson states that he has no idea what went on between Dr Row and Dr Maree however recalls having been involved in a ward round with Dr Maree and Dr Ahmed. He states that the staff were not 100% sure "why the nasogastric tube had been put in P68 " and he states that Dr Maree had ordered the nasogastric tube be removed."

Dr Ahmed indicated in his statement that

"He remembered the case well and remembered his concern that she required nasogastric feeding which was the principle issue of concern for her at the time. He could not recall any specific discussions around the insertion or removal of the nasogastric feeding tube."

It would appear that on the balance of probabilities, Dr Row had requested the insertion of the nasogastric tube to effect nasogastric feeding of the patient, and that Dr Maree subsequently ordered the removal of the tube without consulting Dr Row.

4.3.4 Allegation 4

Dr Maree failed to demonstrate appropriate concern over the death of a patient.

Findings

There was insufficient evidence to find that Dr Maree did not have appropriate concern over the death of a patient.

Reasons for Findings

Dr Row based his claim on an interaction with Dr Maree following the death of P67 ; the case referred to in Allegation 2. In his interview (Witness 1), Dr Row is recorded as follows:

"Dr Row indicated that he believed that Dr Maree had demonstrated a lack of empathy over the loss of life in the case of P67. Dr Row stated that he had a "corridor discussion" with Dr Maree after he heard of the patient's outcome in Townsville. Dr Row states that Dr Maree said to him "that he was dead anyway".

Dr Row states that these words implied to him that Dr Maree did not care about the patient."

Dr Manderson did not observe the particular interaction however noted in his interview (Witness 5):

"That he was not surprised by this issue, he stated that Dr Maree can appear to be resistant to suggestion and implied that he may not welcome criticism. Dr Manderson indicated that he had experienced some situations where Dr Maree appeared to be reluctant to transfer patients at a point that Dr Manderson was normally comfortable with."

Dr Ahmed also did not recall any specific issues surrounding P67, death, however stated that:

"It was difficult to sit together and discuss important things with Dr Maree. He stated that it appeared that Dr Maree was "not very keen on clinical work" and that he appeared to focus specifically on management issues."

Ms Elspeth MacDonald, Deputy Director of Nursing identified that she believed that:

"There may be a cultural issue with how he addresses people. Ms Macdonald identified an issue with a midwifery patient who had a significant weight problem. Ms Macdonald identified that this patient had been attending on a regular basis for some weeks, as she was now overdue in her pregnancy. She identified that Dr Maree told the patient "you should loose weight". Ms Macdonald was concerned that this was advised to the patient at a very late stage of her pregnancy when she had no capacity to lose weight.

Dr Maree identified that with this particular patient he felt that his English language skills may have let him down, and that he had not intended offence to the patient (Witness 37)

Ms Ann Nielson, Registered Nurse, is recorded in her interview (Witness 4) as follows:

"Ms Nielson noted that Dr Maree could be somewhat flippant on Ward rounds and identified a particular case with P69 who had been a long term patient at Charters Towers Hospital, having been transferred from Townsville General Hospital sometime in July. She stated that he was a Nursing Home Type Patient and that Dr Maree had demonstrated an attitude towards him that made her feel uneasy. Ms Nielson stated that within earshot of the patient Dr Maree would make comments or demonstrate an attitude that appeared to be inappropriate and unprofessional. She stated that it appeared that he was saying such things in order to curry favour with the Nursing staff on the Ward".

These issues give rise to the perception from the investigation officers that Dr Maree's communication may convey unintended messages as a result of his need to translate his thoughts from Afrikaans to words in English (Witness 37).

4.3.5 Allegation 5

Dr Maree mismanaged a patient with a perforated eardrum and acted dishonestly with the patient's family.

Findings

Dr Maree performed a procedure on a young patient with a foreign body in his ear. His records of the case were entirely inadequate and his arrangements for follow up care were inadequate. There is good evidence that he provided inaccurate and inappropriate advice to the parents of the child and strong suggestion that he was dishonest in his recollection of events

Reasons for Findings

The patient in question was P81 D.O.B. 30th July, 1996. Dr Row stated in his interview (Witness 1) that

" P81 had been admitted on the 16th October and had been discharged the same day. P81 had had a beetle in his ear, which had been removed under general anaesthetic. Dr Row observed that the operative notes had been recorded in the outpatient file in the medical record and stated as follows:

'Theatre (Maree/Ahmed) insect removed from right ear. Wash out with normal saline.'

Dr Row indicated that he would normally expect some comment in the medical records about the state of the ear canal including damage occasioned by the insect such as scratches inside the ear canal or damage to the tympanic membrane. Further he would expect some provision of post-operative orders such as "nil by mouth" or "routine observations".
Dr Row stated that he saw the patient subsequently on the 30th October 2000 at which time the patient's mother advised him in Dr Row's words "the patient was not given an appointment for review". Dr Row questioned the appropriateness of this as he identified that if no damage had been done he would have indicated to the family to come back if any problems had occurred. On examination Dr Row states that he found a wet perforation of the right tympanic membrane and noted that this had been treated by a General Practitioner, the patient had been given antibiotics and ear drops. Dr Row's notes indicated that there was a perforation of the tympanic membrane and that the patient should be treated with Sofradex for one month with a possibility of an Ear, Nose and Throat consultation. The mother stated that she had previously been unaware of the perforation of the tympanic membrane. Dr Row indicated that there was nothing in the medical record to indicate a perforation had occurred, in the initial consultation. There was no identification of the potential cause for perforation such as an operative cause whether the insect had caused the perforation, or whether a subsequent infection had caused the perforation.

When this issue was addressed with Dr Maree, Dr Row states that Dr Maree advised that he had noted the perforation in the operating theatre and that he had discussed this with the father at that time.
There is no record of either the perforation or the discussion with the father. Dr Row indicates that he believes that this perforation should have been recorded in the operative notes and that follow up arrangements should have been made. Dr Row indicated that his normal expectation for follow up

would have been to consider sending the patient to an Ear, Nose and Throat Surgeon or at the least reviewing the patient in one weeks time.

Dr Manderson indicated (Witness 5) that he had not been involved in the P&I case, however:

"Indicated that he had been involved in a quality project in the hospital performing chart reviews. Dr Manderson indicated that he selected a random number of records and reviewed them to identify the quality of the records. Dr Manderson stated that it was his observation that "Dr Maree does not seem to write many notes", however that "usually his notes were sufficient". Dr Manderson observed that Dr Row's notes are often difficult to interpret and may be deficient in documenting a plan or reason for admission.

Dr Manderson indicated that Dr Maree's lack of documentation should have caused some alarm bells in retrospect."

Dr Bashir Ahmed was the anaesthetist for the case and is recorded at interview (Witness 6) as follows:

Dr Ahmed stated that he gave the anaesthetic for P&I who had an insect in his ear. Dr Ahmed recalled the case and stated that Dr Maree had performed an ear wash-out with a syringe. Dr Ahmed stated that he did not recall any discussion about a perforated ear drum either during the procedure or after with the patients family and stated that he could not recall Dr Maree having made any comment about having observed perforation at the time of the procedure.

Dr Maree in his written statement (Appendix 4) directly contradicts Dr Row in several aspects:

*"After induction of the anaesthetic by Dr Ahmed I proceeded to remove the insect from the ear. **Even before I started the procedure I noted blood in the ear canal.** The blood in the ear canal is documented to have been present even when the patient presented to the Hospital the night before. The insect was removed and the ear washed with Saline. As there was still blood in the ear canal I could not comment on the **condition of the tympanic membrane.** That is the reason why I did not mention the condition of the tympanic membrane in my notes; simply because I could not state with absolute certainty whether the membrane was intact or not. In retrospect I agree that I should have noted in the operative notes that there was blood in the ear canal. I also verbally commented during the procedure that it was possible that the tympanic membrane might be ruptured, but **I could not visually confirm this.** As mentioned before the membrane might have been ruptured even before the patient was taken to theatre.*

*I then left the theatre and **have not seen the patient or the family since.** I did not discuss the condition or any possible complications with the parents. As I was requested by Dr Row to remove the insect from the ear in a patient that had been admitted and treated by him, I assumed that he would again see the patient on his (the patient's) arrival in the ward. From the patient's notes it is clear that **he was not seen by any doctor** prior to discharge and that indeed he was given no follow up appointment or medication to take home.*

*A very important point is that the nursing staff **did NOT contact any doctor (either Dr Row or myself)** prior to the patient leaving the hospital. It is clear that the patient was discharged without a doctor being aware of the discharge. When hearing nothing further from the ward I assumed that Dr*

Row had seen the patient after the patient left theatre. It is possible that Dr Row assumed that I have done the discharge planning and follow-up. Therefore he did not see the patient either, after the patient left theatre. I believe poor communication led to this unfortunate incident and it again highlights the fact that a patient should be ***assigned to specific doctor*** *who takes responsibility for the care of the patient and who can see cases through from initial presentation to discharge.*

The second part of the allegation centres on ***honesty with patient's family.*** *I believe I have not been dishonest with the patient's family, as I have never spoken to the family or father. Dr Row states that I have told him I had spoken to the father. I can remember speaking to Dr Row about the case and I can remember he mentioned to me that when he saw the patient on 30/10/00 the eardrum was perforated. I can also remember that I did say the eardrum might have been ruptured in theatre. I cannot recall the remainder of the conversation with Dr Row, but as I had not seen the parents, I would not have told him that I had discussed the case with the father. As previously mentioned I find* ***communication*** *with Dr Row very difficult and this could be another example of us misunderstanding one another.*

In conclusion: it cannot be ascertained at which stage the membrane was perforated. It could have happened at any stage ***prior*** *to the theatre procedure,* ***during*** *the theatre procedure, or* ***after*** *the theatre procedure, but prior to the consultation with Dr Row on 30/10/00, and finally: a communication breakdown was present between Dr Row and myself.*

With respect to the procedure performed by Dr Maree, the investigation officers sought advice from Dr Andrew Swanston (Appendix 6), ENT Surgeon at Townsville General Hospital who states:

"As a clinical rule, if there is any suspicion of perforation of the tympanic membrane, syringing should be avoided.

On the question of blood in the external ear canal, this is often associated with a hard foreign body and initial attempts by the patient, parent or carer, to remove the object – producing a minor laceration of the canal skin; under these circumstances, where there is no other indication suggesting a perforation, syringing may be a convenient method of removing a Foreign Body, but I would prescribe a local antibiotic ear drop for a short course post-operatively to avert the possibility of local infection.

In the current case it is my opinion that in the absence of any history of drum perforation, in a one off presentation of Foreign Body in the canal, and if the object could be visualised, then syringing could be used in the absence of more sophisticated means of extraction. Post operative cover should be exhibited and the patient reviewed until the canal and ear drum attained normality."

P 81 were interviewed (Witness 28) and directly contradicted Dr Maree's assertion that he had not spoken with them after the case:

"Following the operative procedure Douglas took some time to wake up and Dr Maree was reported to have come out to speak with P 81 *r. He showed them the insect that had been removed and placed it into a container for them to take away and stated "everything went alright". He stated further that "they got as much out as they could" and he "did the best he could".*

:r indicates that she asked if he required any follow-up and she states that Dr Maree advised "no, he will be alright". P81 :r states she asked if there would be any permanent ear damage and she advised that Dr Maree responded "no he should be ok"."

This account from the P81 family was very clear and completely in accordance with the statement made by Dr Row. Dr Maree was afforded the opportunity to respond and indicated (Witness 37) that he had no recollection of speaking with the family. Dr Maree conceded that it was his responsibility as the surgeon providing care to speak with the family and that it was also his responsibility to organise for follow –up care for the patient. He acknowledged that he had failed to make appropriate follow – up arrangements for the patient, that he had failed to take adequate operative notes, and failed to provide appropriate advice to the family.

Dr Maree inappropriately attempts to deflect his responsibility for these issues in his written statement (Appendix 4), as quoted above, by referring to a system of rostering staff so that one doctor will provide care from initial assessment to discharge. This appears to be a consistent theme in Dr Maree's defence.

At best, Dr Maree's lack of recall of his discussions with the family is very surprising. At worst, Dr Maree may have acted dishonestly in recalling the events surrounding this case.

4.3.6 Allegation 6

Dr Maree commenced patients on anti-tuberculosis treatment against Queensland Health policy and specialist advice.

Findings

Dr Maree did commence anti-tuberculosis therapy on a patient against Queensland Health policy and against the direct advice of one specialist and at least the strong suggestion of another. However, he was faced with a patient he believed to be dying and he believed that commencement of the therapy might save her life. The patient survived.

On a second occasion Dr Maree prescribed therapy usually reserved for the treatment of tuberculosis, without good evidence of tuberculosis. The treatment was inappropriate.

Reasons for Findings

Dr Row raised two cases of concern in his interviews (Witness 1)

Case One, P82

"The first case of concern was a patient by the name of P82 D.O.B. 25th June, 1982.

P82 was noted to be an eighteen-year-old with Systemic Lupus Erythematosis is who had a number of complications with opportunistic infections including melioidosis and cryptococcal

meningitis. Dr Row indicated that she had had a pericardial effusion but no documented tuberculosis.

P82 had been admitted to Charters Towers Hospital on 13 September 2000, and discharged on 21 September 2000. She had been admitted by Dr Izak Maree with Afebrile Tachycardia, Peripheral Oedema, Muffled Heart sounds, and a known Pulmonary Effusion. She had been admitted managed with Oxygen Therapy, Antibiotics, Lasix and an examination had been ordered of her blood. She was also commenced on Isoniazid and Rifampicin on the same day. Dr Row's review of the Medical Records demonstrates a note from Dr Maree on 14 September 2000, indicating that Dr Maree had spoken with Dr Robert Norton, Microbiologist, Townsville General Hospital. Dr Norton noted the patient had been discharged of her own accord from Townsville General Hospital and that there was no intent for the patient to return. Dr Maree's notes also indicate that he discussed the case with Dr Peter Keary, Physician Rheumatologist, at Townsville General Hospital. The notes indicate that Dr Keary did not believe that the case was Tuberculosis, and the patient should be given E.P.O. 4000 units twice weekly, and should be given Prednisone 1gram orally on three (3) occasions.

Dr Row indicated that on the subsequent Ward round he expressed his concern that the medication should be discontinued as there was no evidence of Tuberculosis, and that such treatment was against Queensland Health Policy. Dr Row admits that at the time he thought that Dr Maree's experience in South Africa might have given him a better exposure to Tuberculosis. Whilst he states that he felt uncomfortable with going against a Specialist's advice, he states that he was moderately supportive of the decision to proceed with Anti Tuberculosis treatment. This being on the basis of his perception that Dr Maree had had extensive experience with Tuberculosis in South Africa.

The policy referred to in Dr Row's interview is outlined in a Memorandum from Dr John Youngman, General Manager Health Services Queensland Health, dated 26 July 1997 (Appendix 7)

Dr Manderson was also present on the ward rounds for P82 and is recorded in his interview (Witness 5) as follows:

Dr Manderson was well aware of the issues for P82 , a patient who had presented with a pulmonary effusion. Dr Manderson stated that on the whole he thought it (DR Maree's treatment) was "a good call". Dr Manderson stated that Dr Maree observed "haven't they aspirated the pericardium" "in South Africa that's want we would do". Dr Manderson stated that Dr Maree had observed that "fibrin strands plus an effusion equalled tuberculosis". He stated that Dr Maree had commenced anti-tuberculosis treatment and the patient had appeared to improve.

Dr Manderson indicated that he was aware Dr Keary, specialist physician at Townsville General Hospital was not happy with this treatment. However, he stated that he believed that Dr Maree was unaware about the TB protocols and was aware that having commenced the treatment it was now a clinical problem to cease the treatment. Dr Manderson stated that it was his understanding that "this woman is crook and will die" and consequently indicated that it was his belief that the appropriate management had been undertaken.

Dr Bashir Ahmed had previously worked in South Africa and was specifically asked about practice in that country with respect to tuberculosis therapy (Witness 6).

"Dr Ahmed indicated that he was unaware of any specific discussions with Dr Row and Dr Ahmed about the use of anti-tuberculosis treatment. He stated that he was aware that tuberculosis was very

common from his experience in South Africa. However, in his experience in South Africa it was not common to commence treatment until a proven diagnosis was established. Dr Ahmed indicated that he was not aware of Queensland Health departmental policy with respect to tuberculosis management, however that it would be his expectation to investigate suspected TB and establish proof of the disease. He advised that he would attempt to identify common problems first and seek specialist advice and follow that specialist advice.

Dr Ahmed was asked specifically about practices for empirical treatment in South Africa and he advised that the approach was always to see direct evidence of tuberculosis prior to commencing treatment and if no direct evidence could be established then treatment would only be consider empirically after excluding other diagnoses.

Dr Maree initially contacted Dr Keary, as he had been the physician responsible for the care of P82 prior to her absconding from Townsville General Hospital, He was asked for his recollection of the case (Witness 13).

"He (Dr Keary) recalls that there had been some discussion of tuberculosis with respect to her pericardial effusion however that he considered the effusion to be related to systemic lupus erythematosis and not due to an infective cause."
Dr Keary stated that he regarded that tuberculosis was always a possibility in these cases however with no knowledge of contact with tuberculosis and with the absence of chest x-ray changes he did not believe it was a likely proposition. He stated that being an aboriginal patient and immuno-compromised would increase the possibility of TB.

He further stated that there had been some cases of tuberculosis around Charters Towers, however he believed he would not normally recommend empirical treatment with anti-tuberculosis drugs in this sort of situation. Dr Keary indicated that this patient is quite a difficult patient from a management perspective. Whilst he would normally not recommend treatment for tuberculosis without specific referral to a Tuberculosis or Infectious Diseases Specialist he understood that it was the responsibility of the treating doctor to deal with the patient as they presented to them.

Dr Keary indicated that he would normally expect and would train junior medical staff to seek further investigation prior to commencing anti-tuberculosis treatment, this may include early morning urine samples, chest x-ray and sputum. He stated that whilst it would not be his practice to start empirical treatment he certainly would not recommend it without a very high index of suspicion of tuberculosis being present.

Dr Maree contacted Dr Robert Norton, Clinical Microbiologist at Townsville General Hospital after Dr Keary had advised that he did not believe that P82 had tuberculosis. In his interview (Witness 7), Dr Norton stated that:

" He would not have advised commencement of anti-tuberculosis treatment without stronger evidence of existence of tuberculosis. He stated that it would be highly unusual to have a tuberculous pericarditis in the absence of an abnormal chest x-ray and he believed that as the bare minimum a chest x-ray and sputum culture should have been performed. Dr Norton states that the single most important issue in this case would be to achieve a microbiological diagnosis, this would be preferably by direct aspiration of the pericardial fluid. If the patient had refused to have an aspiration of the pericardial fluid he would have had in preference have waited and watched the progress of the case. Dr Norton outlined that anti-tuberculosis treatment brings with it a number of risks and side effects and significant inconvenience to the patient.

He stated it was his belief that he would require a lot more proof, such as previous evidence of tuberculosis, to suggest that anti-tuberculosis treatment should be commenced. Dr Norton indicated that he had significant experience working with tuberculosis and had been previously employed at a tuberculosis hospital in the United Kingdom. He stated that whilst he was unaware of South African practice he understood that in India and Papua New Guinea where there were limited laboratory facilities empirical treatment was much common as there was a belief that the patients may never been seen again once they left a hospital facility.

Dr Maree's account of his management of P82 is provided in his written statement (Appendix 4)

"I first saw P82 on 13/09/00, which was only two days after my commencement of duties at Charters Towers Hospital. I noted she was febrile, had a tachycardia and had 3+ peripheral oedema. Her temperature was 37,9; pulse rate 101; BP150/80. I also took note of the known ***pericardial effusion and left pleural effusion.*** *The second important point of the diagnosis is now found: An echocardiogram done on 07/09/00 at Townsville General Hospital noted a left sided pleural effusion as well as* ***"fibrinous strands seen in the pericardial fluid space"*** *A pleural effusion raises suspicion of TB but fibrinous strands in a pericardial effusion is very typical of TB. This pericardial condition is noted as the* ***'bread and butter'*** *appearance of TB of the pericardium, and is almost always only present in TB cases. I mentioned this fact to Dr Row on the ward round on 14/09/00, who agreed with my statement. The technical facts just presented can be verified from medical textbooks on the matter.*

Blood results *available to me on 14/09/00 indicate the following:*
Hb 11.2; WCC 5,8 and a significant monocytosis of 1,35 (Normal range of 0,1-1,00).
A monocytosis in the presence of a normal or elevated WCC and a low Hb is further typical of TB. I do agree that the Prednisone the patient was on could contribute to the monocytosis.

Let us briefly look at the ***clinical picture.*** *P82 was short of breath, had severe peripheral oedema and was febrile. TB does present with persistent low-grade fevers, which spike during night-time. This is known as the* ***night sweats*** *of TB and was present in her case. Her temperature chart can be studied to verify this. She was so short of breath that she needed continuous Oxygen and could not even walk to the toilet. The nursing notes of 14/09/00 at 13.30 confirm this and showed that she could not even shower without assistance and needed* ***continuous oxygen.***

On the morning of 14/09/00 doctor Row stated that he feared she would ***pass away*** *very soon. I agreed with him and we discussed the case. Dr Manderson was also present. I pointed out all the above clinical signs to him and he agreed that it was highly likely she suffered from TB. We discussed further tests that should be done to confirm the diagnosis. Tests that could be performed, were* ***Drainage of the pericardial effusion*** *and obtaining an ADA level on the fluid as well as a TB culture. This was not possible as P82 refused to return to Townsville and furthermore a culture result would take 6 weeks to yield TB growth. A* ***lymph node biopsy*** *is a further option to discover disseminated TB. As P82 was in a very serious condition regarding general oedema, such a procedure would not only be technically difficult but she was not a candidate for anaesthesia.* ***Blood cultures*** *could be done to investigate other causes as well as a* ***CRP*** *and ESR. These blood tests were ordered.*

I suggested to Dr Row that we start P82 on a ***2-week trial period of TB drugs*** *and then reassess the situation. He agreed and I can very clearly remember his words: "she is dying and we have*

nothing to lose". I agreed with this statement. As it turns out P82 has recovered and lives a normal life today.

The diagnosis was thus made on the following grounds: .

1. *An immuno-compromised patient on immuno-suppressive drugs.*
2. *Evidence of previous opportunistic infections.*
3. *A pleural effusion present.*
4. *A pericardial effusion with the typical appearance of a tuberculous effusion.*
5. *Blood results that showed a low Hb and a monocytosis.*
6. *A clinical picture of night sweats.*
7. *A patient whose life was in danger and we could not wait 6 weeks for confirmation of results.*

*Before we proceed to describe P82 **response to the treatment and her recovery** I must point to 2 **conversations** I had with specialists regarding her case.*

*Before commencing the trial of TB drugs I consulted with 2 specialists. The first conversation I had was with **Dr Keary**. P82 was under his treatment and absconded from treatment only a few days before 13/09/00 when she presented to Charters Towers. She **refused** to return to his care although he offered to take over her care again. I mentioned the possibility of TB to him, but all he said was that she does not have TB and handed the phone to his registrar. His registrar stated that he was only aware she suffers from SLE and that is what she should be treated for. The conversation ended there and I returned to Dr Row stating that Dr Keary does not think we should treat her for TB. Dr Row said that I should rather discuss the case with **Dr Norton**- a microbiologist at Townsville General. I followed Dr Row's advice and phoned Dr Norton and discussed the case with him. He **agreed** that TB could not be ruled out and that it would not be considered unjustified if we started her on TB drugs. I again returned to Dr Row and told him that Dr Norton was in agreement with starting the TB drugs. I found the situation very uncomfortable as it was only my second day in Charters Towers and Dr Row suggested that I **phone one consultant to override the decision of another."***

Case Two, P83

Dr Row identified at interview (Witness 1), that he had further concerns about a child whom he maintained was commenced on anti-tuberculosis therapy.

"A second issue with Tuberculosis was identified as a baby P83 , D.O.B. 22nd March, 1999. P83 had been born prematurely and had suffered Bronchiolitis infection (with an unidentified pathogen) which had required ventilation and transfer to Townsville sometime in her past. P83 was admitted to the Charters Towers Hospital on the 9th October 2000 with a diagnosis with a "failure to thrive". Dr Row had the opinion that the patient had not been fed properly and had been in the care of an aunt. At eighteen months old he noted that the weight was approximately 6.9 kilograms and he noted that this was below the third centile. Dr Row states that he advised Dr Manderson and Dr Maree on a ward round that the patient was "chesty because of prematurity" and required feeding.

Dr Row observed that Dr Maree stated that "these children have Tuberculosis". Dr Row indicated that there was no further interaction at that point but he stated that they should have a paediatrician review. Dr Row states that Dr Maree commenced treatment with Rifampicin and that he was

unaware of this commencement for some five days. At this point he insisted on stopping the medication and Dr Maree ceased the medication.

Dr Row indicated that at no stage were any pathogens isolated but a subsequent x-ray performed on the sixth of November demonstrated patchy bronchopneumonia. Dr Row stated that blood results during the admission in question were unremarkable.

Dr Row observed that when the treatment was ceased on his insistence that Dr Maree appeared to be somewhat indifferent to this change in treatment."

Dr Manderson had some discussions with Dr Maree about this case, recorded in his interview (Witness 5):

"With respect to P83 *Dr Manderson indicated that he had not been party to any discussions regarding the commencement of Rifampicin treatment but remembers talking with Dr Maree about children with severe malnutrition. Dr Maree had indicated to him that the commencement of anti-tuberculosis treatment he could expect to see the child initially lose weight and then forge ahead. Dr Manderson indicated that this is exactly the course that occurred and that the young patient went home looking much better. Dr Manderson indicated that Family Services had been involved in this case and it had been a difficult environment in which to work. Dr Manderson stated that he believed that there may have been a "different way of doing things" and believed that the treatment approach taken by Dr Maree in this case "what they did in Zambia". Dr Manderson recalls thinking that the treatment involved "was an odd thing to try"."*

Dr Ahmed was asked specifically about patient P83 (Witness 6)

"Dr Ahmed recalled this patient well and identified that he believed the main problem with the child was that she was neglected and malnourished. Dr Ahmed indicated that he believed nutritional care was the most important aspect of this baby's treatment and he did not know when or why anti-tuberculosis therapy was commenced. Dr Ahmed indicated that he believed that there had been no specific diagnosis established and that he would normally expect a specific diagnosis to be established before commencing treatment."

Dr Guan Koh, paediatrician and neonatologist at Kirwan Hospital for Women, was asked to consider the management of P83 ;(Witness 14)

"Dr Koh was provided with the background to the admission of P83 *to Charters Towers Hospital, that being failure to thrive in an aboriginal child. He was advised that empirical treatment with Rifampicin was commenced for suspicion of tuberculosis in this case. Dr Koh advised that this form of treatment was not standard in Australia and not in agreement with Standard Practices. Dr Koh stated that Rifampicin had potential side effects and that it was unacceptable to use this drug in the absence of a clear indication of tuberculosis. Dr Koh stated that to achieve such an indication of tuberculosis that a chest x-ray, early morning urine, gastric aspirate and Mantoux test would be performed and if these tests were negative he would be even more unlikely to recommend a course of treatment of tuberculosis treatment. Dr Koh stated further that in the management of tuberculosis it was important to involve public health officials in order to treat the whole context of the problem rather than simply the patient. He believed that this may involve chemo-prophalaxis of patient contacts."*

Dr Maree has provided his response to these concerns in his written statement (Appendix 4).

"The file in this case is also very bulky and to supply a very lengthy argument about the whole case is, in my opinion not indicated. The question that needs answering is: " did Dr Maree commence TB treatment on this patient, and if so, what were the indications for doing so?"

Now we need to specify what TB treatment consists of. As was illustrated in the case of P82
TB treatment consists of a combination of at least four drugs. The drugs used are INH, Rifampicin, Ethambutol, and Pyrazinamide. These drugs need to be given concurrently and for a period of at least six months. In complicated cases as in Atypical Mycobacterial infection or documented drug resistance the clinician can also add a range of further drugs, including Kanamycin, Klarithromycin or a Quinolone. It is very clear from the file that at no stage was TB treatment, as defined above, prescribed to the child.

The answer to the first part of the question is that I did not commence the child on TB treatment.

The confusion in Dr Row's mind might have arisen from a discussion we had about malnourished children on ward round. I believe this is the conversation he also refers to. During that conversation we discussed malnutrition in general and I did state that children presenting with malnutrition in South Africa often suffers from TB. This fact can be verified statistically.

The confusion in Dr Row's mind might further have been exacerbated by the fact that I have prescribed Rifampicin to this child. Rifampicin is an antibiotic, which has other indications apart from being one of the drugs prescribed as part of a TB treatment regime. The choice of Rifampicin stemmed from the fact that the child presented with a respiratory tract infection in the presence of malnutrition and "failure to thrive". The choice of antibiotic can be debated but this is a good choice from my experience with malnourished children in Africa. I would have considered another choice of antibiotic; for example Amoxicillin or Augmentin had the child not been malnourished.

***In summary:** This is a case of a **malnourished child** that presented with a **chest infection.** A multi-disciplinary approach was followed to address the reason for her malnutrition and an antibiotic was prescribed for her chest infection. No evidence of the existence or treatment of TB can be found from the records.*

In both the cases identified above, there are substantial inconsistencies. In the case of P82 , Dr Maree asks us to believe that Dr Norton implied agreement with anti-tuberculosis treatment by his statement that Dr Norton "agreed that TB could not be excluded". This certainly contrasts with the tone of information supplied by Dr Norton. Nevertheless, Dr Maree does outline a rationale for treatment, which is very thorough in retrospect. However it would appear that this recollection might be somewhat generous, given that his initial comments on the ward round appear to imply that he had already established his treatment plan. It would also appear that the patient has improved, whether through the treatment offered or the natural course of the illness we will never know.

What is reasonable in the practice of a tertiary facility must always be tempered with the realisation that the practitioner in Charters Towers, faced with a patient he believes to be dying, will and should take all steps he believes warranted to save the patient in front of him. It would appear that Dr Maree established a reasonable level of agreement with his local

colleagues before taking this step, and he could not be reasonably expected to be familiar with Queensland Health policy so early in his tenure at Charters Towers.

With respect to P83 Dr Maree asks us to believe that he had not commenced treatment for tuberculosis. Further he suggests that the staff (Dr Manderson, Dr Row, and nursing staff) were mistaken in their interpretation of his intentions. He claims that his use of the antibiotic Rifampicin was indicated because of the child's respiratory infection and malnutrition. At best, this would seem to be an odd choice of antibiotic; at worst Dr Maree has been dishonest in his explanation in an attempt to justify his treatment. Dr Norton advises (Appendix 7) that this medication has a very limited application and does not extend to non-tuberculosis respiratory infections.

4.3.7 Allegation 7

Dr Maree has an unacceptable level of skills in interpreting Chest X-rays and ECGs.

Findings

On at least two occasions, Dr Maree made fundamental serious and persistent errors in diagnosis from ECGs, which could have led to significant adverse patient outcomes.

Reasons for Findings

Dr Row indicated at his interview (Witness 1) that his concerns in this regard related to a single incident on both issues.

"Dr Row stated that on one occasion, Dr Maree, whilst in the Emergency Department had held up a chest x-ray. Dr Row observed that the chest x-ray appeared to him to be normal with some rib cartilage calcification. He states that Dr Maree put the x-ray on the viewing box said "Mets, Mets, Mets, Mets" (indicating metastases) pointing at the rib cartilage calcification. Dr Row states he said, "I don't think so". Dr Row observed that the patient involved had previously suffered from prostrate cancer and that Dr Maree did appear to be serious on this issue. Dr Row believed that this indicated Dr Maree's inability to interpret a chest x-ray.

With respect to E.C.Gs Dr Row indicated that Dr Maree had on one occasion interpreted a ECG demonstrating sinus arrhythmia (with P Waves visible) as being in atrial fibrillation. Dr Row indicated that there was no record of either of these cases and does not recall Dr Maree having missed any serious abnormality on chest x-ray or ECG

Dr Ahmed was unaware of any specific issues with Dr Maree's performance in recognition of x-rays and ECGs and said that he had never been in a position to discuss any specific cases with Dr Maree."

Subsequent to Dr Row's interview, Ms Elspeth MacDonald, Deputy Director of Nursing, advised in her interview (Witness 2), that there had been concerns raised by nursing staff about the care of a patient by the name of P84 On review of the charts, the Investigation Officers were concerned that there was an obvious myocardial infarction at the point of admission of the patient, which appeared not to have been diagnosed appropriately in the initial assessment by Dr Maree.

Further, the management appeared to be inappropriate for the patient. Facts agreed by all witnesses, including Dr Maree are as follows:

- After admission with a diagnosis of unstable angina pectoris, the patient proceeded to develop complications, with a sudden drop in blood pressure.
- Dr Maree had left the campus to attend a meeting at Mossman Hall and nursing staff had some difficulty in contacting him.
- He then gave some telephone orders for treatment but did not ask nursing staff to arrange a medical review.
- Nursing staff were concerned about the patient, so organised for the PHO, Dr Manderson to attend.
- Dr Manderson then contacted Dr Maree (still at Mossman Hall) to share his concerns about the patient.
- Dr Maree gave a telephone order for an adrenaline infusion to be commenced concurrent with the existing nitrate infusion.
- Dr Maree did not seek advice at any stage from any other practitioners in the care of the patient.

Several staff at different levels were asked to review the ECG presented to Dr Maree at admission of the patient and were asked for their thoughts on the management of the case.

Dr Ahmed (Witness 6)

Dr Ahmed ... correctly diagnosed an inferior myocardial infarction.... Dr Ahmed ... identified that he would have had significant concerns when the patient developed severe hypotension. He was concerned that the hypotension may have been due to the extension of the myocardial infarct or from the drugs used. He further stated that he would treat such a drop of blood pressure as an emergency situation.

Dr Kiwan, Townsville based cardiologist (Witness 11):

Dr Kiwan stated that the clear diagnosis of P&Q *at admission was that of an inferior myocardial infarction with severe ischaemia in the anterior chest leads of the ECG. He said that any junior resident or registrar should be able to diagnose this from the ECG and the classical ischaemic chest pain history that the patient provided. Dr Kiwan stated that his management of choice in that situation would be to admit to the coronary care unit with complete bed rest and oxygen and a "good dose" of morphine and thrombolysis. Dr Kiwan stated that the patient should not have been commenced on Tridil initially. In this situation with persistent chest pain over 24 hours and with maximal anti-anginal treatment the patient required urgent transfer for coronary angiography and probable coronary angioplasty or cardiac surgery.*

Dr Kiwan noted that he believed the ECGs performed on this patient were inadequate and that he would have expected at least five to six ECGs over the nine-hour period rather than the two that were taken. Dr Kiwan stated that he had serious concerns about the drop in blood pressure and stated that he would expect a doctor to attend within five minutes in such a situation. He stated further that in such a situation he would cease Tridil infusion and may use Adrenaline for a short period, however would not consider using Tridil and adrenaline together over such a long term as the 24 hours it was continued. Dr Kiwan stated that a telephone order for adrenaline was not appropriate and that the patient should be seen by a doctor prior to commencement of adrenaline therapy.

Dr Kiwan stated that it is his belief that a tertiary centre should have been contacted in the context of the patient's clinical presentation.

Dr Manderson noted (Witness 5) that Dr Maree appeared to be quite capable of interpreting orthopaedic x-ray's with no problems and stated that he had no concerns about his capacity to interpret ECGs. Dr Manderson had been involved in the care of P84 at the request of nursing staff who were concerned about his condition after their phone contact with Dr Maree. Dr Manderson had no comment about the care of the patient, and was not asked specifically about the care, as at the time of his interview, the Investigation Officers were unaware of his full involvement in the case. However, Dr Manderson was asked to comment on the ECG and immediately correctly diagnosed an inferior myocardial infarction.

Registered Nurse, Andrea Wade had been the primary nurse involved in the care of P84 In her interview (Witness 16), she stated

That this was an elderly patient with chronic obstructive airways disease and had attended Charters Towers Hospital with chest pain. She stated that Dr Maree had established a GTN infusion, however was confused as to why he had not given the patient morphine. She stated that this was strange in her experience, as the normal course of events would see the patient established with morphine, oxygen, rest and GTN as required.

Ms Wade stated that at around 8:00 am a ward round was conducted and that she had not given medications by that stage as she had not been able to find the medication chart, however she had been conducting five minutely observations. She states that Dr Maree came in to do the rounds and had asked why no morning medications had been provided. Ms Wade subsequently found the medication charts and she felt reprimanded by Dr Maree and had been instructed to give the morning medications.

When she read the chart she found that the clexane and atenolol the patient had been ordered..Ms Wade states she questioned Dr Maree on this drug order and he observed that he did require the atenolol to be given and felt the "benefit outweighed the risks".

Ms Wade stated that approximate one hour later the patient become bradycardic and hypotensive. Ms Wade indicated that she phoned for Dr Maree on the mobile phone and his wife answered the phone, as he had left the mobile at home. His wife advised that he was at Mosman Hall and Ms Wade attempted to contact him there, to be advised that he was in a meeting with the Director of Nursing and he would return her call. Ms Wade indicated Dr Maree did phone back some time later and advised to titrate the patients GTN. Ms Wade remained concerned and contacted Dr Manderson who subsequently reviewed the patient and contacted Dr Maree directly.

Dr Maree at that stage, advised to set up an adrenaline infusion and Ms Wade expressed her concern that she was expected to juggle an adrenaline infusion and a GTN infusion, which she had never done before. She expressed, that whilst she could not recall the exact time it had taken for Dr Maree to return to Charters Towers Hospital, she believed it may have been up to an hour after her initial phone call. She stated that she understood that the diagnosis of the patient had been an unstable angina with a possibility of an infarct and reinforced her surprise that no morphine had been ordered. She also expressed her concern that both nitrate patch and GTN infusion were given to the patient and that they had also been prescribed atenolol.

Ms Kay Lowe, Registered Nurse (Witness 22)

Ms Lowe stated that she was not initially involved with the care of P84, however that she had become involved at a later stage and had developed concerns that Morphine had not been used to control P84's pain. Ms Lowe stated that she had been involved in a Ward round with Dr Maree and Dr Manderson and had asked why no Morphine had been used. She states that Dr Maree had responded that "Morphia masked the pain".

Ms Lowe said that she was unsure about how to go about discussing her concerns and the following week had been to Townsville. Ms Lowe stated that she went to visit staff in the Coronary Care Unit in Townsville and spoke with the Nurse Practice Co-ordinator there. She obtained protocols from the staff and on return to Charters Towers spoke to Dr Maree to express her concerns that the Morphia had not been used. She stated that Dr Maree had indicated to her that he would have used Morphine in a younger person. She states that it was her impression that this was an incomplete response.

Ms Lowe stated that it was her understanding that Townsville based protocols were to be incorporated at Charters Towers Hospital and that there may be developments of clinical pathways for the management of chest pain. She stated that she was only aware of nursing protocols in place for the management of chest pain, and that to her knowledge there were no medical protocols in existence in Charters Towers.

Ms Lowe was shown the presentation ECG of P84 and was asked to comment. She observes that there was S.T. elevation in leads II-III and A.V.F. and that there were changes in leads V 2 and V 3. Ms Lowe interpreted this as the patient was heading for an inferior myocardial infarct. She stated that in her past experience after this form of initial ECG, the patient would be expected to receive thrombolysis and clexane, and that they would be placed on continuous cardiac monitoring. She stated that there would be a second ECG performed approximately half an hour after the thrombolysis had been commenced and then there would be hourly ECGs for the next four hours. Subsequently eight hourly ECGs would be performed. She was unaware of whether this was in the current nursing protocol at Charters Towers Hospital.

Ms Lowe indicated she had further concerns about the use of G.T.N. and adrenaline together in infusion. She had developed concerns about the high level of G.T.N. given to P84 and felt that this was possibly responsible for the significant drop in blood pressure. She expressed her concern that adrenaline and G.T.N. running together was inappropriate, and stated that when she questioned Dr Maree in this regard she did not receive an appropriate answer and she was not satisfied with the standard of the response.

Ms Alicia Horrocks Registered Nurse, Level 2 in Emergency Department was shown P84's ECG (Witness 24)

She identified that there was S.T. segment changes and suggested that the patient would be in severe chest pain moving towards an infarct. She stated that in the normal course of events she would have expected he would be admitted to the Extended Care Unit, and would be provided with thrombolysis and morphine.

When Dr Maree was interviewed, he was provided with the charts of P84 (Witness 37). When asked to interpret the ECG, he indicated that the presentation ECG was in fact available only at the ward round three hours after presentation and that the ECG taken at the

patient's presentation was not in the file. He proceeded to interpret the ECG for the Investigation Officers. His interpretation was manifestly incorrect in the first instance, suggesting initially that changes on the ECG were not significant enough to suggest an infarction had occurred. When he was questioned further on this, he indicated that he had in fact diagnosed the ECG at the 8 AM ward round as a myocardial infarct, and had adjusted his treatment plan accordingly.

When questioned on his management of this case, Dr Maree displayed great confusion, appearing to the investigation officers to be initially defending one diagnosis, then another, identifying that his treatment was aimed at angina, then claiming the same treatment was aimed at myocardial infarction.

Dr Maree demonstrated a significant lack of credibility in his defence of this allegation. The investigation officers were left to conclude that

- Dr Maree had made an incorrect diagnosis at the point of the patient's admission to hospital
- Dr Maree had initiated treatment on the basis of the incorrect diagnosis.
- Dr Maree had left the hospital to attend a routine administrative meeting without effecting appropriate handover of the patient.
- Dr Maree had left his mobile phone; the primary means of contact when off campus, at home where it was answered by his wife.
- When contact was established, Dr Maree failed to recognise the seriousness of the situation and did not respond in a timely fashion.
- When Dr Maree was contacted for a second time regarding this patient, he ordered an inappropriate treatment regime.
- When Dr Maree returned to campus he failed to recognise his diagnostic error and failed to seek specialist advice.
- Dr Maree continued an inappropriate treatment regime for a significant time period, despite staff concerns.
- Dr Maree was asked specific questions about his inappropriate treatment regime by RNs Wade and Lowe and he failed to recognise these warning signals.

During the course of interviews, there were occasional fleeting references to a patient with an unusual cardiac rhythm. No staff member could accurately recall details; however, Dr Maree identified the case from a reference by Dr Manderson (Witness 5)

Dr Manderson indicated that he had experienced some situations where Dr Maree appeared to be reluctant to transfer patients at a point that Dr Manderson was normally comfortable with. Dr Manderson outlined two cases one where the patient in the ECU with an unusual cardiac rhythm who Dr Maree chose to "hang on to".

Dr Maree was invited to comment on this issue in his interview (Witness 37) and identified that he remembered the patient referred to by Dr Manderson. Whilst Dr Manderson had indicated that Dr Maree had "hung onto" the patient, Dr Maree indicated that he had in fact been attempting to transfer them to Townsville General Hospital. He identified that he had significant concerns about the patient and the refusal by the cardiology registrar at Townsville General Hospital to accept the patient. He states that he was asked by the registrar at Townsville General Hospital to perform a cardioversion on the patient.

This advice certainly appeared to contrast with Dr Manderson's recollection, who had offered the observation as an expression of concern, having already identified his close personal friendship with Dr Maree. Furthermore, the statement did not "ring true" for the investigation officers in the light of their personal experience in dealings with Townsville General Hospital. Consequently, the patient's identity was tracked and the chart reviewed. The patient was identified as P86

Upon review, it became clear that Dr Maree had incorrectly diagnosed her cardiac rhythm at the point of admission (0200 hrs) and had commenced inappropriate therapy. Dr Maree conceded that he had made an incorrect diagnosis and had commenced incorrect therapy on that basis. Dr Maree has recorded in the charts that he contacted Dr Alana Harris, Cardiology Registrar at Townsville General Hospital and discussed the case, commencing appropriate drug therapy at that time. He makes no record at this point to suggest discussion of electrical cardioversion with Dr Harris, nor his request for transfer of the patient.

From the experience of the investigation officers, it would be highly unusual for staff at Townsville General Hospital to refuse to accept patients as Dr Maree has indicated at interview. Indeed it would be extraordinary for them to ask that a rural hospital practitioner perform a procedure such as electrical cardioversion in a stable patient, unless they were extremely confident in the capability of that practitioner and the practitioner was comfortable in performing the cardioversion. This pattern of practice was confirmed in a telephone interview between Dr Johnson and Dr Harris (unrecorded), and in a meeting with Dr Alex Roarti, also a cardiology registrar at Townsville General Hospital (also unrecorded).

The investigation officers were left to conclude that:

- Dr Maree had misdiagnosed a very clear atrial fibrillation as supra ventricular tachycardia.
- Dr Maree had incorrectly assessed the severity of the patient's condition.
- Dr Maree had instituted inappropriate therapy on the basis of the incorrect diagnosis and assessment.
- Dr Maree performed an elective cardioversion of the patient who was not clinically requiring this level of intervention in a situation where he claims he was uncomfortable to proceed with the procedure.

4.3.8 Allegation 8

Dr Maree demonstrates a lack of commitment to clinical duties, including after hours.

Findings

There was insufficient evidence to suggest that Dr Maree does not demonstrate appropriate clinical commitment.

Reasons for Findings

After discussions with Dr Row (Witness 1), Ms MacDonald (Witness 2), and Ms Nielson (Witness 4), it was apparent that there was no case to answer for Dr Maree in this regard. There was no evidence to suggest that he was less likely to attend and assess patients overnight, which had been the inference from Dr Row's interview.

4.3.9 Allegation 9

Dr Maree is not entitled to the clinical privileges that have been granted to him.

Findings

1. Dr Maree has not yet been through a formal process for assessing clinical privileges.
2. On speaking to referees, Dr Maree does have reasonable levels of experience to expect that he should be able to exercise clinical privileges in General Medicine, General Practice Surgery, and Anaesthetics in a rural hospital setting. He would appear on the basis of experience to require some refresher training before exercising privileges in obstetrics.
3. On examination of evidence about Dr Maree's observed skill level, he is not competent to exercise privileges in General Medicine, General Surgery, Anaesthetics or Obstetrics.
4. Dr Maree has practiced medicine well beyond the bounds of his competence and has not sought to ensure adequate knowledge of basic equipment and local procedures before embarking on potentially dangerous practices.
5. Dr Maree has sought to teach procedures to junior medical staff using techniques he knows to be at significant variance from standard teaching and surgical practice.
6. Dr Maree' standard of clinical record keeping has been shown to be substantially inadequate on several occasions. This includes incomplete recording of emergency care, incomplete or indeed in one case, absent anaesthetic records, and incomplete and inaccurate recording of an operative procedure.
7. Dr Maree has operated in breach of informed consent.

Reasons for Findings

In considering this issue, the investigation officers gave weight both to the evidence of prior experience, and the evidence of competent practice, both of which are required for the award of clinical privileges.

Prior Experience

Dr Maree presents his prior experience in his written statement (Appendix 4) and his application for appointment (Appendix 1). He further elaborates on this experience at his employment interview, as recorded in Mr Sladden's notes on the interview process (Appendix 1).

The following is extracted from Dr Maree's written statement

Obstetrics

1994: The three months training as a resident doctor in Obstetrics is covered in my CV. During this period I performed (not assisted) at least 40 Caesarean Sections. I am very certain about the amount because the residents kept a record amongst themselves to see which doctor performed the most Caesarean Sections. During the year I also performed forceps deliveries and Ventouse deliveries, but cannot supply accurate numbers.

1995: As can be verified from my CV, I spent this year as locum at various venues throughout South Africa. My CV also mentions my stay in Estcourt in Kwa Zulu Natal from 8/95 until 1/96. The shared position as district surgeon with my colleagues meant that I was also on call in a 1 in 3 roster for the local hospital. The hospital is extremely busy and more than one doctor is on call each night, but for different departments. My call included being on call for all Caesarean Sections. My recollection is that I performed a Caesarean Section at least once every week. The period of stay was roughly 22 weeks, which would equate to about 22 Caesarean Sections performed during the period. Dr Wolfaard who was one of my colleagues at the time can verify the facts.

1996: During the second half of 1996 I worked as a freelance locum in Britain. It was during this period that I also met Dr Lloyd Green who is currently Medical Superintendent at Weipa Hospital. One of the locations I worked at was St Mary's Hospital in Portsmouth, as a Senior House Officer in Obstetrics. I am uncertain about the exact dates but it was a period of about one-month. The exact dates can be verified by contacting Humares Locum agency in the UK. Upon request I shall supply their contact details to the Investigating Officers, or the fact can be verified by calling Dr Lloyd Green. My responsibilities included antepartum, intrapartum and postpartum care. I also assisted at one or two Caesarean Sections (I am uncertain about the exact number).

1997-1999: I was employed by the Sir Albert Medical Centre in South –Africa. I performed at least 2 Caesarean Sections during the period and assisted at more than 5 Caesarean Sections. This period is elaborated upon in the following paragraphs.

*The fact that I was involved in obstetrics at the **Sir Albert Medical Centre** in South-Africa can be verified from my references. **Dr Piek** is a private consultant that I used to refer patients to and as such was happy to act as a reference for my Obstetric skills. Dr Piek was also a consultant at the Kalafong Hospital where I received my training in Obstetrics during my sixth year as a medical student.*

*Dr Row states that he believes I have been doing "very little obstetrics over the previous 12 months." I do not dispute the fact that not many Obstetric cases were handled by GP's solely (ie. at Sir Albert Medical Centre), and that most cases were referred to a consultant that performed the Obstetric care, in our facility, with the assistance of the referring General Practitioner. I used to refer my patients to Dr Piek who performed the delivery and if need be performed the Caesarean Section. These facts can be verified from Dr Piek as well as Dr Stander (Medical Services Manager of Sir Albert Medical Centre at the time). When on call after hours and a Caesarean Section had to be performed on a patient that was not under the care of an Obstetrician, the **General Practitioner on call** would perform the procedure with the help of his colleagues.*

*The number of Caesarean Sections I have performed during my career equals roughly 65 (see the above explanation) before my arrival in Charters Towers. The number of Caesarean Sections I have **assisted at**, in my opinion, is roughly double that number.*

Anaesthetics

*Firstly, a brief background of my **recent experience** in South Africa. At least for the last 8-12 months before my arrival in Charters Towers I performed anaesthetics for at least two weekly lists at Sir Albert Medical Centre. Before this period I performed anaesthetics as regularly, but on a different rostered arrangement. The lists were on Mondays and Thursdays and most cases needed a General Anaesthetic. **Dr Cooper and myself** worked as a "team" during the period and he can be contacted in Canada to verify this. An accurate breakdown of the number of anaesthetics I performed can be*

obtained as record was kept of every procedure performed. Sir Albert Medical Centre is a private institution and billing can only be done based on accurate information. Our salaries were also dependent upon performance. The records will also show that during most months I was the General Practitioner that performed the most General Anaesthetics in the hospital and in months that I was not first I was second. Lastly: Sir Albert Medical Centre is a very busy large hospital and has three operating theatres fully booked daily from 08.00 until 17.00. I also gave anaesthetics for a urological list performed on Fridays by a specialist, although this was not a fixed arrangement and only occurred about once to twice a month when the regular specialist anaesthetist was unavailable.

Dr Maree provided further evidence about his surgical experience at interview (Witness 37). The Investigation officers sought to confirm the experience described with Dr Maree's referees, Dr Stander (Witness 33), Dr Wolfaard (Witness 31) and Dr Green (Witness 30). Each practitioner described Dr Maree as highly competent. Dr Stander reinforced his extensive experience in giving anaesthetics, Dr Wolfaard and Dr Green attested to his general clinical competence. None could provide independent witness to Dr Maree's obstetric experience. Dr Maree calculated his anaesthetic numbers at approximately 500 per annum over the preceding 3 year period.

Dr Maree provided further advice about his surgical experience and indicated that he had shared the role of surgeon with his colleague at Sir Albert Medical Centre, and that he performed many minor surgeries over the last three years. He stated that he did not perform any significant intra-abdominal procedures over this time. (Witness 37)

On the basis of this information, Dr Maree's experience would indicate that he should have current skills in anaesthetics and may require some retraining and assessment in surgery and obstetrics before exercising privileges.

Demonstrated Skills

Dr Maree has been exercising extensive clinical privileges since his arrival in Charters Towers. Several cases were raised with the Investigation Officers which raise concerns about the standard of care provided by Dr Maree. These cases will be considered under specific privilege categories. Only cases where specific concerns have been established to the satisfaction of the Investigation Officers will be listed, other inconclusive cases are reflected in witness interviews.

Obstetrics

On the evidence of Dr Row (Witness 1) and Dr Manderson (Witness 5), Dr Maree's skills in operative obstetrics appear to be acceptable.

With respect to Dr Maree's handling of neonates, some concerns are raised in the consideration of P87 . In this case, concerns were raised by Dr Manderson (Witness 5), the senior midwife, Ms Chris Butler (Witness 23) and the attending RN, Andrea Wade (Witness 16).

Dr Manderson stated that the patient involved had been identified as Group B Streptococcus positive and that the baby when born was "the flattest I have ever seen". Dr Manderson stated that he had commenced resuscitation of the baby and asked for Dr Maree to be called, he stated that Dr Maree attended quickly and had been able to suggest a couple of interventions that Dr Manderson had not yet undertaken. These included the injection of some glucose solution and Naloxone and that after

some failed attempts to gain peripheral venous access an umbilical vein catheter was inserted. The initial umbilical vein catheter fell out while Dr Maree and Dr Manderson were attempting to secure it and Dr Manderson stated that the second one had been difficult to get in. Dr Manderson stated that Dr Maree had ordered intravenous fluids and noted that he believed it seemed like a lot of fluids at the time. Dr Manderson recalls having asked Dr Maree "is that too much" Dr Manderson believes that he may have asked that question twice. Dr Manderson states that Dr Maree had advised that "no, that will be all right for now". Dr Manderson states that he deferred to his superior's knowledge and commenced the infusion as requested.

Dr Manderson stated that the following day the baby was transferred to Townsville after it had a seizure in the morning.

Dr Manderson indicated that the intravenous fluids had continued on the patient overnight and that the transfer was conducted with Dr Maree flying to Townsville with the patient. Dr Manderson stated that Dr Guan Koh, Neonatologist from Kirwan Hospital for Women had contacted him some days later and had indicated that whilst the child was OK he believed that the cause of the seizure had been from hyponatraemia from excessive fluids administered during the resuscitation. Dr Manderson indicates that he advised Dr Maree of this information and stated that Dr Maree had appeared to accept the information but did not appear to give it great credence. When pressed Dr Manderson said that the response from Dr Maree was "Oh OK" but there was no further discussion.

Ms Christine Butler

Ms Butler indicated that P87's *mother had prolonged rupture of membranes but had not established labour for some time. She stated that it was her belief that Mother probably should have had antibiotics earlier than they had been commenced, given the presence of her Group B streptococcus. Ms Butler stated that the intrapartum care was within normal limits until the baby was delivered and that the baby was quite flat on delivery at around midnight.*

Ms Butler stated that she was attending to the mother who had a retained placenta and she didn't see a lot of what was happening in the resuscitation. She stated that she was aware that the umbilical catheter had fallen out in the first attempt of insertion and that the second attempt the umbilical catheter did not go in as far as expected. Ms Butler stated that all staff appeared to be shocked that the baby had "come out flat" and that she was aware that Dr Maree appeared to think the reason for the baby's state was that they had been affected by the epidural analgesic provided to the mother.

Ms Butler indicated her surprise to this belief and stated that the mother had not received any analgesic within the two to four hours prior to the delivery.

Ms Butler stated at the time that Dr Maree gave the fluid orders, she had been somewhat surprised and asked Dr Maree whether he was sure he was given the correct quantities of fluids.

Ms Butler believes that in retrospect the rate of infusion was over twice of what should have been given.

Ms Butler states at the time she questioned Dr Maree she understood him to be calculating the figures in his head and that he wrote up the fluid orders indicating that he was clear about the rate of infusion that he wished to establish.

Ms Butler indicated her concern that when the abdominal distension was noted some hours later;

that the fluids were recommenced despite her concern that fluid was running into the peritoneum.

Ms Andrea Wade

Ms Wade indicated that she was on duty when P87 *was born and that she had assisted in his resuscitation. She stated that* P87 *had been born down stairs in the maternity area rather than in the labour ward upstairs and that Chris Butler had been attending as the midwife.*

She stated that she had initially stayed outside to watch the ward however had been called in to assist with the resuscitation. She stated that Dr Manderson was present and she observed that the baby was not breathing. Dr Manderson commenced resuscitation with oxygen and the air viva and had asked her to call Dr Maree. Ms Wade stated that Dr Maree came quickly and took control of the situation and at that stage the baby was breathing.

She stated that Dr Maree requested that Narcan be given and that she attended with a dose of 400 micrograms. Dr Maree asked if that was the right dose and she advised that was the paediatric dose.

She stated that Dr Maree put in an umbilical catheter that came out before it was secured. He had requested a size 5 feeding tube to perform the umbilical catheterisation, despite the fact that she was aware there was a formal umbilical catheter available in the neonatal resuscitation trolley.

Ms Wade indicated that Dr Maree had established an intravenous infusion of 5% dextrose and that the rate had been established on the basis of Dr Maree's calculation of 120 millilitres/kilogram for the first eight hours.

Ms Wade states that she checked with Dr Maree three times regarding the volume of 40 mls per hour that had been established. Ms Wade recalls having thought that this amount appeared to be excessive as in her recollection it was the same as the toddler resuscitation rate. She states that she remained on duty and had phoned Dr Manderson at approximately 6:00 am concerned that the neonate's abdomen appeared to be distended. She was concerned that the fluid may be running into the baby's peritoneum however states that Dr Manderson did not appear overly concerned. Ms Wade stated that the baby subsequently suffered from fits and required evacuation to Townsville.

Dr Guan Koh, Neonatologist at Kirwan Hospital for Women was involved in the retrieval of the patient and the subsequent care in the Neonatal Intensive Care Unit. He provided evidence at Witness 14.

Dr Koh observed that the records from Charters Towers tallied well with his recollection of the events and notes from Kirwan Hospital for Women. He states that the baby appeared to be "flat at birth" with a good heart rate and responded well to basic resuscitation measures. He stated that a dose of Narcan had been given to deal with the perception of a possible opiate depression and that an umbilical line infusion had been commenced. Dr Koh noted that the blood sugar level had been reported as 2.4 and that the neonate was pink, breathing room air. Dr Koh stated that there were occasional drops in oxygen saturation and that the baby weighed approximately 3kgs. He stated that he would normally give fluids at a rate of 10mls per kg per hour in resuscitation for hypovalemia which would drop to around about 10mls per hour at 10% dextrose in this sort of case.

Dr Koh said he was uncertain as to what the intention would have been for running the infusion at

40mls per hour and indicated that at this rate it may put the baby at risk particularly if it was allowed to continue for any long period. He stated that this was a huge volume for a baby at this size.

Dr Koh was asked what action a practitioner should take if another doctor questioned the rate of infusion. Dr Koh stated that he would expect that the senior practitioner would work out the rate again with the other doctor to demonstrate that they had obtained the appropriate rate. He outlined that he believed that there was a duty to the doctor in training to ensure that the appropriate rate was established to their mutual satisfaction. Dr Koh stated that whilst the rate of intravenous infusion was high he believed that it was not in the range where the baby was put at risk of death within the time frame that the infusion was running. Dr Koh stated that he was uncertain whether the subsequent seizure and hyponatremia in the patient were due to the increased fluids however he did believe that this was potentially a factor involved.

Dr Koh stated that "alarm bells should have been ringing" with the rate of 40ml per hour and they should have been attended to particularly when another practitioner had raised the issue. Dr Koh further indicated that if there had been a further delay in the retrieval of the patient it could have been a "catastrophic" result, however in the circumstances he believed that the baby did not suffer from the management administered at Charters Towers Hospital.

Dr Koh indicated his believe that a positive aspect could be derived from this case if a list of relevant drug and fluid dosages was developed and provided to country practitioners.

Dr Maree was asked about this case at interview (Witness 37) and indicated that he had calculated the fluid rate utilising what he regarded to be an accepted world standard. He cited a reference text in emergency medicine (Appendix 9), which refers to a rate of infusion for rehydration of children based upon percentage dehydration. He recalculated the rate during interview and found that he had been using the incorrect weight during the course of the resuscitation (being 3.8kg rather than 3.08kg) however concluded that his rate of infusion was correct.

The Investigation Officers were greatly concerned that Dr Maree had used an incorrect formula for calculation of the rate of infusion in the first place. This concern was reinforced with the knowledge that he had used an incorrect weight for the child to establish the infusion. The concern was further reinforced with the realisation that he had failed to recognise the concerns of his three staff who all claim to have questioned the rate with him. The concern however, is magnified substantially by Dr Maree seeking to justify a formula, calculation and rate that was manifestly and incomprehensibly incorrect and had put the child at significant risk of death.

Even after reviewing this case with the Investigation Officers, Dr Maree could not accept that he had adopted an inappropriate rate of infusion or calculation formula.

Surgery

Dr Maree had performed a number of surgical procedures during his time at Charters Towers Hospital. This included the removal of foreign body from the child's ear, as described in Allegation 5, as well as other procedures, including tubal ligation.

Staff highlighted the case of P88 who had presented for elective tubal ligation.

Dr David Row (Witness 1)

When asked about Dr Maree's technical skills Dr Row referred further to a case where Dr Maree had performed a tubal ligation on a patient named . P88 . Dr Row states that this operation took some two hours, which he indicated was an extensive time to perform such a procedure. He stated the patient had be moderately obese and required a significant laparotomy to perform the procedure. Dr Row indicated that this was hearsay, which had been related to him by Dr Bashir Ahmed who had been conducting the anaesthetic. Dr Row states that he understands that it took one and half hours to gain access to the abdominal cavity and that Dr Ahmed had been wondering about the delay.

Dr Derek Manderson (Witness 5)

observed that he had worked with Dr Maree in the performance of a tubal litigation which had been somewhat difficult. Dr Manderson stated that he was invited to do the procedure by Dr Maree and that he had seen many such procedures done in the past. Dr Manderson stated that the patient was somewhat overweight but that he and Dr Maree had had significant problems finding the peritoneal cavity.

Dr Manderson indicated that he was unsure as to why this occurred and stated that Dr Maree during that case had stated that he had "never had this much trouble before". Dr Manderson stated that he could not recall the exact position of the incision of this patient but agreed that it may have been a relatively high incision.

Dr Bashir Ahmed (Witness 6)

Dr Ahmed was asked about the case of . P88 who had presented for tubal ligation. P85 had a general anaesthetic performed by Dr Ahmed with Dr Maree and Dr Manderson performing tubal ligation. Dr Ahmed indicated that the anaesthetic had commenced shortly after 9.00am and finished close to 11.00am. Dr Ahmed indicated that he believed that this was a long time for a tubal ligation and stated that it was his understanding that Dr Maree could not "find the tube".

Dr Ahmed indicated that it was Dr Maree's practice to use an incision between the umbilicus and the pubic bone, which was somewhat higher than Dr Ahmed had been used to. Dr Ahmed stated that he had never seen such an incision before and felt very sorry for the patients who had a cosmetically questionable incision.

Dr Ahmed indicated that it could be difficult to identify structures in the abdomen when there are adhesions present. However, in this particular patient there had been no prior surgery and no indication of any intra-abdominal problems and felt that the case took a long time for such an uncomplicated situation.

Dr Ahmed offered his observation that Dr Maree appears "not to be very confident with surgery and does not look to have experienced hands and appears shaky".

Ms Andrea Wade (Witness 16)

Ms Wade states that she was not working in the operating theatres on the day that P88 had her tubal ligation, however that she knows P88 personally. Ms Wade stated that she had

heard that the incision on P88 was high and they had some difficulty locating the fallopian tubes. Ms Wade stated that some weeks later she had been involved in assisting in a tubal ligation with Dr Maree as the surgeon and she noted that the incision was midway between symphysis pubis and the umbilicus and the patient was six (6) weeks post partum. Ms Wade stated that she question Dr Maree about the incision and asked why it was so high. Dr Maree responded that "it was a safety precaution to avoid the bladder".

Ms Wade indicated that access to tubes was somewhat difficult with the right tube being quick to access and the left tube being slow. She stated that this was perhaps an hour to an hour and a half operation. Ms Wade stated that she had only seen a tubal ligation by laparotomy performed through a pubic hair line incision in the past.

Ms Wade indicated that Dr Maree's response to her questions had been appropriate and that he had been very easy going and easy to get along with. Ms Wade stated that she indicated her concern further by asking 'let me know when you reached the common bile duct'.

Ms Criena Preston (Witness 18)

Ms Preston stated that she had been the Scrub Nurse during P88 's tubal ligation. She stated the case commenced with Dr Maree making a small incision just below the umbilicus. She stated that she found this incision to be unusual and that she had not seen it prior to Dr Maree's arrival in Charters Towers. The first time she saw it she questioned him about that form of incision and was informed that it was to avoid rupturing the bladder. Ms Preston stated that Dr Maree was performing the surgery. She had understood that Dr Manderson was intending to do the operation, however that P88 was a relatively large lady and as a result Dr Maree had decided to do the operation.

Ms Preston stated that the initial incision was approximately five centimetres long and that after forty to forty-five minutes Dr Maree had not been able to identify the fallopian tubes. Dr Maree stated he believed that it was because the patient had a full bladder and requested that an indwelling catheter be inserted. The insertion of the catheter took approximately five to ten minutes and the catheter drained between forty and sixty mls of urine. Ms Preston stated that she was aware that the patient had been fasted from 6.00PM the night before and the procedure had started at 9.00a.m. Prior to the procedure starting, she had confirmed that the patient had voided her bladder.

On recommencing the operation Dr Maree extended the incision across the abdominal wall approximately twenty to twenty-five centimetres. At that stage Dr Maree made a comment to Dr Manderson that he was not yet in the peritoneal cavity. Approximately ten to fifteen minutes later Dr Maree identified the fallopian tubes and performed a tubal ligation.

Ms Preston stated that it was his usual practice to resect approximately two to three centimetres of fallopian tube and then apply liga-clips. Ms Preston stated that when questioned about his form of incision, Dr Maree had responded appropriately and had explained well his reasons for the incision being sub-umbilical and that he did not take offence to the question.

Dr Maree in his written statement (Appendix 4) offers

As indicated, a tubal ligation was performed on her by Dr Manderson and myself. As further indicated the procedure took around 90 minutes to perform. As indicated by Dr Row the case is based on hearsay evidence from Dr Ahmed, as Dr Row was not in theatre at the time.

At my suggestion Dr Manderson commenced the procedure, because he had been allowed very limited opportunity to perform surgery during his period at Charters Towers. I assisted him. We proceeded very slowly as P88 suffers from obesity, I did not wish to rush Dr Manderson, as his experience was limited. After performing the skin and subcutaneous incisions he divided the rectus sheath. This is normal procedure. Before entering the abdominal cavity the next step would be to perform the incision through the peritoneum. At this stage I stopped Dr Manderson and enquired whether a urinary catheter was in situ, as the bladder appeared distended. I was concerned about causing injury to the bladder when performing the peritoneal incision. A catheter was not in situ and a tray had to be prepared for insertion of a urinary catheter. I inserted the urinary catheter, resulting in sterility being lost and the patient needing to be draped again. I had to resterilise and new packs needed to be opened. This caused a considerable time delay, but needed to be done to ensure the safety of the patient.

*After insertion of the catheter I proceeded to gain entry to the abdominal cavity. As mentioned the patient was obese and I could not bring out the fallopian tubes to tie them off through the incision made by Dr Manderson. Normally the fallopian tubes are brought to the surface through the incision made in the abdominal wall. If I were to attempt this in this case, there would have been the risk of tearing the Fallopian tubes, as the abdominal wall was very thick due to obesity and the tubes not long enough to extend all the way to the surface. The only alternative, **in the interest of not causing injury to the patient**, was to enlarge the existing abdominal incision and perform the ligation under visual sight intra-abdominally. I proceeded to do this and the incision was closed without incident afterwards. The patient made a complete recovery and no complications resulted.*

*If I acted in haste and not taken **due precaution**, as illustrated above, an adverse outcome might have resulted from either injury to the bladder, or the Fallopian tubes being torn. The **safety of the patient** was considered more important than a quick procedure.*

In Summary:
The time delay resulted from:

1. *Dr Manderson starting the procedure.*
2. *A urinary catheter having to be inserted after the procedure was already underway.*
3. *The need to resterilise the operating field.*
4. *The abdominal incision having to be enlarged in the interest of safety.*

Professor Michael Humphries was contacted for his opinion on the management of this case (Witness 8)

Professor Humphries was advised that observations of staff in the operating theatres indicated that the incision on P88 was located somewhere between the umbilicus and the symphysis pubis. Professor Humphries indicated that where a tubal ligation is to be performed by laparotomy in uncomplicated cases the incision preference is a pfannenstiel incision and this incision is over the upper border of the pubic hairline. He stated that in an 88.5kg woman this should require a maximum of an 8cm incision.

Professor Humphries went on to state that if a transverse incision was made high up in the abdominal wall greater than half way towards the umbilicus from symphysis pubis the abdominal wall anatomical structure changes and may make the completion of the incision more difficult.

Professor Humphries observed that the operation taking over 1½ hours was excessive and his

expectation would be that this sort of case the operation should no longer than 30 minutes. Professor Humphries expressed a view that with the surgeon taking over one hour to access the peritoneal cavity was significantly excessive and that he would expect that at a registrar level the absolute maximum time taken to access the peritoneal cavity should be 20 minutes. Professor Humphries stated that he believed that a rural general practitioner performing such procedures should be performing at a registrar level.

Professor Humphries made further observations about the performance of a tubal ligation in this way and raised questions for the Investigators to follow-up.

1. Appropriateness of tubal ligation by laparotomy
Professor Humphries stated that he believed it was appropriate for tubal ligation to be performed by laparotomy only where the patient is aware that laparoscopic tubal ligation is available elsewhere and is prepared to go ahead with procedure.

2. The length of the wound
Professor Humphries suggested that an appropriate evaluation should be made of the length of the wound.

3. Position of the wound
Professor Humphries suggested that appropriate evaluation should be made of the position of the wound to make an assessment of the appropriateness of surgical technique.

4. Use of Liga Clips
Professor Humphries stated that he was not aware of liga clips having ever been used in the performance of tubal ligation. He stated that in his understanding that liga clips where small staple like structures normally used for establishment of haemostasis in difficult to access situations. He stated that the use of non-absorbable materials in the performance of tubal ligation had been demonstrated to have a higher level of sterilisation and that absorbable materials only should be utilised.

Following Professor Humphries comments, the Investigation Officers spoke with one of Dr Maree's referees in South Africa, Dr Johan Wolfaard (Witness 31), who advised that where tubal ligation os to be performed by mini-laparotomy in South Africa, it would only be performed by pfannenstiel incision. Both agreed that the only exception to this would be in the **immediate** post partum patient, where a small sub-umbilical incision is indicated.

Dr Maree in his interview (Witness 37) indicated to the Investigation Officers that he routinely performed tubal ligation through an incision somewhere between the umbilicus and symphysis pubis. Dr Maree was not able to offer any specific landmarks for his incision and confirmed that he chose this form of incision to avoid the bladder. Dr Maree went on to outline the case and his technique for performing tubal ligation, reading from the clinical record. He examined the pathology report and advised that he had performed a partial salpingectomy on the patient, removing the distal portion of the fallopian tubes, as he could not gain access to the mid-section of the tubes. Dr Maree was asked whether a partial salpingectomy carried with it any different risks or considerations for the patient when compared to a tubal ligation. Dr Maree indicated that the procedures were significantly different in that they afforded the patient a significantly different possibility of reversal of sterilisation at a later date.

Dr Maree confirmed that in his understanding the patient had been consented for tubal ligation and not partial salpingectomy, however, identified that he believed it to be appropriate to proceed to partial salpingectomy on the basis of difficulty in completion of tubal ligation, without seeking the consent of the patient. He further identified that consent for tubal ligation had been obtained by Dr David Row, and that he had not advised the patient about his technique prior to commencing the procedure.

The Investigation Officers were sufficiently concerned about Dr Maree's assertions that they contacted the pathologist who had examined the specimens presented by Dr Maree. The Investigation Officers felt that if an alternative operation had been performed, then they may need to advise the patient.

Dr McBride indicated (Witness 36) that the sections submitted were in fact from the middle third of the fallopian tube. Dr Maree was advised of this development and expressed great relief, after confirming that indeed the change in procedure from tubal ligation to partial salpingectomy was not uncommon for him. Dr Maree had drawn a diagram illustrating his technique for the Investigation Officers (Appendix 10)

Dr Maree was asked if he could describe changes in the structure of the abdominal wall from the symphysis pubis to the umbilicus. He was unaware of any changes.

In his responses to questioning on this case it is clear that Dr Maree has a very inadequate knowledge of abdominal and pelvic anatomy to be performing elective procedures. Dr Maree recognised that the technique he employed was not standard teaching in either South Africa or Australia, and advised that he had developed the approach without reference to any authority. He also stated that he was teaching Dr Manderson his technique, which raises significant questions about his clinical judgement and medical ethics.

The admitted willingness to perform routine procedures without appropriately informed consent, whilst admitting knowledge of the concept and application of informed consent further calls professional judgement and ethics into question.

Anaesthetics

Dr Maree has performed only four general anaesthetics at Charters Towers Hospital. His level of record keeping and anaesthetic technique raised some concerns with the Investigation Officers. Records of Dr Maree's anaesthetics were provided to Dr Vic Callanan, Director of Anaesthetics at Townsville General Hospital (Witness 9) and Dr Scott Simpson consultant anaesthetist at Townsville General Hospital (Witness 10).

Dr Callanan

Patient 1 – P89

Anaesthetic was performed by Dr Maree. Dr Callanan said that there was no obvious record of pre-operative assessment that the intra-operative records appeared to be incomplete with only one blood pressure recording being a major deficit. He identified that there was no record of anaesthetic on the traditional anaesthetic chart and that the patient had a thiopentone and suxamethonium induction with no record of what endotracheal tube was used, no record of the anaesthetic circuit used and no record of intravenous access. He pointed out that the chart was unsigned and stated that he would be highly critical of a registrar who had completed an anaesthetic with documentation such as that.

Patient 2 – P91

Dr Callanan observed that this patient had presented for bilateral tubal ligation. He stated that he could see no evidence of pre-operative assessment, no record of a pre-medication. He stated that there was no record of the anaesthetic observations on the standard chart, however the automated recording demonstrated a reasonable level of completion.

Dr Callanan stated that the endotracheal tube and anaesthetic circuit were recorded but there was no name of anaesthetist and the record was unsigned.

Record 3 – P92

Dr Callanan observed that there was no anaesthetic record at all for this case and that there was very inadequate documentation of the admission, no record of the operative procedure or the anaesthetic in the file at all. The only assessment of the child in the file pertained to the assessment of their dislocated elbow but with no information recorded about the general state of the child. Dr Callanan indicated that this was a highly unsatisfactory level of documentation.

Dr Simpson

P89

Dr Simpson stated that recording of end-tidal carbon dioxide was noted on the record, which were shown to be in kPa which he understood to be the preferred practice for South African practitioners. He stated that the anaesthetic was for the conduct of dilatation and curettage, that there was no record of the airway used in the anaesthetic and that the patient had been identified as a difficult patient prior to the conduct of the anaesthetic. This was identified by a "Mallonpatti score" which anticipated a high chance of difficult intubation. Dr Simpson observed that there was only one blood pressure measure prior to the administration of anaesthetic with no blood pressure recording during the conduct of the anaesthetic.

Dr Simpson noted that the oxygen saturation had dropped shortly after induction and that there was 21% inspired oxygen at the point of induction. Dr Simpson noted that there was some concerns that:

1. *there was no mention of the airway used*
2. *the patient appears not to have been pre-oxygenated*
3. *The oxygen saturation appeared to drop significantly after the induction.*

At interview (Witness 37) Dr Maree was asked to review the charts of P89, P91 and P92. He acknowledged that he had not appropriately recorded information for P89, and that he had not recorded his name and signature on the P91 record, he further was asked about the absence of any record of anaesthesia in the P92 record. Dr Maree defended the lack of any detail of anaesthetic having been given by stating that it was his common practice to give small doses of Propofol in an emergency department setting for the reduction of fractures and that he considered it to be a relatively insignificant issue. He acknowledged under questioning that he had caused the level of consciousness of the patient to be altered and that he had erred in not recording this event appropriately.

With respect to the record of P89, Dr Maree was asked if he had pre-oxygenated the patient as would be the normal circumstance for a "rapid sequence induction". Dr Maree indicated that this was his normal practice, and identified after review that although this was not recorded on the anaesthetic chart, that there was evidence that he had pre-oxygenated the patient. Dr Maree identified that during this case, which was the first

anaesthetic case he had performed at Charters Towers Hospital, he had experienced significant difficulties in the operation of the ventilator on the anaesthetic machine, and that the ventilator had been "alarming". He stated that he had disconnected the ventilator and "hand-bagged" the patient for the remainder of the case. Dr Maree indicated that following the case he did not seek further training on the ventilator and had not arranged for the ventilator to be serviced.

Dr Maree was later asked to demonstrate the operation of the ventilator by the Investigation Officers. It became clear that Dr Maree did not understand the operation of the ventilator, and could not adjust it appropriately to ensure adequate ventilation of the patient.

Dr Row (Witness 1) and Elspeth MacDonald (Witness 2) had raised concerns, about a "Scuffle" which had occurred in theatres between Dr Ahmed and Dr Maree.

Dr Maree advised in his written statement (Appendix 4)

I move on to the alleged "physical tussle" between Dr Ahmed and myself.

The patient referred to is P90 *. Dr Row points out: "this information was conveyed to him third hand from Elspeth Macdonald the Assistant Director of Nursing". Note that* ***neither Dr Row nor Ms Macdonald*** *was in theatre at the time and the evidence is regarded as "hearsay" and should be treated as such. I shall however from memory convey what happened on that day.*

The child was booked to have six teeth extracted by Dr Geoff Hill (a dentist) on 05/12/00. As such a nasal intubation is definitely indicated and I conveyed this to Dr Ahmed. I was in theatre as I had performed surgery on the previous case and had not left theatre yet. Dr Ahmed indicated that he was uncomfortable about a nasal intubation and I got the impression that he has not done many nasal intubations in the past. I offered my help to him, but he still seemed uncomfortable. The "physical tussle" might refer to my action of taking the tube from his hands and offering to do the intubation myself. I then proceeded to perform the intubation after he induced the patient.

I have done many nasal intubations and am competent in performing the procedure. I again point to my experience and interest in Emergency Medicine as well as the fact that I regularly performed the procedure for tonsillectomies and teeth extractions in South Africa.

I allegedly achieved intubation ***"after three attempts".*** *To address the fact I unfortunately need to give a lengthy explanation on how nasal intubations on children are performed, and thereby show that this was not a difficult or extraordinary case.*

The procedure starts with induction of anaesthetic either by a gaseous substance or intravenous drug. When the patient is asleep an oropharyngeal airway is placed and adequate time is allowed for the patient to be "deep enough" to allow intubation. Now the oropharyngeal airway is removed and a laryngoscope is inserted to visualise the airway, the vocal cords and check for any excessive secretions. (In this case there were secretions and I removed them by using a suction apparatus). The laryngoscope is then removed and the oropharyngeal airway inserted again. This is done to ensure that no problems will be encountered when inserting the endotracheal tube itself, and to ensure adequate oxygenation prior to intubation another period of time is allowed to elapse. Only then can the anaesthetist confidently insert the naso-tracheal tube. The tube is then inserted and again the airway is checked afterwards to ensure the tube is correctly in place.

As described above the process takes place in three steps and the laryngoscope is inserted at three steps during the procedure. ***The steps being:***

1. *The "check" of the airway and cords prior to intubation.*
2. *The insertion of the naso-tracheal tube itself.*
3. *The confirmation of successful placement after the insertion of the tube.*

As can be seen from the above, a naso-tracheal intubation in a child consists of more steps than intubation via an oral route in an adult. It seems that these steps have been mistaken as three attempts and that I "persisted", whilst I should have not. I am confident enough in my explanation of the process of naso-tracheal intubation to ask that a Consultant Anaesthetist verify the facts.

Dr Ahmed had a somewhat different view of events, as did other nursing staff present at the time of the incident.

Dr Ahmed (Witness 6)

Dr Ahmed was asked specifically whether he recalled an incident in operating theatres where he had had a disagreement with Dr Maree. He recalled that there had been a young child P90 *aged 2½ who required a dental extraction. Dr Ahmed indicated that whilst it was his normal practice to give the majority of anaesthetics at Charters Towers Hospital at the time he understood there was a general policy that young children would not come for routine surgery. Dr Ahmed indicated that he had some difficulties in finding the connections for the anaesthetic machine to cope with the young child and the staff in the operating theatres were not used to dealing with young children. He indicated that he was unaware as to why the child had been booked on the list at Charters Towers Hospital, however he felt that the performance of the anaesthetic was within his level of experience and he was happy to proceed. Dr Ahmed indicated that he had taken some time to set-up appropriately for the anaesthetic performing all dilutions of anaesthetic drugs and setting up his anaesthetic tray appropriately before proceeding to anaesthetise the child. Dr Ahmed indicated that he was just about to administer the anaesthetic when Dr Maree attended theatres and asked why he was taking so long.*

Dr Ahmed indicated that Dr Maree had used words to the effect of "Bashir you are taking too long, let me do it, give me the laryngoscope, I will intubate". Dr Ahmed indicated that Dr Maree then took over the induction of the child's anaesthetic and that an intravenous line was inserted and a gas induction was performed. Dr Ahmed indicated that Dr Maree attempted a nasal intubation of the child and failed on two attempts. Dr Ahmed states that he saw the oxygen saturations were dropping and asked Dr Maree to stop and insert an oral endotracheal tube. Dr Maree refused and attempted to insert nasal tube, again this time successfully. Dr Ahmed indicated his concern that this practice was unsafe, has potential for trauma to the larynx and potential for inflammation and airway obstruction was significant with two failed attempts. Dr Ahmed indicated that he believed that this was unsafe practice. Dr Ahmed was asked if there was any physical contact between he and Dr Maree during this procedure. He indicated that here was no physical contact and that he had been verbally asked to stand aside.

Ms Andrea Wade (Witness 16)

Ms Wade indicated that all the staff were apprehensive with the anaesthetic for P90 *as they do not normally perform anaesthetic on two year olds and that she was aware that this particular case would require a nasal intubation. Ms Wade indicated that the anaesthetic circuits were normally set up for adult patients and that it took sometime to get the equipment together for the paediatrics case. Ms Wade indicated that she believes that this was the second case on the list and that they had made up some time on the first case and were taking their time to ensure that all of*

the equipment was in place. She stated that Dr Maree had attended and attempted to "hurry us up" and had inquired whether there had been a problem. He was advised that there was no problem however he "kept coming and going".

Ms Wade stated that she left the operating theatre for a short time to find Dr Maree preparing to put the tube down and Dr Ahmed questioning on what was happening. She stated they appeared to be arguing and the voices weren't raised but the tone of conversation appeared to be abrupt. She stated that Dr Maree was doing the intubation, which was surprising, as it was Dr Ahmed's case. She stated that Dr Ahmed was advising to put in an oral tube and that Dr Maree refused and continued to put in a nasal tube.

Ms Wade stated there appeared to be some form of physical scuffle with Dr Ahmed attempting to take over the intubation and control the laryngoscope. Dr Maree persisted to perform the intubation. Ms Wade stated that after the case Dr Ahmed appeared to be very stressed and that he had expressed his concern that persisting to attempt a nasal intubation on this patient was inappropriate as it may cause inflammation and occlude the airway. Ms Wade stated the nursing staff were concerned about the behaviours and felt it represented unprofessional behaviour with Dr Maree at fault. She stated that Dr Ahmed appeared to be in control of the situation and that time was not a critical factor.

Ms Wade observed that Dr Maree appeared to be upset at the last minute cancellations in the theatres and stated that in the past he had wanted to add more cases to become more productive in the theatres He further insisted that timely starts to theatres be available and that subsequently he had failed to turn up on time to theatres

Ms Preston (Witness 18)

Ms Preston stated that she was on duty in Theatre on the day that Dr Bashir Ahmed was scheduled to perform an anaesthetic on P90 *, a two year old requiring a dental extraction. She stated that Dr Ahmed had checked the machine and set up for the anaesthetic very thoroughly. She stated that he was always very thorough in preparing for a case, and this was particularly so with the young toddler. She stated that Dr Ahmed had inserted a cannula and had commenced the anaesthetic with gas and then injected the patient with an induction agent. Prior to that Ms Preston recalled that Dr Ahmed had checked with the Dentist to ensure that he was happy for an oral endotracheal tube and the Dentist had stated that he was happy with such a tube. She stated that Dr Ahmed had the tube ready to insert when Dr Maree came in and advised that he believed that a naso-tracheal tube would be more appropriate in this patient. She stated that he advised that he would put it down and moved Dr Ahmed aside.*

Ms Preston stated that it was her belief that Dr Maree attempted four times to pass the naso-tracheal tube without success and that at that point Dr Ahmed had attempted to take over the intubation and pass an oral endotracheal tube. She stated that as Dr Ahmed approached the patient's head he was shouldered out of the way by Dr Maree who persisted to pass a naso-tracheal tube. She stated that Dr Ahmed had been quite concerned at that stage and had stated "the child is not breathing".

Ms Preston stated that she believed that it was quite rude and inappropriate for Dr Maree to behave in this way with this patient. She stated that Dr Ahmed had the child asleep and there was no cause for any concern when Dr Maree came in and took over the care. There had been no indication Dr Ahmed was in any way lacking in control of the situation.

Ms Preston stated that after the case she was aware that Dr Ahmed was quite anxious and that it was most unlike him, and that she had significant concerns that the behaviour by Dr Maree had been very unprofessional and that it was inappropriate.

Dr Vic Callanan (Witness 9) and Dr Scott Simpson (Witness 10) were asked for their comments on the events outlined by staff.

Dr Callanan

Dr Callanan stated that if the person who had started the anaesthetic was appropriately experienced it was only appropriate to interrupt if the person performing the interruption was more experienced than the other practitioner and concerned that something was not being done correctly.

Dr Callanan was asked about the risks of nasal intubation and he observed that in a two-year-old the risks of nasal intubation were higher than in adults and the intubation was more difficult. There is a risk of damaging the adenoids. However, Dr Callanan stated that a nasal intubation was appropriate in the case of P9O *as she was expected to have a dental extraction.*

Dr Callanan was asked about the appropriateness of a rural practitioner providing anaesthetic on a 2½-year-old child. He stated that normal expectation would be that a rural practitioner would not anaesthetise a child less than three or four years unless they were experienced in paediatric anaesthesia and had maintained ongoing skills with anaesthesia in children.

Dr Callanan was asked about the failed attempts at nasal intubation and he observed that between each attempt the anaesthetist should "back-off" assisting the child to breathe through the mask. He indicated that where there had been a drop in the patient's oxygenation or where the child was "lightening" it might be appropriate to stop the intubation and settle the child with appropriate oxygenation and mask breathing. He stated that after two failed nasal attempts to intubate, it would be appropriate to attempt an oral intubation on subsequent attempts. The only reason to have a further attempt at nasal intubation would be if the anaesthetist had a very good idea of what had caused the failure of the previous two attempts and what would be done differently to assist with the intubation on the following attempt.

Dr Scott Simpson

Dr Simpson indicated that it was his belief that the interference in the delivery of an anaesthetic should not occur except in exceptional circumstances and that he had not seen it happen in his practice. He believed that it would only be justifiable if the anaesthetist appeared to be having difficulty and if they had either asked for help or they were in significant problems. Dr Simpson was asked his views of multiple attempts of intubation and he indicated that his advice to registrars was that they should only ever have a maximum of three attempts of intubation. He stated that after first attempt the anaesthetist should attempt to identify what went wrong in the first attempt and rectify that in the second attempt. The third attempt should only be undertaken where the anaesthetist had been able to obtain a good view of the vocal cords and was clear on the actions they could take to correct the failure in the preceding two attempts. He stated that it would not be appropriate to proceed on a third attempt unless this condition was met.

Dr Callanan was asked to comment about the nasal intubation technique described by Dr Maree. He advised (Appendix 11) that Dr Maree's technique was highly unusual and inappropriate, as it would increase the risk of trauma to the patient without improving the

prospect for successful intubation.

At interview, Dr Maree (Witness 37) confirmed the technique he outlined. He was asked if he was aware of Dr Ahmed's experience in anaesthetics, he indicated that he did not know. He was asked how he had come to the conclusion that Dr Ahmed was not comfortable performing the intubation by nasal means and that he believed that this would have been the most appropriate approach in the circumstances.

Dr Maree was asked if he was aware of what drugs had been drawn up for the patient's induction. He indicated that he did not know. He was advised of comments provided by Drs Callanan and Simpson and offered no comment.

Dr Maree was asked what means he would use to ensure that the tube was placed correctly. He reinforced the information provided in his statement. He was asked whether he was aware of any other means of confirmation of correct tube placement. He indicated that the "capnograph" could be useful. He was asked to draw a capnograph tracing and detail its parameters. Dr Maree drew a diagram (Appendix 12) and indicated that the capnograph showed the oxygen levels in the endotracheal tube. After some consideration, Dr Maree appeared to become agitated and requested a short break. Following this break, Dr Maree changed his mind and stated that the capnograph demonstrated the total gas pressure in the endotracheal tube.

Dr Maree was asked if he was aware whether the monitoring equipment demonstrated a trace for carbon dioxide levels. He advised that the equipment did not show such a trace, and that it showed only a numerical value for the CO2. Dr Maree was asked if he understood the significance of CO2 and he indicated that Dr Simpson had advised him that return of CO2 indicated that the tube was in the correct place.

Dr Maree was shown drawings of capnograph tracings provided by Dr Simpson (Appendix 13) demonstrating the different traces expected in different clinical settings, including oesophageal intubation and anaphylaxis. Dr Maree offered no comment.

Dr Maree was later asked to demonstrate the anaesthetic monitoring equipment. He was shown the trace for CO2 on the monitor and indicated that he had been unaware of the significance of that trace.

Dr Maree's conduct of routine, non-emergency anaesthesia is of grave concern. It is clear that he did not have an adequate understanding of the function of the anaesthetic machine and monitoring equipment. He did not know how to operate the ventilator and clearly had no knowledge of one of the most important safety features of the anaesthetic monitoring system. To proceed to perform elective anaesthesia with this unacceptable level of knowledge of the machine raises serious questions about clinical judgement, professional ethics and lack of concern for patient safety.

Dr Maree's behaviour in taking over the induction of anaesthetic and intubation of the patient in this case was inappropriate and misconceived at best, exceedingly inappropriate, unprofessional and possibly dangerous at worst.

General Medicine

Apart from the cases of concern identified earlier, in Allegation 7, Dr Maree's management of a patient admitted with diabetic ketoacidosis was also raised with Investigation Officers by Ms Elspeth MacDonald (Witness 2).

P93 was admitted under the care of Dr Maree on 30 November 2000 after Dr Maree was contacted by nursing staff at around 0700. Dr Maree states (Witness 37) that he was at home when he was called by RN Chris Butler, who advised him that the patient had a blood sugar level of 28. Dr Maree states that he offered to attend straight away and was advised by the RN to have his breakfast and a shower before attending. Dr Maree states that he arrived shortly before the ward round at 0800 and assessed the patient, whom he found to be in diabetic ketoacidosis. He states that he commenced therapy as recommended in the RACGP guidelines.

Ms Butler in her interview (Witness 23) stated

That P93 attended to the Charters Towers Hospital and came in through the Extended Care Unit for assessment. She states that she was on duty at approximately 7:00 am when he attended and that her initial assessment was that his blood sugar level was approximately 28 mmol, which she considered to be extremely high. She states that she contacted Dr Maree and that he gave a phone order for ten units of actrapid subcutaneously at approximately 7:05 am.

Ms Butler indicated that she believed that Dr Maree did not come and see the patient until 8:00 am. She states that by that stage she had established intravenous access and that she had normal saline running to maintain the line.

Ms Butler indicated that she was concerned about this patient, as she believed that his diabetes mellitus was out of control following a drinking binge and that his sugars were "sky high". When Dr Maree attended Ms Butler states that she arranged for Bev Guy the diabetic nurse, who happened to be passing by, to speak to Dr Maree regarding the appropriate treatment regime.

Ms Butler stated that Bev Guy showed Dr Maree the protocols for treatment and that Dr Maree appeared to be prepared to listen but still went on with his own "train of thought".

Ms Butler states that Dr Maree wrote up an order for therapy including one litre of normal saline, 20 mmol of potassium chloride added, to be run intravenously over two hours and a syringe driver with ten units of actrapid in 10 mls, being run at the rate of seven units of actrapid per hour.

Ms Butler indicated that she was deeply concerned by this order as she believed the rapid infusion of potassium chloride may prove dangerous to the patient. She states that Dr Maree proceeded to go out to Mosman Hall and that she contacted Dr Ahmed to come and review the patient.

Ms Butler states that Dr Ahmed changed the orders as he was concerned with the inadequacy of the insulin dose and the delivery of potassium chloride and that Dr Ahmed wrote up a sliding scale of insulin therapy.

Ms Butler indicated that she believed the patient was in a critical condition, that he was responsive but lethargic, the potassium was very high and such a patient would normally be managed in an intensive care environment. She expressed concern that Dr Maree was relying on a finger prick

blood sugar level with no arterial blood gas measures in his management of the patient. Ms Butler stated the patient was normally managed on twenty units of protophane nocte and twenty units of actrapid tds.

Ms Bev Guy (Witness 25) confirmed that she had provided Dr Maree with guidelines for the care of Diabetic Ketoacidosis and provided a copy of those guidelines (Appendix 14)

Dr Maree acknowledged at interview (Witness 37) that the guidelines were received and that he had commenced therapy in accordance with those guidelines. When shown the guidelines, he contradicted himself by admitting in fact that he did not follow them. Dr Maree was asked if he had ascertained the patient's potassium level before commencing therapy, he indicated that he did not. He acknowledged that the potassium, when recorded did prove to be high. Dr Maree continued to defend his treatment orders for the patient however acknowledged that he had not attended for close to one hour after the initial phone call and had left the patient before the assessment was completed. He acknowledged that the patient represented a medical emergency and acknowledged that he had ordered therapy for the patient before completing the assessment of the condition.

The Investigation Officers have grave concerns that Dr Maree did not recognise the seriousness of this life threatening condition and had ordered commencement of therapy, which could very easily have resulted in a fatal outcome, without adequately assessing the patient. There is a very clear concern that Dr Maree endangered the life of a critical patient, firstly by his lack of urgent response, secondly by his incomplete assessment and commencement of inappropriate therapy.

4.3.10 Allegation 10

Dr Maree misled the interview panel during his selection process.

Findings

There is insufficient evidence to suggest that Dr Maree intentionally misled the interview panel during his selection process.

Reasons for Findings

Dr Row in his interview (Witness 1) stated:

That he had been involved in the appointment process for Dr Maree and that he developed concerns at the time of the interview, which was conducted over the telephone. Dr Row recalls having made a comment to Mr Peter Sladden, District Manager that this was an issue of "a bit of a pig in a poke". By this Dr Row indicated he meant they were taking a "bit of a risk" with this appointment.

Dr Row indicated that some South African doctors appear to have enormous experience in a short time of post graduation but observed that he believed that Dr Maree did not appear to have that much training from his Curriculum Vitae. Dr Row indicated that he believed that the experience that Dr Maree had had at the mine medical Centre appeared to be nebulous. He stated that he had spoken to one referee who was a doctor and that he could not recall which doctor.

Dr Row recalls that the doctor that gave the reference gave no specific details about Dr Maree's experience but stated that he was "very good at everything". Dr Row states that the referee did not elaborate and provided no evidence of the numbers of patients treated that would support that statement.

Mr Sladden advised in his interview (Witness 15) that:
He had no concerns about the accuracy of the information presented until the issues were raised in Dr Row's letter.

Mr Sladden stated that after receipt of Dr Row's letter he was disappointed and angry and had some concerns that the references obtained from South Africa may be inaccurate. He indicated that in subsequent discussions he had developed some concerns that there may be some substance to the allegations.

The Curriculum Vitae provided by Dr Maree made it difficult to quantify his level of experience, particularly in the procedural fields of obstetrics and anaesthetics. The interview panel had written evidence that Dr Maree had served one year as a "houseman" in the fields of Internal Medicine, General Surgery, Obstetrics and Gynaecology and Paediatrics and then had a range of locum jobs in a variety of hospitals.

In his written statement (Appendix 4) Dr Maree indicated he had only performed 4 caesarean sections in the last 4 years, but prior to this had performed up to 65 Caesareans without assistance. He claims that he requested assistance in performing the first few Caesareans at Charters Towers during the course of his telephone interview. The Investigation Officers have been unable to confirm this in discussion with Mr Sladden or Dr Row.

Dr Maree's level of anaesthetic experience was confirmed by his referee, Dr Stander (Witness 33).

Whilst there is no evidence he deliberately misled the interview panel, it is difficult to obtain hard evidence [eg theatre records, log books etc] to support Dr Maree's claimed level of experience.

4.3.11 Allegation 11

Dr Maree may have acted incompetently in a fatal event in operating theatres on 17 December 2000.

Findings

1. **Dr Maree agreed to perform a semi-elective anaesthetic on a Sunday evening on a patient who presented significant anaesthetic risk, without adequate knowledge of the anaesthetic equipment, the monitoring equipment and drug dosages.**
2. **He was unaware of basic safety features of the monitoring equipment, which may have assisted him in saving the life of a patient.**
3. **There is significant evidence to suggest that Dr Maree did not recognise the development of critical problems with the delivery of the anaesthetic until prompted by other staff.**

4. **There is significant evidence that Dr Maree failed to appreciate the significance of critical parameters conveyed by the monitoring equipment, and failed to trust the equipment to deliver accurate information.**
5. **Dr Maree, after realising the seriousness of the situation, administered paralysing medication that could have contributed to the fatal outcome for the patient.**
6. **Before commencing the delivery of the anaesthetic, Dr Maree was aware that he was not sufficiently familiar with aspects of the anaesthetic equipment and had not taken steps to familiarise himself with that equipment.**

Reasons for Findings

In attempting to understand the events and sequence in an emergency setting, the Investigation Officers undertook interviews with all personnel present in the theatres at the time of the fatal event. The Investigation Officers were specific in advising staff that they were not seeking to establish a cause of death, as that was a matter for the Coroner, rather, that they were seeking to identify any competence issues on the part of Dr Maree. Each was asked to provide their own recollection of events. Dr Maree declined to discuss the case beyond the responses he had provided in his written statement. Rather than impart interpretation on statements in such a serious issue, the Investigation Officers include below significant excerpts from the records of interview of the witnesses present at the time of the fatal event.

Dr Maree's written statement (Appendix 4) offers the following:

The event refers to a case that is currently awaiting a ***Coroner's investigation.*** *As such I have not had insight into the file and will only comment on the two allegations by Dr Row, pertaining to the case.*

Firstly referring to the ***anaesthetic record*** *not being available from the machine. Dr Scott Simpson is a Consultant Anaesthetist employed at Townsville General Hospital. He was phoned very early during the case and it was on his advice that the patient was disconnected from the anaesthetic machine to exclude the possibility that any malfunction occurred with the machine. When* ***switching off the machine,*** *the memory from the machine was also cleared and therefore a print out could not be obtained. Very accurate manual records are available and were made by* ***Mr Peter Kelly,*** *a Registered Nurse. Mr Kelly was asked to come to theatre very early during the procedure and was asked not to assist in the case but simply keep minute-by-minute notes of what happened. His notes are filed in the patient file.*

Secondly: *Second hand information indicates that I indicated the* ***"sats are wrong".*** *Early during the procedure I asked for a second portable saturation monitor to be brought to theatre to verify the accuracy of the anaesthetic record. If I did not believe the saturation monitor I would not have gone to the trouble to verify the reading from a second independent machine. Again I point to* ***Dr Simpson's advice*** *that any equipment malfunction must be ruled out. Even before this advice from Dr Simpson the second machine was already brought to theatre to verify accuracy and exclude any equipment malfunction. This is a* ***standard procedure*** *to follow in an emergency.*

Dr Manderson (Witness 5) indicated:

that he was contacted at approximately 18.15 hours on the 17th December 2000 by theatre nurse Bev

who stated that "there was a problem with a patient dropping sats". Dr Manderson indicated that he grabbed his stethoscope and ran from his house, which was only a short way from the operating theatre complex. Dr Manderson stated that when he arrived he found Dr Maree mouth breathing through the endotracheal tube. Dr Manderson states that he asked Dr Maree "what happened" and Dr Maree responded "that he believed there had been a reaction to anaesthetic drugs". When asked why he was mouth breathing Dr Maree indicated that he was unable to obtain enough pressure in the circuit to ventilate using the black bag. Dr Maree indicated that there may be an anaphylactic reaction to anaesthetic agents and indicated that he had checked both the airway and the tube. Dr Maree had stated that the patient had "crashed" on induction.

Dr Manderson states that he then proceeded to ring the Anaesthetists at Townsville General Hospital, he noted that the saturation on the oxygen monitor at that time were approximately 55-60% and that the patient appeared mottled.

Dr Manderson stated that as there was no telephone in the operating theatre he proceeded outside and contacted Dr Scott Simpson, Consultant Anaesthetist at Townsville General Hospital. Dr Manderson indicated that he assumed that the patient had cardiac output at this stage as the pulse oxymeter was still measuring oxygen saturation and the staff were not performing cardiac pulmonary resuscitation. Dr Manderson indicated that he believed the patient was bradycardic however he stated that he believed it was "not as low as 30 or 40 beats" per minute. Dr Manderson noted that the blood pressure cuff was not inflating and that all monitors appeared to be working. Dr Manderson states that he discussed the situation with Dr Scott Simpson who then ran through the drugs that the patient had been given. Dr Simpson's advice that it sounded like it may be an anaphylactic reaction; he then asked Dr Manderson if the patient had any urticaria. When Dr Manderson relayed this question to Dr Maree, he replied that the patient did not have urticaria.

Dr Manderson states that Dr Simpson asked if the patient had pneumothorax and advised to insert to needles into the second intercostal space. Dr Manderson stated that around this time the patient went into asystole and Dr Simpson advised him to go in and help commence cardiopulmonary resuscitation.

A portable telephone was obtained around that time and taken into the operating theatres, Dr Manderson states that Dr Simpson had advised the patient be given Atropine and Adrenaline. Dr Manderson states that the endotracheal tube was changed at least five to ten minutes into the management of the arrest. After the change the endotracheal tube Dr Manderson stated that Dr Maree had observed that "she seems to be becoming easier to ventilate". Dr Manderson noted that there appeared to be some improvement in the patient's colour at this point.

At this point in the interview Dr Manderson stated that he would be requesting a copy of the tape and stated that he was trying to hold a neutral ground on the issues

Dr Manderson stated that he had alternated between cardiopulmonary resuscitation and "bagging" the patient with Dr Maree and that through the arrest they had managed periods of ventricular tachycardiac and ventricular fibrillation as well as bradycardia. Dr Manderson indicated that he felt that the arrest was well managed.

Dr Manderson was asked if he had observed at any stage the endotracheal CO_2 reading on the monitor and Dr Manderson was unaware of such a reading was noted.

Dr Manderson was further asked about the state of the monitors at the end of the resuscitation

attempt. Dr Manderson indicated that as he and Dr Maree were leaving the alarms were ringing still on the monitors and he asked Dr Maree whether the alarms should be turned off.

Dr Manderson states that he understood from Dr Maree's response that the monitors should be turned off and he proceeded to do so.

Dr Simpson (Witness 10)

Dr Simpson was asked to review the notes taken by Dr Maree immediately following the events of 17th December 2000, the record of interview with Dr Manderson and Dr Simpson's own notes of his telephone conversation during the course of the arrest.

Dr Simpson observed that there were a lot of inconsistencies between the times recorded on the various methods of reporting. He observed that there appeared to be some inconsistencies between his recollections of the time, his conversation with Dr Maree during and after the arrest and with the record from Dr Manderson. Dr Simpson indicated that such a degree of inconsistency could easily be explained by the nature of events in a cardiac arrest. However, certain aspects did not seem to be gelling for Dr Simpson.

Dr Simpson stated that he retained his belief that there were four possible causes for difficulty in ventilating the patient as observed in the situation of P94 *. He stated that the first consideration would be whether the endotracheal tube was in the correct place, if that was in the correct place then he would seek to exclude:*

- *a problem with the patient;*
- *a blocked endotracheal tube; or*
- *an equipment problem*

and he stated he gave advice to this effect during the course of the arrest.

Dr Simpson was asked what indicators there would be with a correctly placed tube. He stated that he would expect in normal circumstances that an anaesthetist would identify visibly that the endotracheal tube was in the correct place by direct laryngoscopy and that they would observe the pattern of end-tidal CO_2 on the monitoring system.

Dr Simpson explained that the end-tidal CO_2 monitor would show an immediate return of carbon dioxide in the case of a normal intubation. In the case of anaphylaxis there will be some diminution of the carbondioxide response, with a good response immediately diminishing over time. In oesophageal intubation he stated there would only be an initial blip as carbondioxide came out of the stomach however, after that there would be no carbondioxide response. He stated that this was a very good indicator of whether oesophageal intubation had been performed or whether the intubation was in fact successfully in the trachea

Dr Simpson stated that he had asked immediately on being called whether the tube was in the correct place and was advised that there was good air entry, which indicated to him that the tube must have been placed appropriately at the time. He therefore proceeded to guide Dr Maree and Dr Manderson through an assessment of the patient and the equipment to ensure that all appropriate steps were taken.

Dr Simpson advised that all anaesthetists are trained in "failed intubation drill" whereby each intubation should be approached with due caution and if you were expecting difficulty with an intubation, short acting agents would be used to allow possibility of reversal and "bail out". Dr

Simpson stated that if intubation was successful and ventilation was failed then a further drill was required to identify the potential issues that may correspond to that situation. He stated that he would expect an anaesthetist to work systematically through excluding possibility of a blocked tube patient problem or an equipment problem.

On reviewing the notes Dr Simpson stated that his understanding of the case is now somewhat confused as the fact of the change of the endotracheal tube had not been made known to him at the time of the first contact nor the use of Adrenaline in the early resuscitation attempts.

He stated that if the patient was suffering from anaphylaxis that the Adrenaline should have had an immediate affect in improving the situation.

Dr Simpson indicated that in a subsequent telephone call with Dr Maree at approximately 9.30 on 17th December 2000 (initiated by Dr Simpson to see how Dr Maree was coping), Dr Maree had indicated that the endotracheal tube had been changed some 10-15 minutes into the incident. Dr Maree was asked whether he had observed if any carbondioxide had come back up the tube. Dr Maree appeared not to be able to answer the question and responded that the oxygen had shown as 100% inspired and 97% expired oxygen. Dr Simpson stated that at that time doubted that Dr Maree had understood the question.

Dr Simpson observed that much of the events of the incident had occurred prior to the telephone call to him and he stated that approximately 30 minutes had elapsed before his contact.

Dr Simpson proceeded to state that he believed at the time of the cardiac arrest when he was in discussion with Dr Manderson and Dr Maree, that the arrest appeared to have been well managed. Dr Maree appeared to be cool and calm and to have responded appropriately to advice. He observed that many of the discrepancies that he has seen in the timings are explainable however he stated that he has concerns about what he was not told at the time of the initial telephone call. This was with regard to the endotracheal tube and the use of Adrenaline. He expressed further "grave concerns" over the use of vecuronium apparently shortly after induction. Dr Maree advised Dr Simpson that he gave a dose of vecuronium shortly after the induction of anaesthesia as he had found the patient difficult to ventilate. Dr Simpson stated that this went against the standard anaesthetic view that "if you can't ventilate - don't paralyse".

Dr Simpson stated that he could not understand the timing of the vecuronium, that it did not make sense to him to use the drug on induction in combination with suxamethonium, as recorded in Dr Maree's notes, nor in the dosage that it was used. He further stated that the use of neostigmine five minutes subsequently would not have any effect on the vecuronium and would not have assisted in reversing the paralysis.

Dr Simpson stated that he had had a meeting with Dr Maree on Thursday 21st December 2000 at Dr Maree's request when he came down to Townsville. He stated that it appeared that Dr Maree had been trying to come to terms with the complaints that had been made against him as well as the anaesthetic death.

Ms Wade (Witness 16)

Ms Wade identified that she had been working in the wards as a Level I Registered Nurse on Sunday 17 December 2000. She stated she had received a phone call from Dr Izak Maree who indicated that he would be doing a dental extraction at 17:30 hours and had requested that she make

arrangements for that to be done. She stated that the ward was quiet and that they had enough staff to allow for two Registered Nurses to attend in operating theatres without calling any additional staff. She stated that Bobby Chandler had helped her set up and that patient P94 had arrived with a badly swollen face at approximately 5:00pm. P94 appeared apprehensive and frightened and Ms Wade and Bobby Chandler had prepared her for operating theatres.

Ms Wade stated that she went in to theatres to set them up for the operation and got the patient onto the table. She stated that a nasal intubation was anticipated and she got the equipment for that intubation. Ms Wade indicated that she and Dr Maree had spent a few minutes checking the anaesthetic machine, as Dr Maree had been concerned about possibility of leaks. She stated that the machine appeared to check out normally.

Dr Maree than gave a verbal walk through of the procedure that he was expecting to follow. He established intravenous access and the patient was pre-oxygenated on 100% oxygen. Ms Wade stated that she was certain the oxygen was on as she had checked it herself, having had a previous incident where the oxygen had had been turned on. Ms Wade stated that the pre-oxygenation was in place for "a good couple of minutes".

Ms Wade stated that the intubation went normally and that the "tube went in fine". She subsequently noted that the oxygen sats where dropping, initially to 86% and then subsequently to approximately 65%. Ms Wade stated that she felt the chest did not appear to be rising and her initial response was "Oh my God what have you done?"

Ms Wade stated that she had checked the air entry and had established that she could hear the "whoosh of air going in". She stated that she had looked at the stomach underneath the sheets to see if the stomach was rising and had identified that it had not been. Ms Wade stated that the patient had then become "twitchy" and Dr Maree had told her to "give Vecuronium". Ms Wade stated that she had been used to anaesthetic drugs having being drawn up prior to the anaesthetic as this had been Dr Ahmed's practice, however the medications in this case had not been drawn up previously and that she had been required to draw up the vecuronium. She states that Dr Maree had not indicated to her what dose of vecuronium to give, simply to give an ample. She noted that she gave 4 mgs and at the time of the administration of the vecuronium, she appeared to be pale and was become peripherally cyanosed. After the vecuronium, Ms Wade stated the patient became bradycardic and she was ordered to give atropine.

Ms Wade stated that at some stage during the events that Dr Maree had requested another pulse oxymeter, as he did not believe the oxygen saturation readings and that he doubted whether the anaesthetic machine was working appropriately.

Ms Wade indicated that at some stage Dr Maree had indicated to Dr Lingard that he was happy for him to go ahead with the procedure and then subsequently changed his mind. She stated that Dr Maree had attempted to hook the patient up to the ventilator and had "hand bagged" the patient but neither of these helped with the ventilation. Subsequently he attempted to do mouth to tube breathing and she stated that she could see the chest partially rise. She was not aware whether air was coming back out of the tube and felt that it was similar to an asthmatic case where you could get air in but no air would come out.

Ms Wade indicated that Bobby Chandler had asked if there was any possibility whether this might be an allergic response. Dr Maree had initially indicated that he did not believe that this was the case, however after attempting mouth to tube ventilation, he indicated that he did believe it was possibly

an allergic response, subsequently hydrocortisone was given. Ms Wade indicated that Dr Maree was asked whether he needed any help and he responded in the negative, appearing confident that he was in control of the situation.

Ms Wade states that she initiated of her own volition for a staff member to collect an air viva and to press the buzzer three times. She recalls having asked Dr Maree whether he wanted Dr Manderson to attend and advised that Dr Maree had indicated that he did not wish for Dr Manderson to attend. Ms Wade recalls having ask Dr Maree if he wanted to change the endotracheal tube and his response was initially 'no'.

Ms Wade states the endotracheal tube was changed around 18.15 hours at the time contact was established by Dr Manderson with Townsville General Hospital. She does not recall any change in the patient's condition at the point of the change of the tube however she thought the colour picked up.

Ms Wade stated that she believed that Dr Maree had "done all that he could do and managed as well as he could in the circumstances". Ms Wade stated that she did not believe that additional help could have assisted in a major way.

Ms Wade indicated that she did have some concerns about the management of the case. She was concerned that not all the drugs were drawn up prior to the case and that the monitor had been set on manual so there was one blood pressure recording conducted throughout the case. She further indicated some concerns that the anaesthetic machine had been turned off at the end of the resuscitation.

Mr Kelly (Witness 17)

Mr Kelly stated that he was one of the three (3) Registered Nurses on duty on that evening shift on 17 December 2000. He stated that he was covering the Outpatients area and had been attending Outpatients when P94 *came in for admission for her tooth extraction. Mr Kelly stated that the extraction had been booked for 5.00 – 5.30p.m. and that he was on the Ward when the staff were admitting the patient. He recalls that* P94 *had a "needle phobia", and that her defacto was in attendance with her. Mr Kelly stated that he had helped transfer* P94 *to the Operating Theatre and had advised the defacto that the procedure would take in the order of three-quarters of an hour to an hour.*

Mr Kelly states that in his recollection around 1745 hours he was attending a patient on the ground floor when he heard three rings on the patient call system which he interpreted as an emergency call. He stated that he saw from the annunciator panel that the call had come from Operating Theatre, and that when he attended the Operating Theatre he could see that there was some form of resuscitation ongoing. He arranged for another Registered Nurse to attend straight away and ran into the Theatre. He states that he saw P94 *was quite cyanosed and mottled, and saw that a Registered Nurse was drawing up adrenaline.*

He states that he interpreted that the anaesthetic drugs had been given only in the last three to four minutes and noted that a naso-tracheal tube was in place. Mr Kelly states that he assisted in getting drugs for the resuscitation and stated that "drugs were going everywhere", and that his role was partly to record the drugs that were used. Mr Kelly states that he remembers looking at the screen off the anaesthetic monitor and saw that the oxygen saturations were dropping into the low eighty percent range. He states that he did not notice carbon dioxide or the pulse rate.

Mr Kelly observed that Dr Maree appeared to be well in control of the situation and that in his understanding the arrest had been well run. He stated that Dr Maree appeared to be stunned by the events that had been happening.

Dr Lingard (Witness 19)

Dr Lingard indicated that P94 *had been a Townsville resident with her parents living in Charters Towers. Dr Lingard observed that* P94 *had been very apprehensive with her dental treatments and had some bad dental experiences in the past. He stated that he had not treated her very often, however had performed one previous extraction, which had resulted in a "dry socket" and that she had previous problems with other dentists.*

Dr Lingard stated that in the course of the dental illness leading to her treatment at Charters Towers Hospital he had seen P94 *on the Wednesday the 13 December 2000 when she presented with a severe toothache in her upper right eye tooth. Dr Lingard stated that he had removed the pulp from that tooth under nitrous oxide and local analgesia. He stated there was no great evidence of infection at the time and he applied an antibiotic dressing. On the 15 December he was advised that the patient had facial swelling to the level of the eye and was back in Townsville. He asked* P94 *to see a general medical officer in Townsville and obtain some erythromycin which on his advice, she did, and commenced a course of treatment at 11:00 am.*

On Saturday 16 December, Dr Lingard had a call from the patients fiance stating that she had been to the hospital overnight requiring an injection for pain and the pain had returned that morning and it was severe with significant swelling. They agreed to return to Charters Towers and was seen by Dr Lingard at approximately 3.00 PM.

Dr Lingard had hoped that some drainage might be possible from the infected area and he reopened the canal. He stated that there was no relief for pain and no exudate and so he attempted to file through the apex of the tooth. He stated that there was no immediate relief for pain and there was no exudate and although the patient was better for a few minutes the pain returned and there was no improvement on subsequent attempts.

Dr Lingard observed that there was no specialist endodontist in Charters Towers or Townsville and he attempted to contact Dr Anthony Oliver, an oral surgeon in Townsville. After two and half hours of work on the tooth he had believed that he had done all that was possible and had decided on another day on antibiotics.

Dr Oliver was not immediately available however called back later on that evening. Dr Lingard advised Dr Oliver that the patient had expressed the view that she couldn't live with the pain. Dr Olivier suggested that this was probably just a simple expression of how she was feeling and the most appropriate antibiotic in these sort of situations might be clindamycin. Dr Lingard said that he had to drive down to Townsville on the Sunday 17 December and a message had been left for him on his home answering machine from the father of the patient stating that she was in severe pain. She was subsequently bought into Charters Towers Hospital at approximately 2:00 PM for another injection for the pain.

When Dr Lingard phoned the family at approximately 3:00 PM the patient was sleeping. He attempted to get in contact with Chemists to see if he could find clindamycin and made inquiries about the availability of general anaesthetic. He stated that Dr Manderson was on call and advised

that Dr Maree may be available after 5:00 PM. Subsequently Dr Maree contacted Dr Lingard and Dr Lingard explained the situation to him.

Dr Maree was provided with some medical history that the patient was allergic to penicillin and had a history of asthma and bronchitis. Dr Lingard said he saw the patient subsequently at approximately 4:00 PM and the pain had returned at that stage. He canvassed the option of the extraction of the tooth under a general anaesthetic with the family and stated the swelling had not improved as he was anticipating a difficult extraction.

The arrangements were made for an extraction under general anaesthetic. Dr Lingard subsequently attended the hospital and took some instrumentation with him into the operating theatres. He states that he was pleased to observe that Dr Maree was planning on doing a nasal intubation as this made the procedure easier for him from a dental viewpoint.

Dr Lingard indicated that it was apparent that things were not going right from an early stage of the case and he observed that at one stage the patient went through some involuntary jerking. He stated that Dr Maree had made a comment about it being "a time of turbulence". He stated that Dr Maree had indicated that the monitors were not getting good readings at one stage and that Dr Maree had asked if Dr Lingard was aware whether the patient was a heavy smoker as he believed that she had poor circulation. Dr Lingard observed there appeared to be lots of checking of machinery and the patient going on and that the patients colour had looked reasonable to him, initially, and that there were significant concerns expressed before the patients colour started to go off. Dr Lingard recalls a comment at one stage that "the lips are not blue".

Dr Lingard offered his observation that there seemed to be "good teamwork" with Dr Maree issuing directions that were clear and the staff responding quickly and effectively. He stated that although there was a heightened level of concern no one appeared to "lose their cool". Dr Lingard observed that at the debriefing session the most likely cause of the problem was identified as an allergic response to an agent used in the administration of the anaesthetic.

Dr Lingard states that initially Dr Maree and Dr Manderson had been to see the father and the fiance and that he had attended sometime later speaking to the father, fiance and mother. He states that the fiance appeared to be speechless and upset and the father and mother were not angry, they were amenable to talking and appeared to have some concerns about P94 *'s children from an earlier relationship and there was apparently some concern about a custody situation.*

Dr Lingard stated he attended the funeral and that Dr Maree had also been in attendance with his wife. Dr Lingard indicated he had never previously met Dr Maree and that he had been enormously appreciative of his availability to assist with an emergency anaesthetic.

Ms Chandler (Witness 26)

Ms Chandler identified that she was rostered on duty for the ward areas on the 17 December 2000 when P94 *attended for surgery. She went to prepare the theatres with Registered Nurse Andrea Wade. Ms Chandler observed that in the course of the anaesthetic, she noticed the cannula was inserted and the anaesthetic was given and the patient was moaning a lot, as she was pre-oxygenated.*

When the patient was intubated, Ms Chandler noted the oxygen saturation appeared to be dropping very quickly. She stated they went from the mid 90% range down to 88% very quickly. She stated

that she pointed this fact out to Dr Maree who appeared to believe there was a problem with the pulse oxymeter. His indicated his concern that the finger probe may be faulty and he asked for a portable pulse oxymeter from the ward area.

Ms Chandler stated that she observed Dr Maree indicate to the Dentist, Dr John Lingard that it was appropriate for him to proceed with the surgery and she noted at the time that she did not believe it was appropriate to commence. She noted as the saturations continued to drop, he advised Dr Lingard it was inappropriate to proceed with the case.

When Ms Chandler went to obtain a portable pulse oxymeter she recalls returning to the operating theatre to see P94 *'s colour "was terrible". She noted that the patient's nail beds were blue and that the limbs appeared to be reddish colour. She stated there was no reading obtainable on the portable pulse oxymeter and the lowest reading that she recalls having seen on the monitor, was approximately 56% oxygen saturation.*

Ms Chandler observed that during the induction phase and the establishment of ventilation through the endotracheal tube, Dr Maree made comments as if he was an airline Captain.

Ms Chandler states that she had been advised by the other staff that this is his usual practice prior to the cas. However she was surprised when she heard him say words to the effect of "this is your Captain speaking we are cruising at something thousand feet, we are now experiencing some turbulence". She expressed that she thought at the time that this might be some sense of bravado.

Ms Chandler stated that after the intubation, Registered Nurse Andrea Wade had obtained the stethoscope and listened to the patient's chest to establish that she was satisfied that there was appropriate air entry on both sides. Ms Chandler stated that the management of the situation was under control and when she asked if Dr Maree would like for her to call Dr Manderson, that Dr Maree response was "no". Ms Chandler recalls thinking at the time that she hoped that his pride did not override his judgement in this decision.

Ms Chandler recalls asking Dr Maree whether the patient may be reacting to the anaesthetic. She recalls that Dr Maree indicated that "he did not believe so". Sometime after Dr Maree had indicated that he did not wish for Dr Manderson to attend, she recalls Registered Nurse Andrea Wade asking her to ring the buzzer three times to summon assistance.

Ms Chandler recalls having been asked to perform a twelve lead ECG and put up an intravenous infusion, as well as assisting Registered Nurse Wade in checking vecuronium, neostigmine and adrenaline (which Nurse Wade had drawn up).

Dr Vic Callanan (Witness 9)

Dr Callanan was (then) asked to review the notes of patient P94 *who had an anaesthetic for dental extraction on Sunday 17th September 2000 and subsequently died from complication of that anaesthetic.*

Dr Callanan read the record of interview from Dr Manderson, the notes written by Dr Maree the anaesthetist for the case and the notes written by Dr Scott Simpson who had been contacted that Townsville General Hospital during the course of the failed arrest.

Dr Callanan noted that there were discrepancies in timings as recorded and that some things appeared to be unclear. He noted that there was some discrepancy around when the endotracheal tube was changed and noted that this may be important, particularly if the original tube had been placed in the oesophagus.

He indicated from the reading of the notes that essentially there were three possibilities that needed to be considered with the difficulty in ventilating the patient, those being: obstructed endotracheal tube; anaphylaxis; and an oesophageal intubation.

Dr Callanan indicated that the induction with Propofol, scoline and vecuronium appeared slightly unusual and stated that the dose of neostigmine five minutes into the anaesthetic was unlikely to have any desired effects. He stated that the dose of Propofol was adequate for induction however was concerned with the dosage of vecuronium. He was unsure as to why that would be given at induction and if given why such a small dose would be given. He stated that the dose that was recorded as 3/4mg (the original recording being 3mg which had been subsequently changed to 4mg). This indicated a very small dose. He stated that if the vecuronium, which is a muscle relaxant, had been given to prevent muscle pain from the scoline dosage, then too much had been given. However, if it was being used for paralysis then too little had been given. Dr Callanan could not identify why neostigmine would have been given in this patient.

Dr Callanan was asked if there was any way that people could be mislead into believing that there was air entry on auscultation. He stated that on occasions, ventilating the oesophagus can provide the sound of air going into the stomach which in some patients can be mistaken for appropriate air entry.

Dr Callanan expressed a concern that the endotracheal tube had not been changed until after the commencement of the cardiac arrest. He stated that:

- *there should have been some observation of the end tidal carbondioxide tracing after the first few breaths that the patient had taken;*
- *there should have been a plan developed for what to do if there was difficulty with ventilation;*
- *this would include checking the machine and changing the endotracheal tube;*
- *this is basic anaesthetic practice and people should not be performing anaesthetics if they were not aware of that fact;*
- *by looking at the expired carbondioxide a very clear picture of what had happened with the intubation would have been established*
- *with a normal intubation there would be a pattern of expired carbondioxide that would clearly indicate the position of the tube was in the appropriate place.*

Dr Callanan suggested a number of questions to seek answers to:

1. *Was the patient pre-oxygenated and if so for how long*
2. *Was the patient cyanosed when air entry was confirmed by nursing staff and at what stage was air entry confirmed in the anaesthetic?*
3. *Was air entry confirmed at the time of intubation of the patient*
4. *Was there air coming back out of the endotracheal tube*
5. *Was the stomach visibly distending on the patient*
6. *Was the end-tidal carbon dioxide tracing observed at any stage*
7. *Was the patient difficult to ventilate from the first breath*
8. *Was a pre-anaesthetic assessment performed?*

Dr Callanan further indicated his concern at Dr Maree mouth breathing down the endotracheal tube. He could only foresee circumstances for mouth breathing where either there was no self-inflating bag available for the anaesthetist or where the anaesthetic circuit was faulty.

Dr Callanan indicated that he was not concerned about the patient selection for anaesthesia in this case and indicated further that he had concerns that a mast cell tryptase test had not been taken immediately following the patient's death, which could have determined the presence or absence of anaphylaxis.

Following from the interviews with witnesses and evidence previously provided by Dr Maree (Witness 37), the Investigation Officers requested the Dr Maree provide a practical demonstration of the anaesthetic equipment in order to gain some insight into Dr Maree's technical ability in performing anaesthetics. This was used partly in considering Allegation 9, and in determining issues in Allegation 11. The investigators were mindful of the anxiety associated with doing such a demonstration during an investigation following the death of a patient, but maintain that all doctors performing anaesthetics should have a set routine that is consistent and safe. The following observations were made:

1. Demonstrate the routine for checking the anaesthetic machine.
   - He performed this in a very disorganised and clumsy fashion
   - He had a problem activating the nitrous oxide flow meter. It was only after a number of attempts that he recalled the oxygen flow needed to be activated first as a safety measure to avoid hypoxia in the patient.
   - He was asked had he completed his check of the anaesthetic machine and on this prompting, he recalled the sucker should be checked.
   - He was further asked was checking the soda lime part of the requirements. On this prompt, he replied "yes" and proceeded to check the soda lime.

2. He was asked to hook up the ventilator - he was then requested to increase the ventilation rate.
   - He became somewhat agitated when he was unable to show the investigators how this was done.
   - On direct questioning, he admitted, he did not know how to alter the ventilation rate.

3. He was requested to indicate what drugs would he draw up for an anaesthetic on a 100kg male having an appendicectomy. He indicated Propofol, then scoline. On asking about long acting muscle relaxant, he indicated he would use vecuronium. On questioning the dosage he would use, he said "4 mg".
   - He was given a chance to clarify the dosage, but did not.
   - The dosage was quite clearly incorrect, thus the investigators asked him for the formula he uses for calculating vecuronium; he did not answer.
   - It was clear to the investigating officers that he did not know the appropriate dosage for vecuronium.

4. He was then asked to demonstrate his knowledge of the anaesthetic monitor.
   - It was clear he had limited knowledge of the monitor.
   - The critical issue was whether he had knowledge of the carbon dioxide waveform [essential in determining if an endotracheal tube is placed correctly].
   - Prior to the demonstration in theatre, he indicated the monitor simply gave a numerical value for carbon dioxide and not a waveform.

- When he was asked to indicate what the waveform was on the last line of the monitor, he clearly did not know.
- He agreed that he was unaware of this feature of the monitor.

Summary

A 37 year old female died in the process of having a semi-elective anaesthetic.

The critical issue of the cause of death will be the subject of a coroner's investigation. From evidence provided to this investigation, it appears likely that high on the list of possible causes will be anaphylaxis or incorrect placement of the endotracheal tube.

The issue for determination by the Investigation Officers in this investigation with respect to allegation 11 is whether there is evidence that Dr Maree behaved either carelessly or incompetently in the conduct of this anaesthetic. Central to this task is both finding whether Dr Maree had the skills and knowledge to undertake a semi-elective case on a high-risk (106kg) patient, and finding whether his actions on the 17 December were demonstrably incompetent.

There is significant evidence to support the following conclusions:

- Dr Maree did not have adequate knowledge of the anaesthetic equipment at Charters Towers Hospital to safely perform routine or semi-elective anaesthesia using that equipment.
- Dr Maree is not able to describe an adequate "failed intubation drill" to provide safe anaesthesia.
- Dr Maree is not able to describe an adequate "failed ventilation drill" to provide safe anaesthesia.
- Dr Maree did not have adequate knowledge of the anaesthetic monitoring device that would enable a practitioner to accurately determine the position of the endotracheal tube and manage a patient with "failed ventilation".
- Dr Maree did not change the endotracheal tube until the patient was in the process of cardiac arrest, as would normally be expected in a failed intubation or failed ventilation situation.
- Dr Maree demonstrated inadequate knowledge of the dosage of vecuronium and used this muscle relaxant drug in an inappropriate way, which could have compromised his ability to resuscitate the patient.

It is important to note that it remains the responsibility of the attending anaesthetist to familiarise themselves with the function of the machinery and medication upon which they will rely in the performance of general anaesthesia. Dr Maree agreed with this suggestion from the Investigation Officers.

But for Dr Maree's decision to provide non-emergency anaesthesia in an situation where:
- he did not possess adequate knowledge of the anaesthetic equipment and monitoring devices to provide safe anaesthesia;
- other options for care were available; and
- his performance of the technical aspects of the anaesthetic and resuscitation was questionable;

it is highly possible that the patient would have survived.

5 DISCUSSION

Dr Row, Senior Medical Officer made 11 serious allegations against Dr Maree.

The Investigation Officers found insufficient evidence to draw adverse conclusions for the following allegations:

Allegation 1

Dr Maree is unwilling to assume clinical duties.

Allegation 2

Dr Maree misdiagnosed a patient with a perforated gut, which may have contributed to the death of a patient.

Allegation3

Dr Maree did not handle a difference of clinical opinion appropriately.

Allegation 4

Dr Maree failed to demonstrate appropriate concern over the death of a patient.

Allegation 8

Dr Maree demonstrates a lack of commitment to clinical duties, including after hours.

Allegation 10

Dr Maree misled the interview panel during his selection process.

The Investigation Officers found that there is significant evidence to support adverse findings in the following allegations:

Allegation 5

Dr Maree mismanaged a patient with a perforated eardrum and acted dishonestly with the patient's family.

Allegation 6

Dr Maree commenced patients on anti-tuberculosis treatment against Queensland Health policy and specialist advice.

Allegation 7

Dr Maree has an unacceptable level of skills in interpreting ECGs.

Allegation 9

Dr Maree is not entitled to the clinical privileges that have been granted to him.

Allegation 11

Dr Maree may have acted incompetently in a fatal event in operating theatres on 17 December 2000.

It is clear Dr Row had significant concerns to make such serious allegations. The issues surrounding Dr Maree's distribution of duties are matters that would normally be handled by the District Manager in liaison with the aggrieved parties. Throughout the course of the investigation it became clear that Dr Row has at times been noted to have a somewhat "difficult" communication style, and there is little doubt that there was some degree of personality conflict in the relationship between Dr Row and Dr Maree. The Investigation Officers acknowledge that there are some incidents and issues that have been raised by Dr Maree in his defence against the allegations that cast Dr Row in a dim light. For example, Dr Row's letter to Dr Maree prior to his departure from South Africa (Appendix 15). The Investigation Officers have not sought to extend the terms of reference of the inquiry to look into these issues, as they would appear to fall within the normal ambit of management of the District Manager.

It is clear that the Medical Superintendent of a rural facility is the key position for ensuring quality clinical practice. The appointment process and granting of clinical privileges must to be part of the one process to ensure that the appointed practitioner is capable of exercising the responsibilities incumbent in the role.

It is difficult for appointment committees to properly assess overseas doctors for key positions. The appointment of doctors under the Medical Superintendent is of less concern, as their clinical acumen is supervised and scrutinised by the Medical Superintendent, but none the less, they should still be credentialled as part of the appointment process. Where there remains any doubt as to their clinical ability, then temporary appointment could be considered, with permanency only granted following supervision and recommendation by the relevant specialist authority.

At this stage there is limited support from the major provincial centres in assisting rural hospitals with clinical training and setting acceptable guidelines/protocols. Specialty outreach visits may assist this process.

Whilst the Investigation Officers recognise the seriousness of the allegations against the individual [Dr Maree], due consideration must be given to the process of appointment, clinical privileges and supervision from the provincial centres to minimise the risk of such events being repeated.

6 CONCLUSION

The Investigation Officers conclude that:

6.1 Dr Maree is not competent to perform in unsupervised clinical practice.

6.2 Dr Maree, through negligent action may have contributed to the death of a patient under anaesthetic.

6.3 Dr Maree's experience and good references appeared adequate to have reasonable confidence in his suitability for appointment.

6.4 The appointment process of senior medical staff from overseas has numerous risks associated with establishing levels of clinical competence relative to the Australian experience.

6.5 The orientation process for Dr Maree was inadequate to identify his actual level of skills or to provide him with adequate knowledge of the Australian system for him to function independently.

6.6 The evidence that several clinicians were unaware of the provisions or existence of the policy with respect to tuberculosis management raises concerns that the process for dissemination of Queensland Health clinical policy and clinician adherence to that policy.

7 RECOMMENDATIONS

7.1 Consideration be given to commencing disciplinary action against Dr Maree.

7.2 Consideration be given to continuing Dr Maree's suspension from duty during the process of disciplinary action if such action is contemplated.

7.3 In the event that Dr Maree is returned to duty with Queensland Health, it is strongly recommended that he perform no clinical duties until recognised authorities undertake formal assessment of his skills.

7.4 It is recommended that this report be submitted to the Medical Board of Queensland for further consideration and action as deemed appropriate by that body.

7.5 It is strongly recommended that the findings under Allegation 11 be referred to the Coroner, Charters Towers District for further consideration.

7.6 Consideration be given to expediting the development of clinical networks across the Northern Zone Queensland Health in the areas of:

a) Neonatology
b) Obstetrics
c) Anaesthetics
d) Surgery

7.7 Such networks may include in their terms of reference:

a) development of common clinical protocols;
b) assistance with training and development of rural and isolated practitioners;
c) liaison visitation; and
d) direct supervision / continuing medical education on a programmed basis.

7.8 Such networks may include representation from:

a) Consumers;
b) Isolated Practitioners;
c) Rural Practitioners;
d) Practitioners from secondary referral centres; and
e) Practitioners from tertiary referral centres.

Professional representation may include personnel from a broad range of clinical disciplines.

7.9 Consideration be given to review of the appointment and clinical privileging processes for Senior Medical Staff in the Northern Zone. Specific considerations to be addressed may include :

a) Clinical Privileges considerations to be centralised into single Northern Zone Clinical Privileges Committee, appointments processes to remain the responsibility of relevant districts; and

b) Interim clinical privileges awarded to be subject to formal skill assessment by recognised authority.

7.10 Consideration be given to review of the processes for dissemination of Clinical Policy in the Northern Zone.

Dr Andrew Johnson
Executive Director of Medical Services
Townsville Health Service District
Date: 13 February 2001

Dr David Farlow
Director of Medical Services
Proserpine Hospital
Date: February 2001