Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

MR D C ANDREWS SC, Counsel Assisting
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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 2) 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BRISBANE

..DATE 22/09/2005

..DAY 9

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 10 A.M.

COMMISSIONER: Further to my intimation yesterday, I now give the following direction. I direct that any person who is concerned that I may make a finding against him or her in respect of conduct the subject of any of the Terms of Reference and who contends that, arising out of the orders of Justice Moynihan made on 2 September 2005, any witness should be recalled to give further evidence, make submissions in writing to me by 10 a.m. on Wednesday, 28 September 2005, as to 1. the witness or witnesses whom it is submitted should be recalled; 2. the substance of the evidence of that witness about which further questions should be asked; 3. a brief description of those questions; 4. the reason or reasons why it's necessary in the interests of justice to recall that witness in order to ask those questions.

This direction is given and should be complied with on the assumption that I have access to but have not yet seen the video-recording of the evidence of the following witnesses who gave evidence before Commission of Inquiry No. 1 of 2005, namely Ms Toni Hoffman, Mr Robert Messenger, Dr Peter Miach, Mr Michael Demy-Geroe, Dr Dennis Lennox, Miss Susan Huxley, Ms Linda Mulligan, and in part the evidence of Mr James O'Dempsey.

I should say also that a subpoena has issued to the relevant television station to produce the balance of the evidence which was admitted into this Inquiry from the terminated Inquiry, but I can't inform you of the result of that.

Yes, Mr Douglas?

MR DOUGLAS: Yes, thank you. Can I indicate before I call Dr Stable that the witnesses for next week, as I understand it, Commissioner, will be posted on the website this morning.

COMMISSIONER: Thank you.

MR DOUGLAS: So there will be advance notice for those who desire to know that. I call Dr Stable who is in the witness box. Could Professor Stable be sworn?

COMMISSIONER: Yes.

ROBERT LYNTON STABLE, SWORN AND EXAMINED:

MR DOUGLAS: Is your full name Robert Lynton Stable?-- It is.

You reside at an address known to the Commission?-- That's correct.

By way of occupation, you're a duly qualified medical practitioner registered in the State of Queensland?-- That's correct, as a specialist in the State of Queensland.

And, professor, apart from other roles in which you presently serve, you are the vice chancellor of Bond University?-- That's correct.

Thank you. You have a Bachelor of Medicine and a Bachelor of Surgery from the University of Queensland?-- That's correct.

Is that not so?-- Mmm hmm.

You will have to answer so the ladies can take it down?-- That's correct.

And, professor, you also hold a Masters degree in Health Planning from the University of New South Wales?-- Masters degree, yes, correct.

You were Director-General of health in Queensland from January 1996 until January 2004. Is that not correct?-- That's correct, although I was on leave for the last couple of months of that period.

Thank you. For all practical purposes you ceased as Director-General on 31 October 2003 because you took up your accumulated leave?-- Some of it, yes.

Thank you. To your knowledge, standing in your lieu as Acting Director-General thereafter for the balance of your formal tenure was Dr Buckland?-- That's correct.

During your tenure as Director-General you served three ministers of various governments. Is that not so?-- That's correct.

The current Premier, Mr Beattie, was Health Minister for a very brief period of time at the commencement of your tenure?-- Yes. I should also add actually there were five, because the Premier Borbidge was Minister when the government changed for one week and then, of course, the government changed again in '98, and Minister Beattie - then Premier Beattie was Minister again for a short period of time.

Thank you. In the main the ministers that you served during your tenure were Mr Horan who was a member of the Borbidge coalition government?-- Correct.

And Ms Edmond who was a member of the Beattie labour government?-- Correct.

Professor, you've provided a statement to the Commission. That statement is dated 16 September 2005?-- That's correct.

Is the content of that statement true and correct to the best of your knowledge and ability?-- It is.

I tender that statement, Commissioner.

COMMISSIONER: Yes, that will be Exhibit 366.

ADMITTED AND MARKED "EXHIBIT 366"

MR DOUGLAS: Professor, do you have a copy of your statement with you?-- No actually, I don't think I do.

I'll have a copy put in your hands, if I may?-- Thank you.

Professor, could I deal first with the issue of credentialling and privileging, and to assist you, that is addressed at paragraphs 77 and onwards on page 12 of your statement?-- Mmm hmm.

In paragraph 79 you give emphasis to the distinction between role delineation, credentialling and privileging respectively?-- Yes.

And it's correct to say that those three concepts require consideration at the coalface in that order, but then again cumulatively. Is that correct?-- Well yes, role delineation is obviously first, as to what that hospital is able to do, and that was first done in about 1993, I think, and then credentialling of what the specialist is in fact qualified to do, and privileging as to what they can do in that hospital where the role delineation has been determined.

When you say role delineation arose in 1993, what are you speaking of specifically in that regard by reference to that year?-- Well, that was the first year that Queensland public hospitals went through a process of trying to match what the facilities were, what the resources were, with what the capacity to do certain work was.

Did that role delineation ensue after that date on a periodic basis in order to determine that the designated role delineation from time to time ought be maintained or diminished or amplified?-- Yes. I don't recall the period of time, but it was an ongoing process as to what that hospital was delineated to perform.

Credentialling requires, I suggest, an individual practitioner's actual training and capabilities to be assessed?-- That's correct. Can I just qualify that for specialist staff - and I think one of the weaknesses that have come out of this is that it's not clear in the policy, in my reflecting on it recently, about senior medical officers. Certainly junior medical officers, it's quite clear they're not subject to credentialling. They're in training positions and under supervision. I think there is a grey area for senior medical officers which needs to be addressed.

I'll come to that. You say privileging involves a determination of what services that particular doctor or practitioner can provide at that particular hospital?-- That's correct.

So it's a matter of matching the practitioner and his capabilities to the facilities at the hospital?-- That's correct.

In the context of surgery - or a surgeon, I suggest, that process of privileging would involve a determination, among other things, of whether the types of surgical procedures which it is proposed from time to time that that surgeon undertake is matched to the hospital in terms of what might arise from that surgery in terms of the staff otherwise available to assist in the surgery, the availability of post-surgery treatment for recovery, and also the provision of services at that hospital to deal with post-operative complication?-- Yes.

In paragraph 81 of your statement you say, and I quote, "In my opinion, as a senior medical officer" - you put in italics "SMO" - "and not a registered specialist in Queensland, Dr Patel should never have been appointed to the position of Director of Surgery." You adhere to that statement, don't you?-- I do.

In other evidence given before this Commission, professor, I'd ask you to assume - it was actually given by a Dr Mattiussi, who you may know - it was suggested at one point that when a surgeon assumes the mantle of Director of Surgery, his or her additional duties are essentially administrative in nature and thereby that person's status as a senior medical officer ought not preclude such an appointment. What do you say to that?-- Well, as a director there are administrative duties, correct, but this was Director of Surgery, and in fact in evidence already submitted to the previous Inquiry by Hedley Thomas, he quoted an interview with me-----

COMMISSIONER: Don't tell us about that.

MR DOUGLAS: Don't tell us about that, but do tell us what your opinion is, please?-- Well, with due respect, it's important because he asked me this exact question.

COMMISSIONER: I don't care whether he asked you that question or not, professor. We just want to know what your opinion is?-- Would you repeat the question, please?

MR DOUGLAS: Thank you. I've put to you what Dr Mattiussi had to say. I've paraphrased it. The essence of his evidence at one point was that if a surgeon is to assume the mantle of Director of Surgery, the additional duties assumed by that mantle involve duties which are essentially administrative in nature, and thereby his or her status as a senior medical officer prior to that would not preclude such an appointment?-- If they're going from senior medical officer to Director of Surgery I would not agree. If they're going

from surgeon to Director of Surgery I would agree.

You know that Dr Patel, from what you understand to be the facts, was registered on an Area of Need basis as a senior medical officer?-- As I understand from evidence given, that's correct.

In paragraph 82 of your statement you refer to credentialling by reference to Queensland Health policy which obtained at the time. Are you referring there to the policy as to credentialling and privileging which was introduced, in written form, by Queensland Health in 19 - I should say in 2002?-- The last update was in 2002, but it was first introduced in written form, I think, in 1993.

Thank you. When you speak in those series of paragraphs as to the credentialling and privileging process, in terms of what actually happened on the ground, are you able to say at what point your expectation was that credentialling and privileging should take place in terms of it being anterior to or subsequent to the appointment of a surgeon to practise in a Queensland hospital?-- Well, in terms of appointment of a surgeon to practise in a Queensland hospital, the policy, I believe, is quite clear, in that it happens at the time of the appointment.

That's what I'm seeking to clarify with you. The time of appointment suggests in the abstract a point in time?-- Mmm hmm.

At some point in time Queensland Health - or I should say the district which is responsible for the process, appoints a surgeon. "You are appointed on these terms."?-- Mmm hmm.

The credentialling and privileging process, in terms of your understanding of matters as it happened, is it supposed to be before that point in time or after that point in time?-- At that point. The appointment committee is supposed to be comprised of peers, so in a normal process of appointment where there are applicants, there would have been a committee established with the medical director, the - a surgeon from town, perhaps a university representative, and those people are well qualified to make a determination at the time of appointment as to what the credentials are for that particular surgeon.

So as an intellectual proposition to address that, those matters of credentialling and privileging are determined to be satisfactory prior to the appointment of the surgeon in question?-- Well, as part of the appointment process.

COMMISSIONER: I think he means before.

MR DOUGLAS: I think it's suffice, the answers that I've gained.

COMMISSIONER: I understand.

MR DOUGLAS: Could I take you to a different topic now, professor? If I'm going too quickly, no doubt you'll tell me. I want to deal with the issues of waiting lists. You deal with this at paragraph 71 and onwards of your statement. It's on page 12 of your statement. At paragraph 75 of your statement you make the point the decision as to whether or not to publish specialist outpatient waiting lists is a matter for the government of the day and not for Queensland Health as a department?-- Correct.

You make the point at paragraph 72 that the Borbidge government, by Minister Horan, took waiting lists for outpatients and also elective surgery waiting lists to Cabinet?-- All the waiting list data was taken to Cabinet, correct.

And it may not appear directly on the face of your statement, but it wasn't until the Beattie government came to power in 1998 that elective surgery waiting lists were in fact published?-- That's correct.

But at no time were the anterior outpatient specialist waiting lists published?-- That's correct.

You say that was a matter for the politicians to dictate to you, not a decision for Queensland Health?-- Section 54 of the Public Service Act is quite clear about the management control of Ministers over departments.

You were aware - you are aware that during your tenure there existed Freedom of Information legislation in this state?-- Mmm hmm. Correct, yes.

And you were also aware during your tenure that an exemption in respect of Freedom of Information existed in respect of, to put it neutrally, material taken to Cabinet?-- That's correct.

It seems to be implicit in your statement, I suggest, that you have a belief that the waiting lists were taken to Cabinet from time to time by whatever government in order to engage such an exemption?-- I have absolutely no doubt about it.

Is that a matter which you can recall discussing at any time from time to time - or from time to time with the Minister of the day?-- It was a very clear direction. Queensland Health doesn't take things to Cabinet. It's a ministerial process and it's a ministerial direction. It's a minister who finalises the document, and their office and their staff rewrites, often, documents to take to Cabinet.

You say in paragraph 74 of your statement that you have, and I'll quote - you have no difficulty, and I'll quote now, "With transparency of outpatient lists broken down into specialty which include surgical and non-surgical specialties." I think I've quoted that correctly?-- That's correct. I would have preferred it to be the case. It would have supported my ongoing argument since January 1996 about the underfunding of

health in Queensland. In March 1996 the Australian Institute of Health and Welfare reported 16 per cent underfunding in Queensland. To have actually had all that transparent would have been very good for the people of Queensland, but also for the Department.

Your opinion is that if outpatient specialist waiting lists had have been publicised as early as possible, that that would have enhanced argument to obtain greater funding for Queensland Health?-- Absolutely. This has been an issue since the eighties, I might add, but absolutely.

You're on record many times as saying - particularly in recent times - that Queensland Health is underfunded?-- Peter Forster reports 20 per cent, but it's worse than that, and I'll explain that if you wish me to.

Just briefly?-- Well, if we - if Queensland comes up to national average - that's not best, that's national average funding - that's 20 per cent-----

Just be slow?-- Sorry. That's 20 per cent. By coming up by 20 per cent will bring the national average up by a further four per cent, and the Commonwealth Grants Commission which gives money to the states has consistently argued that Queensland needs a five per cent loading because of the critical and essential services in the form of health, police and education to rural and remote areas. That means the underfunding in Queensland Health is currently $1.1 billion. Now, if you want to adjust that for the fact that we pay less salaries in Queensland, every one per cent of salary is worth $30 million. So let's take 150 million off. We're still underfunded to 950 million. That's been an issue with consecutive governments every year I was a Director-General.

Having regard to your comments earlier about the publication of outpatient specialist waiting lists and the enhancement to the argument for better funding that would ensue from their publication, why is it that the politicians of the day haven't disclosed them?-- In discussions I've had both at state level and nationally, as Chair of the Australian Health Ministers Advisory Council, I don't think politicians have wanted to admit - I'll call it political honesty. Either the funding has to be there or there's a limit on services, or maybe even both, and I think there needs to be quite a serious debate in this country to actually bring that to a fore about what actually can be afforded, or are governments going to put in the necessary funding. That's the issue.

The Queensland system presently, and throughout the entirety of your tenure, was contrasted with interstate analogues in terms of dealing with specialist outpatient patients. Is that not so?-- That's correct, yes.

Just explain to the Commission how that was different?-- Well, other states were limiting, or in fact stopping outpatient services. We in fact continue to increase them. In fact during the term that I was Director-General, according

to the annual reports of Queensland Health, there was a 37 per cent increase in non-inpatient occasions of service, which includes outpatients, all those sort of things. But Queensland, when I discussed it with ministers over the years, have always said, "We've got a free hospital system. We intend to keep it." The Commonwealth Department of Health reported in June last year in its annual report of public hospitals that Queenslanders utilise outpatients 20 per cent above the national average, and that reflects the policy of consecutive governments. But I might add, at the same time we're significantly underfunded, but we have this extra demand on our hospitals.

COMMISSIONER: When did the other states cease free outpatient services?-- Commissioner, it's been progressive. In 1998 the Commonwealth, in negotiating the new Australian health care agreements, wrote a clause in that whatever people were providing at that time, the various jurisdictions, was now the new baseline. Up until 1998 the Commonwealth called it cost shifting. Queensland in fact didn't engage in that in any significant way, but there was very significant cost shifting where, for example, certain outpatients - in Victoria you can only go if you're prepared to get bulk-billed. It happened basically, I'd say, during the - up until 1998 significantly, and perhaps still a little bit since, but the Commonwealth tried to stop it happening in 1998. Can I just add with the funding - because, I mean, despite - there's the underfunding issue, and you feel a bit like a lone voice in all this. I mean, The Courier-Mail, on 11 September 1999, bagged the bureaucrats - and I have the quote here if you want it. Matthew Franklin bagged the bureaucrats for saying they need more money in health. "That's all they ever say." It was a pretty lonely argument trying to actually get more money into health.

MR DOUGLAS: Quite apart from the funding - the important funding issue that you've raised, you would agree that there would be other advantages in the publication of specialist outpatient surgical waiting lists?-- Oh, I think there are clear indications. It means, doctors out there in practice can look and say, "Well, there's a wait at this hospital. I'll refer you to another hospital", or can say to the patient, "Look, there's a significant wait, a 12 month wait for this procedure in the public system. I can arrange for you to go privately, but of course you're going to have to pay." But then there can be an informed decision, and of course the public, at each election, can decide whether they want to elect someone who is going to put more money into - and significant and honest more money, not this stuff where it's to cover the labour costs, which just enables us to stand still.

Perhaps if not put more money, perhaps even less money, but restructure the system, and say so?-- Or be honest about, "We can't provide certain procedure in the public system because we can't afford it."

What sort of pressure does the non-publication of lists place on the individual hospital?-- Well, because they have to continue to present the public face that they can do everything - and of course there's been periods where hospital superintendents have done a letter to say, "We can't take this booking", it gets in the media and the politician of the day gets all upset about it. But that's the pressure that hospitals are under.

COMMISSIONER: A point of view was put by one witness that there was really no point in publishing the numbers of outpatient people either waiting for appointment for surgery or already having that appointment but not yet being certified for surgery. Is that correct? Which we've called the anterior lists. There was no point in doing that, because by comparing Hospital A and Hospital B on a numbers basis, there wasn't a fair comparison because there might be more surgeons at one hospital than there are at another. What do you say in answer to that?-- It's a real problem, Commissioner. There is no national standards about how to count. It's been one of the problems we've had in Queensland. The Commonwealth is hoping, I think by the middle of next year - I understand by the middle of next year, to actually have some national definitions so we can have some comparable data.

Do you think there is some advantage in publishing the numbers which were collected but not published?-- Well, the issue, Commissioner is not so much, in my view, the numbers. It doesn't matter how many. It's not the issue of how many people are driving to the Gold Coast - are waiting, it's an issue of how long it takes-----

I understand the point, but the point I'm really asking is is there nevertheless some point in publishing those numbers as some indication from which further inquiries could be made-----?-- Absolutely.

-----of how long it's going to take?-- I support the publication of all the data.

All right. Can I just ask you another question while I'm interrupting, on the question of waiting lists. You said that Minister Horan took all of the data about waiting lists, that's the elective surgery waiting lists and what we call the anterior waiting list, to Cabinet so that none of that could be published. When Minister Edmond became the Minister for Health she, you say in your statement, made a commitment to publish elective surgery waiting lists?-- That's correct.

But that was the list of the second kind, wasn't it, not the list of those people who were on the anterior lists?-- Not the list of the people who were waiting for - to see medical specialists as well as surgical - 60 per cent of a hospital workload is medical work, not surgical work, and they're all on that anterior list.

Forget about medical work for the moment. People who really - whose general practitioner had thought might require surgery

but who had not been certified for surgery at that stage?-- Yes.

That's the lists we're talking about, the anterior lists. Now, as I understand it under - from the time Ms Edmond became the Minister, that anterior lists were still not published, but the subsequent list was. Is that correct?-- It's correct that those awaiting surgery - determined as needing surgery were published, the second list, yes.

The second list, but not the first. Did she ever explain to you why she thought it was a good idea to publish the second list but not to publish the first?-- I think the political debate and pressure, and certainly all the debate - 99 per cent of the debate in parliament that I can recall was always about people who are on the surgical waiting list, and she was responding to the political issue of the surgical waiting list.

But obviously you needed to know both, didn't you? Or is it desirable to the public to know both?-- Well, my own view is it should all be public.

Yes?-- But for only - I shouldn't say "only". Forty per cent of people on the anterior list are probably waiting for a surgical assessment which may result in going on to what you call the - did you call it the secondary list?

Yes?-- The first list includes all kinds of things, including - I mean, in Nambour in the eighties, when I was superintendent, there was a two year wait for paediatrics. They'd be on the medical list, never going to surgery.

Yes, right?-- So there are all these people who are never going to get - are never being considered for surgery but are on that first group.

Mmm. But they were separated out, weren't they?-- Well, no-----

Into specialities?-- At hospital level, yes, but there was no standardisation of criteria, there was no standardised computer system. I think I read in somebody's evidence about the attempts to have some standard computerised system but that was - as I understand it, was never achieved.

No, they were handwritten?-- They were - yes, well, initially in 1996 when Minister Horan said we had to do this with the elective surgery, we had surgeons who kept the waiting lists in their pockets. We actually didn't have them and there was a lot of work done. I actually put a specialist in charge of the waiting list, Dr Michael Cleary, who is now at Prince Charles Hospital, I pulled him out from Royal Brisbane emergency department because I needed a doctor who could negotiate with all the different doctors around the state to have a central waiting list so that we could actually have an idea of who was waiting for surgery for what, where and why.

MR DOUGLAS: And that program commenced in 1998, did it not?-- The program actually commenced in '95 when Minister Beattie first introduced a document, but it only got a head up of steam when Minister Horan arrived.

And on a quarterly basis from 1998 up until mid-2003, you, the Minister and the general manager of health services and you alone would receive reports as to not just the elective surgery waiting lists but also the anterior lists to which the Commissioner referred?-- My understanding is we got those lists right from '96 but I can't remember the detail as to what was in them. They're obviously summary documents which I wasn't particularly interested in.

If the politicians had have been willing, they could have been published?-- Well, yes, anything the department published had to be approved by the Minister and often harder yet, the ministerial staff.

I suggest to you the publication of the elective surgery waiting lists which ensued from 1998 without concomitant publication of the anterior surgical waiting lists was apt to mislead?-- I wouldn't agree because this was - these were patients who were told, "Yes, you need surgery. This is the category that you have now been given and our target is to have 95 per cent of you, if you're in category 1, operated on within 30 days."

If the elective surgery waiting lists are going fairly well over time as they're published but as it transpires, and I thought you said this was the case, that the anterior lists were growing, to publish only the elective surgery waiting list could well mislead?-- What I said was in referring to

the annual report is the throughput of non-patient services grew 37.6 per cent, I think it was, in the years that I was Director-General but it is correct to say that on the evidence I have read certainly in these - in the Commission's documents, that the number of people waiting specialist outpatient appointments also grew during that time, decreased the increased throughput.

COMMISSIONER: Professor, the point that was really being made to you was this: assume you're a general practitioner who has a patient whom you think will require surgery?-- Mmm-hmm.

And you want to advise that patient how long you think he or she will be-----?-- Mmm-hmm.

-----before that surgery ensue, is likely to ensue, assuming it's necessary?-- Mmm-hmm.

You would need to know both the anterior waiting list and the surgical waiting list, wouldn't you, to give some useful advice to your patient as to whether you should continue to make your application to go on that waiting list or perhaps get private treatment?-- I certainly agree with non-urgent categories but the procedure was for obviously emergencies, they presented immediately and Queensland Health dealt with them very well, frankly.

Yes?-- For categories 1, they were jumped ahead of the queue for the appointment. A lot of those waiting appointments, and I'm not pleased about the number of waiting by the way, a lot of them are waiting for procedures which are elective procedures which are in no way life-threatening or - et cetera. For example, ear, nose - grommets or things like that, ear, nose and throat procedures.

Or even hip replacements?-- Hip replacements I think were categorised as category 2 but, yes, you're right, they would go through that system.

Yes.

MR DOUGLAS: And most people were in category 3, the least urgent of the three categories on the elective surgery waiting list; isn't that so?-- In waiting, yes, that would be right I suspect. I'd have to see the numbers but I think that's right.

And, in fact, people for instance, to take up the example given by the Commissioner, who might need a hip replacement although they didn't need a wheelchair, they might well be in category 3?-- I don't recall where - I mean, because there are other criteria about level of pain, those sort of issues, degree of limitation, as to whether they - they would have been category 2 or 3. But I might add, the Australian Orthopaedic Association actually had a policy on categorisation of joint replacements in Queensland trying to observe that policy.

Again, from about 1997 up until the time that you ceased as Director-General, there were - there was a policy within Queensland hospitals of elective surgery targets?-- Mmm-hmm.

Do you agree?-- No, it was from 1996. Mr Horan wrote it into my performance agreement in August 1996.

Thank you. From 1996 until the cessation of your tenure this elective surgery target policy existed. In brief, can you explain that policy, how it worked?-- Well, Minister Horan became Minister. There was an argument, a successful argument for extra funding specifically for elective surgery and, of course, Treasury insisted that for that extra money they see some performance. So targets were set about - that - and, for example, category 1, which were patients who needed surgery within 30 days, that no more than five per cent would wait more than 30 days. So that was how the system worked.

Under that system therefore, an individual hospital which didn't meet its elective surgery targets would suffer a diminution of its funding the next time around; is that right?-- Unfortunately, it's not as simple as that. There was - every hospital had base funding and they - elective surgery is roughly 15 per cent of a hospital's business. So the base funding up until 1995/'96 included them doing elective surgery. Then when additional funding came along and Treasury was saying, "We'll give you extra money and we want you to do stuff with it and we want to see what you did with it", the arrangement that we tried to do was to say, "Well, you have to keep up your base funding commitment to surgery but we will give you additional funding if you do additional surgery, but if you don't do the additional surgery, we will give the money to someone who can do it."

Do you recall a problem arising, say, in about 2001 involving hospitals shifting activity between surgical classes?-- It was also - always an issue of allegations and claims that that - that was possible, yes.

Did that involve, as an allegation, hospitals shifting from, say, the emergency surgery category, which fell outside the elective surgery target policy, into the elective surgery lists in order to garner the extra funding involved under the policy?-- You've shown me some-----

Just answer my question, please?-- -----documents this morning - well, that's the allegation, but can I point out that if you're actually operating on people on time, then you are going to reduce emergency surgery. If people who need an operation within 30 days are getting it within 30 days, then you're not going to do an emergency surgery operation on them in two months' time because they're still waiting for their category 1 operation.

Would you look at this document, please. I gave to your counsel Mr Simon Couper QC two documents this morning to save some time today. One of those is the document you have in front of you now. I'll have it distributed. A copy for the

Commissioner, please. Actually, could I exchange copies with you, sir. This document purports to be a briefing to the Director-General on the 10th of January 2001?-- Mmm-hmm.

You were Director-General at that time, were you not?-- Mmm-hmm, that's correct, mmm-hmm.

I'm not suggesting for a moment that this document bears any initials of yours, Professor. It's a document that's been supplied to us by Queensland Health?-- Mmm-hmm.

Whether another document exists with your initials on, I can't say at the present time?-- I can't either.

Thank you. You've had an opportunity to read this document this morning?-- I have.

All right?-- Quickly.

Thank you. And do you have any recollection of being informed at about this time of information to this general effect?-- Not specifically, no.

Okay?-- But I suspect I was.

The subject matter thereof is the elective surgery activity contrasted with funding over the period from 1996 to 2000?-- That's correct, what it says, yes.

Having perused the document this morning, is there anything in there that from your perspective is untoward or incorrect in terms of your understanding of matters as they were at about the date of that briefing, namely, 10 January 2001?-- I did read it quickly this morning and there were a couple of comments I made to my counsel about it but I can't specifically refer to them. I will note that it says, "This briefing provides a superficial analysis".

I saw that, and your counsel can bring those matters out if he wishes. I tender that document, Commissioner.

COMMISSIONER: All right. That will be Exhibit 367.

ADMITTED AND MARKED "EXHIBIT 367"

MR DOUGLAS: Can I put another document in your hands now. It will be distributed. It is a document dated the 30th of July 2003. It purports to be a submission to one or either of the General Manager Health Services from the Deputy Director-General Policy and Outcomes. The noted subject matter is said to be "Reclassification of Emergency Presentations as Elective Surgery". Professor, can I tell you again this is a document which has been - like the last document, was supplied to counsel assisting this Commission in

the last couple of days. I am not suggesting to you that this document bears your initials or I cannot say to you it was submitted to you for your consideration at any time. Having said that, you've had a chance to peruse the document this morning. Can I ask you a general question first: do you recall at any time being apprised of matters particularly or broadly the subject of this particular memorandum?-- I don't recall the specific issues in this memorandum, no.

What general issues do you recall you were apprised of?-- Well, as I mentioned earlier, there were always allegations and we had to honour them to make sure there wasn't shifting of patients into different categories, and that was from the very beginning in 1996 right through until I left.

Can I just identify a couple of points about this document. If you can go to what is the fifth sheet in, there's a heading "Funding Implications". Do you have that? Top of the page 3, "Funding Implications"?-- Yes, I have it.

Is it correct to say that the thrust of what was being identified by the author of this document then was that some hospitals within the Queensland hospital cohort were reclassifying patients as elective surgery patients whereas in truth they were emergency patients who'd remained after admission in hospital for 24 hours?-- This was the period of time of the indemnity issue when certain hospitals were refusing to do elective work. Now, I've only just seen this this morning. I would - the first question I'd be wanting to do is identify whether there is any relationship whereby hospitals to get patients in through getting surgery was to admit them through the emergency department. That may or may not be the case, I don't know, but the thrust of this is, yes, that people were putting people through the emergency department in spite of the definitions for elective surgery in order to get that surgery done and to access money through the elective surgery program.

What the author has said in the third paragraph, the last sentence, "Using reclassified emergency activity to meet elective surgery targets is double dipping". You'd agree with that, wouldn't you?-- Well, yes, it's funded in the base budgets, although funded inadequately I think is clearly demonstrated.

But funded nonetheless?-- Funded inadequately nonetheless.

Yes. If you look then further - I think it is further down that particular page - it is down that page - the last paragraph, the author says, "Left unchecked, the practice of emergency reclassification will continue to increase in volume and spread. Financial adjustments to those hospitals showing apparently deliberate policy changes in 2002/2003 will send a clear message to all districts that funding is tied to maintaining and increasing real surgical outcomes." It goes on to make certain comments then about matters. If you go then over the page, indeed, over two pages to item 6, you will see a heading "Political Considerations". If you could just read

those two paragraphs, please?-- Mmm-hmm.

There's a reference there, Professor, in the first full paragraph to "CMBS"?-- Mmm-hmm.

What is "CMBS"?-- That's the Commonwealth Medical Benefits Schedule. Medicare, basically, Medibank, Medicare.

Would there be - why is there reference in that context to treatment under that schedule? It's said in an ambulatory setting. What's the pertinence of that to the subject matter?-- If it's done - under the agreement from 1998, the only way we could access Commonwealth funding on a fee for service basis was if it was a new service. So I would imagine this refers to commencing new services on an outpatient basis and accessing Commonwealth Medical Benefit Scheme funding.

Are these serious matters that are canvassed by this memorandum?-- I think clinical services, patient care is very serious and I think that issues to do with training to maximise patient services, patient throughput are very serious and this reflects that people are trying to use some add-on funding to support their underfunded base funding, yes.

Is the subject matter of this memorandum something which you would have expected on or about the 30th of July 2003 would be referred to you as Director-General?-- Yes, I would have, mmm-hmm.

You express that view because the subject matter of what is addressed in this memorandum is that a number of hospitals within Queensland are, in effect, rorting in order to desperately gain or maintain their funding?-- They're using a bucket of funding inappropriately which-----

Did you say inappropriately?-- Well, inappropriately if it jeopardises that funding from Treasury and jeopardises the Minister's ability to deliver on the government's policy commitment to increase elective surgery.

Because of that, that you would have expected this particular issue to be referred to you forthwith?-- Well, subject to whoever received it, which I think was the General Manager Health Services, satisfying him or herself - well, himself that was actually accurate and there wasn't further information to add to it, yes.

Dr Buckland was the director - I'm sorry, was the General Manager Health Services at about this time?-- That's correct, mmm-hmm.

I tender each of those documents, Commissioner.

COMMISSIONER: What do you mean - you've tendered one.

MR DOUGLAS: I've tendered that particular document. I want to ask him some further questions about it.

COMMISSIONER: That's Exhibit 368.

ADMITTED AND MARKED "EXHIBIT 368"

MR DOUGLAS: Can I ask you this, sir: in or about July 2003, to your knowledge did Queensland Health maintain a record keeping procedure in respect of submissions of this type?-- Yes, I implemented a system in 1996 which was still current at the time I left.

And expressed economically, of what did that system consist?-- Well, there was a record kept of submissions to - and briefs and correspondence to both my office and the Minister's office.

Did that record consist - I'll start again. Did that record system embrace the retention of both hard copies and electronic copies of documents of this type generated?-- Not initially electronic but I think towards the end we started a mechanism where we scanned them so that we can refer them as appropriate quickly, but certainly hard copies under the - I think it's the Archive Act, you have to keep correspondence. It's the legislation. You have to keep these documents on the records.

I want to put a hypothetical proposition to you. I want you to assume that the person to whom this is directed receives this document and at some point after its receipt, instructs those who submitted it to him or her that hard copies of a document were to be destroyed and electronic copies of the document removed from the Queensland Health network. Do you wish me to repeat that?-- No, but I don't understand the question. You said you - what's the question?

I suggest to you that such a direction by whoever received it, be it the - either of the two persons nominated on the front page of that document, would be a wholly improper direction to give?-- Well, yes, I mean, the Archive Act, I think, covers that but the person could send it back and say, "I don't think it is right and I want it corrected and I want this taken into account", et cetera, et cetera, et cetera. Yeah.

Even if-----?-- But I'm unaware of your hypothetical happening.

No, can I amplify the hypothetical even to suggest that assume the person who receives it did ask for it to be taken back and amplified?-- Mmm-hmm.

Even in that scenario, to instruct that the document in hard form or electronic form be destroyed would be wholly improper?-- I'm not aware of it happening but - but, yes, I would encourage that the working documents are maintained, yes.

You can think of no sensible reason why a document containing this sort of information would be the subject of scotching from the record?-- No, no.

Do you agree with that?-- Well, yes, I don't think it should have been destroyed.

In the hypothetical circumstance I just put to you?-- Yes.

Commissioner, can I just pause there and say this, that these two documents which have just been tendered, the documents received by the Commission in the last day or so - I can't say exactly when they were received they were received from Queensland Health - they were also received together with information which I emphasise is presently unamplified and not yet sworn to by any person but I believe that will be sworn to either by Mr Walker, that is, Mr Walker whose statement has already been tendered from Queensland Health, or perhaps some other person under him depending on who precisely gives the information. And the information I have from Queensland Health, which is only - with the caveats I have just indicated, is that soon after this document, that is the document which is dated 30th of July 2003, was received - I'm sorry, I'll start again. That soon after it was given to the General Manager Health Services, that a direction was received from the then General Manager Health Services that hard copies of the document were to be destroyed and that the electronic copy of the document removed from the Queensland Health network. Commissioner, that's the extent of the information I have at the present time.

COMMISSIONER: Thank you.

MR DOUGLAS: I have requested Mr Boddice to provide a further statement or statements dealing with that issue.

COMMISSIONER: Mmm-hmm.

MR DOUGLAS: Can I take you to another topic, please. You deal with Vincent Berg in paragraphs 25 and onwards of your statement?-- Mmm-hmm.

You say in paragraph 30 that you have no recollection of dealing with this particular issue, as Director-General?-- Until it was raised in - well, whenever I said it was. December 2002 I think.

My fault entirely. You certainly say that you had dealings with it in December 2002. When the matter came to be ultimately dealt with by decision of the general manager of health services, that was in January 2003?-- I think so, yes, mmm-hmm.

But might it be the case that you were on holidays at that time?-- I think so because there was - on one brief there was an acting Director-General, yes.

In paragraph 37 of your statement you treat the handwritten note of Dr Buckland pertaining to the response to the Townsville Hospital staff in relation to the disclosure of any invalidity - of the invalidity in Berg's qualifications. I'd ask you to assume that the evidence from Dr Buckland is to the effect that the decision which he made is - as is recorded on that particular document in handwriting, was for him a very difficult decision?-- Mmm-hmm.

From that which you've recorded in your statement, you would also characterise it that way, wouldn't you?-- Yeah, mmm-hmm.

Can I ask you to assume also that Dr Buckland says that he consulted with psychiatrists in the Mental Health Unit of Queensland Health in relation to the issue before making his decision which he's recorded. Can you assume that, please?-- I can assume it. I don't know that but I can assume it.

I'm not asking you to do anything other?-- Mmm-hmm.

In light of that assumption - apart from that assumption, I should say, would it be your expectation that Dr Buckland in making such a decision as is recorded would so consult?-- I think it's a reasonable thing to do, mmm-hmm.

You knew that Dr Buckland had no psychiatric qualifications?-- Correct, mmm-hmm.

Indeed, you have no psychiatric qualifications either?-- Worked in general practice and I estimate that 20 to 30 per cent of people in general practice have a mental illness of some form.

All right. You have no specialist psychiatric qualifications?-- I have no specialist psychiatric qualifications.

I suggest to you that it would be your expectation that in respect of such a decision, Dr Buckland would actually canvass a report from a specialist psychiatrist or psychiatrist within Queensland Health to assist him in making the decision which he did as recorded in that document?-- Are you asking me whether he should have got a written report as against a verbal report?

Yes?-- No, I think the - if he's satisfied himself - I'm speculating. If he's satisfied himself by speaking to psychiatrists, that was a reasonable thing to do.

Would you expect some record to be made of the dealings with the psychiatrists that were had in that respect?-- Well, he hadn't recorded it in his handwritten note from what you've shown me but perhaps in retrospect it would have been wise to have included that.

It's a weighty matter, isn't it?-- It's a weighty matter that came to attention two years after the event.

It is a weighty matter involving many patients treated by this man Berg?-- Who had been assessed and were likely to have been seen by doctors since, by the very nature of their illness by a doctor who was in a supervised practice position.

It was a matter which practitioners within the health service at Townsville believed serious consideration should have been given to disclosing to patients Berg's apparent lack of qualifications?-- I'm not sure in that submission or brief that was prepared who actually included that clause. It was prepared by a medical administrator and a psychiatrist, yes, but that is included in the brief as a recommendation, over and above the 50 - 55 I think it was that - that they said needed to be - absolutely needed to be checked and which I understood were checked.

It transpires, of course, that we hear in this Commission hearing today, looking at these matters and looking to see why it was - whether the decision be right or wrong - this decision was made, the fact that there is no apparent record, whether by Dr Buckland or by psychiatrists within Queensland Health, to date as to what founded the advice that was given. It doesn't say much for the record system in terms of decision making, does it?-- Well, I mean, I don't agree. I mean, there are lots of decisions. You have spoken about the documentation, about the number of briefs, admissions, correspondance that comes across the desk. It's massive, being such a large department. The - it's just - we have double the bureaucrats that the previous Commissioner spoke about.

COMMISSIONER: This wasn't a routine matter, professor, was it?-- It was a matter that came to attention two years after the event.

No, no, no. It was a matter which was, at the time it came to attention, important at that time for the people involved; that is, the former patients of Dr Berg?-- Well, there was an assessment made that their treatment had not been impacted and, in fact, arguably because of the nature of their illness may have actually caused further harm to have actually it publicly stated. I'm just trying to work backwards on what's being presented to me as what happened.

MR DOUGLAS: I am asking you about the procedure. If I can follow on from the Commissioner's question, at the time it was a matter of critical importance; is that not correct?-- Well, yes, the fact that we had a chap who it appears was not a registrable practitioner, albeit in a supervised position, but, yes, he shouldn't have been there.

He'd been treating patients in a psychiatric discipline?-- That's correct.

Had he not?-- That's correct.

He'd been treating 250-odd patients or thereabouts?-- Mmm-hmm.

You are not seeking to diminish it in any way, are you, professor?-- Of course not. I have already - I have already pointed out that the - the importance of clinical service, patient services to people of Queensland and every single member of Queensland Health.

In light of what you have said, I will ask you a hypothetical question. Assuming that you had have been making this decision, not Dr Buckland, I suggest to you that you would have been very concerned to make the right decision?-- Absolutely.

It would have been a difficult decision for you as well; do you agree?-- Yes, mmm.

It was hardly a routine matter?-- Mmm-hmm.

It was hardly a routine matter. Do you agree?-- Didn't happen every day of the week, correct, yes.

And it involved a lot of patients?-- Yeah, mmm-hmm.

I suggest that in those circumstances acting properly in the discharge of your stewardship position, in that hypothetical circumstance you would have obtained a report from a specialist psychiatrist or psychiatrists within Queensland Health at least to assist you in making your decision?-- I don't know. I mean, I think on the balance with the two years delay, supervised position, patients on to ongoing care by the virtue of their illness-----

COMMISSIONER: How did you know they were in ongoing care? Did you assume that?-- It is an assumption, yes. But it's an educated assumption based on the fact that they were patients within the Mental Health Service.

You didn't check to see if they were?-- I wasn't aware of it.

No, no, no, but no-one else checked as far as you know to see-----?-- Well, as far as I now know - I mean, I - I presume what you say is correct, Commissioner, but I - I don't know.

MR DOUGLAS: See, the situation we are dealing with, I suggest, in this circumstance, as I will have you to consider as a hypothetical proposition, you have suggestions made by hospital staff on the ground in Townsville suggesting a particular course. The decision-maker ultimately made a decision which was different from that and the decision-maker, I ask you to assume, says, "Well, I got on the telephone and had a conversation with a psychiatrist or psychiatrists and they told me certain things, and then I decided this." You don't think that a cavalier approach to the disposition of what is a very serious issue concerning these 250-odd patients?-- Well, I would have expected that the District Manager, Director of Psychiatry - both of whom I knew very well - would have picked up the phone and spoken to me if they were unhappy with the decision, and that didn't happen.

That's not the question I asked you. Would you please answer my question?-- Well, no, I don't think it was a cavalier approach. On the evidence before me there was consideration. In retrospect it would have been wise, but on the evidence before me, taking into account the circumstances, I think the decision was reasonable at the time.

Bereft of documentation, which dictates what these psychiatrists advise, we don't even know upon what factual premise they proceeded in giving whatever advice they did give to the department in relation to this decision, do we?-- Well, there's the brief you have shown me which I have read.

No, listen to me. Bereft of any document from Dr Buckland,

perhaps, or the psychiatrists, which dictates the reasoning process, the intellectual reasoning process involved in giving advice to Dr Buckland, we don't even know - one doesn't even know whether the factual premises for any advice that is given is in fact correct; is that not so?-- I'm sorry, I would like you to be clear here. You are pointing out there's not enough evidence on a case by case basis?

COMMISSIONER: No, no, I thought the question was fairly clear. The question simply is that if, as Dr Buckland said, he consulted psychiatrists, there's no indication now of what material he put before those psychiatrists?-- Oh, okay, yes.

Or whether it was factually accurate?-- Yes, that's correct. From what I have been shown that's correct.

MR DOUGLAS: Just excuse me, Commissioner.

COMMISSIONER: Yes.

MR DOUGLAS: I suggest to you the modus operandi of having informal conversations with psychiatrists prior to making a decision of this type is one which is well short of proper practice for a decision-maker in this position?-- My personal practice was to make copious notes on the file, but, yes, mmm-hmm.

Such that you could come back later and refresh your memory - at the very least refresh your memory as to why it was you made the decision you did?-- Correct, mmm-hmm.

I suggest to you that a proper practice for discharging this particular decision was to obtain a report from the psychiatrists within Queensland Health to canvas their views in order to assist in making the decision. Do you disagree with that?-- Oh, no, I note your suggestion and-----

It's a credible suggestion?-- It's a credible suggestion.

A sensible suggestion?-- In retrospect, absolutely.

Could I take you to a different topic, please. That is measured quality. Professor, in June 2003 you signed off on a public report on measured quality?-- I have a copy of it so I can recall that, yes.

That's right. That's Exhibit 352 in this Commission, Commissioner. Measured quality was a policy introduced by Queensland Health in about early 2003?-- One of the many projects we did with the funding we secured through the Australian Health Care agreement, quality - money in 1998 - I think it was 1998 - in that process, yes.

And could you tell the Commissioner what you understood to be the essence of the Measured Quality Program and to that to which it was directed?-- Well, we were very keen as an organisation to be able to benchmark where we were at with services and basically looking for opportunities for

improvement. That was the first of what would have been repetitive studies. One element of it was patient satisfaction - there were four elements, one of which was patient satisfaction, and as an organisation endeavouring to provide the best possible health services, we were - we looked at all our districts to see what sort of services, check them against benchmarks with a view to improving services or at least being able to argue for additional funding to improve services.

It wasn't just a matter of funding, I suggest, professor, it was also a matter of implementing policy or to ensure that at one end of the spectrum there weren't hospitals within the Queensland Health cohort who were falling below proper standards?-- Absolutely.

And also it was directed at raising the standards right across the cohort group?-- Absolutely.

And part of the process was to compare relevant groups of hospitals within the cohort?-- Compare like with like, yes.

So you had small hospitals, medium size, large hospitals and also at the zenith the major surgical and referring hospitals?-- Teaching hospitals.

Thank you. So, within, say, a particular group, say the large hospital group, there would be five or six hospitals, whatever the case may be, within that group. Information would be obtained from them. It would go to Queensland Health, it would be collated, and then that information would be put back to the individual hospital for its comments and for feedback to enable in turn those hospitals to look to where they're not performing properly and look to where they are performing well in order to improve standards?-- Mmm-hmm.

Is that not so?-- Absolutely.

It would also provide a basis of information for them to enable them to agitate for greater funding for particular areas within their particular hospital?-- Correct.

So it was a very powerful policy tool in that respect?-- Absolutely. We got commended by the Australian Quality and Safety Council for leading the country with this initiative.

I suggest, though, that you were - that is Queensland Health, I should say - was hampered in one significant regard in relation to the implementation of this policy, and that is that dissemination of policy information?-- There was a prolonged process of getting approval from government. The government having approved it, we - the exercise in the first place, I might add - there was a prolonged process in actually negotiating the release of the final document, but that was no different to any process that I have had with any Minister since I was Director-General.

Well, you say there was a long process involved in getting to

a final document. Are you speaking about the public document which was ultimately released in June 2003?-- Mmm-hmm. Well, yes, the whole - using the material from the survey and what we could provide back, what could be released was a process of negotiation.

The impairment of the process transcended the public report, didn't it?-- Sorry, just ask that-----

I will put it another way. I will be more precise?-- Mmm-hmm.

What you're speaking of in your last few answers is that Queensland Health had to, in effect, negotiate with the government of the day to enable it to be able to release this information, not just to the public, but to the individual hospitals?-- Correct, yes.

It had to negotiate a dissemination policy with the government?-- As we did with all governments I have worked for on such issues, mmm.

Why would Queensland Health have to negotiate with the government in relation to such an issue?-- Because we were a department, not a commission. I mean, there were health commissions around the country and every jurisdiction that had them, that was Western Australia, Victoria, South Australia and New South Wales, closed them down and made them departments because there's much more clinical control over departments.

What is it that's lying at the heart of this negotiation? Is it publication of information that the government may be embarrassed about?-- You'd have to ask the government, but - or the governments - because it was the same under all governments I served, but, yes, they - all governments were highly sensitive to what data was released by the department at any time. All governments used to vet my monthly newsletters. All governments used to vet my annual reports. It's the process of the government that we have and have had whilst I was Director-General.

In order the Commission understands this in the context of this particular issue, you were Director-General for a long period of time, probably longer than most equivalent persons interstate, I believe?-- In the country, for many years, yes.

For many years?-- Unfortunately.

You must have taken this up with the various Ministers that you served?-- Yes.

Can you give us some indication of your dealing with them in that respect, in terms of vetting newsletters or vetting your policies?-- Well, it's a legal direction. I mean, the Public Service Act section 54 quite clearly as Director-General and head of department is an accountable officer. That means the whole department is responsible to the minister of the day,

and the minister of the day delegates their media staff - sometimes called spin doctors - certain responsibilities and there are other staff in the office and whether we like it or not that's the process we have to go through and you can't-----

Whether you think it's a good policy or not?-- Absolutely. In fact, I had major fall-outs with ministerial staff both in Minister Horan's office and Minister Edmonds' office because I argued very strongly for what I felt was right from a Queensland Health perspective, but at the end of day, the government of the day, they have the legislation about the roles and responsibilities of Directors-General and departments and either you follow that or you resign.

I want you to assume that a public servant within Queensland Health, say, in or about early 2003 canvasses with the Minister the utilisation of a document or series of documents being taken to Cabinet in order to gain the freedom of information exemption in this regard. Can I suggest to you that that's a wholly improper approach for a public servant to adopt in the discharge of his or her office?-- As a firm believer in the Westminster system, I would say that is grossly inappropriate for that to occur, and I would have taken steps, if I had been aware of it, and I probably would have fallen foul of some of ministerial staff.

Look at this document, please. The document - it would be better on the screen. Exhibit 340, Commissioner. It is the e-mail.

COMMISSIONER: Yes?-- It's a bit low for me.

MR DOUGLAS: No doubt you have seen that a couple of times in the last few days in The Courier-Mail?-- In the media.

Do you recall receiving that e-mail or an e-mail to that effect at about that time in late 2000 and 2-----?-- I certainly recall the issues, but I don't recall specifically the e-mail, no.

When you say you specifically recall the issues, do you recall the issue being raised following the Cabinet meeting at which measured quality in phase 1 was first considered and discussing it with others at the time?-- Yes. I was very keen to have this data available for use.

Was it a matter which you canvassed with the Minister at the time following this direction?-- I believe I would have but I just don't recall any specific conversation. This was an issue that the - I had my deputies with carriage of because it was such a big issue and there was so much negotiation between the ministerial staff, the Premier's department staff. I mean, there was a lot of negotiation on this. So, my deputies were - both John Youngman and then subsequently Steve Buckland were very heavily involved.

Professor, there's a gentleman by the name of

Mr Justin Collins who's provided the statement to the Commission in relation to this issue. Do you know Mr Collins?-- Well, actually I think it's a girl. I think it's Justine.

Justine, I am sorry?-- I have probably done a great disservice to Justin Collins. So the answer is no, I don't, Sorry. The name rings a bell, but I know it's Justin there, but I thought it was actually a lady. I apologise to him if that's not-----

Be that as it may, gender is irrelevant. Do you know Mr or Ms Collins?-- Clearly not.

Thank you?-- I know there's - of person of that name that works-----

When you say - you know of such a person?-- I know of such a person.

You know of such a person?-- Yes.

Who was from the inception of Measured Quality the person who was responsible at the highest level for the day-to-day operation of the Measured Quality Program?-- Well, was involved in it, at what level I'm not sure, and no doubt would have been personally very committed to trying to get it - get some outcomes from it.

Do you recall making any submissions or exhortations to the Minister or Cabinet following the adoption by Cabinet of the Measured Quality Program to loosen the reins, so to speak, in terms of dissemination of the documents under the program?-- Could I perhaps clarify this, the process for submissions particularly to Cabinet, because there's, I think, a misconception that they are Queensland Health submissions.

Yes?-- Submissions from the department, in fact, go from the Minister and the Minister's office. That's after they have been through the minister's office, the Minister's staff, et cetera, et cetera. They - in the process of getting a Cabinet submission signed off, you have to also get agreement from Treasury and the Premier's Department, and I think Dr Buckland may have given this evidence in something I saw in the media, I think yesterday, that what finally gets to Cabinet under all governments I have served is not necessarily what's started off in the department. It's a process of trying to get, dare I say, sometimes a lowest common denominator of agreement to try and get something up. But I certainly remember that we were putting forward submissions to go through this process to get through and - into the Cabinet process.

There's nothing to inhibit you from suggesting to the Minister or even writing a submission to the Minister requesting some freeing up of any inhibition which Cabinet sought to place on this particular program?-- I had a number of discussions with Minister Horan and Minister Edmonds when I argued they were

the Minister and they shouldn't have to be subservient to bureaucrats in Treasury and the Premier's department for what they could raise in Cabinet and what could be in submissions.

Did you do so with Ms Edmond in relation to this issue?-- I don't remember - I am sure I did but I can't be specific. I can't give you dates. It's an issue that we all felt very strongly about. There'd been a lot of money invested in this program. The government had endorsed it from the very beginning and now there was difficulty actually utilising the data. We were very passionate in Queensland Health about wanting to be able to use this data to improve health services.

Were you ever given a reason by the Minister or by any member of Cabinet as to why it was that this constraint, which you knew of - if you didn't - don't recall the e-mail - was being imposed upon Queensland Health in the implementation of this policy?-- I don't recall specific - I am sure I was, I just don't recall, but our perception was that clearly there were some findings were which were uncomfortable, and that it was causing some concern.

COMMISSIONER: Just remind me again, how did this inhibit the implementation of those policies?-- The findings of the - of the-----

The Cabinet decision not to permit that document to be published?-- Well, the difficulty - my impression is the system had to be changed so that the reports couldn't be printed out at the district level and there was password protection, et cetera, et cetera. Would that would mean is there would be great difficulty in the District Manager or the medical superintend or Director of Nursing sitting down with staff and saying, "This is how we compare with other hospitals." Clearly that has made it very difficult. If the managers say, "We have to improve in cardiac services.", everyone's going to say, "Well, why? Where's the evidence?", and if they are not actually able to use the evidence, then that obviously creates some difficulties.

And did it?-- I just don't recall that, Commissioner.

MR DOUGLAS: Perhaps Mr or Ms Collins can assist us with that?-- I suspect so.

In the same vein, let me show you a portion of a document which was helpfully produced by Dr Buckland in his - in one of his statements. I will have it put up on the screen Commissioner. It may be easier.

COMMISSIONER: Yes.

MR DOUGLAS: For those slightly behind me, it's on page 19 of Exhibit SMB34 to Dr Buckland's second statement. Before we look at that, professor, I don't whether or not you have seen have document - I am not suggesting to you you have - but it is a document produced by Dr Buckland. Can I tell you it's an

extract from a report headed, "Quality Improvement and Enhancement Program." It bears a date April 2003 and Dr Buckland tells us it was produced at his request by Dr Fiumara - I may have wrongly pronounced that - and Dr Huxley and it reviewed a number of programs and policies, including, not solely, measured quality?-- Mmm-hmm.

It's only a single page I wish to look at?-- The program actually required that all the expenditure and programs be reviewed. This wasn't something that Dr Buckland specifically did. It was just part of the requirements that it be done.

Thank you. If you could just scroll up the document. If you could focus your attention in particular on the boxes entitled, "Risk in Issues and Summary"?-- Mmm-hmm.

You will see the first dot point in the penultimate box reads as follows, "The dissemination strategy is critical to success, engagement of clinicians and managers in their application of measured quality reports in effecting change." Was that a view which you enjoyed at that time as well in respect of this policy?-- We have a saying, "In God we trust. Everyone else bring data." I mean, absolutely. If we want to engage change management, you have actually got to use - have evidence to prove that it's necessary.

If the District Manager or the Director of Medical Services in addition go to the surgeons, go to the nurses, go to the other support staff, medical or otherwise, and garner information and give them physical evidence, not just say-so evidence, then that assists in the process the subject of the policy?-- Mmm-hmm.

Do you agree? Can I suggest to you, in fact, it lies at the heart of the policy like this?-- Correct, yes. You have got to give feedback. People collecting data, they have got to actually know they will be able to use the outcome from it.

You see, the first dot point in the last box on the page summary reads, "Program area inhibited in achieving deliverables due to data sensitivity." That may be the language of summary or the department, but are you able to assist us with what that is directed at?-- Well, I think they are arguing that because the data wasn't widely distributed we couldn't engage as many people in improvement processes. I believe that there was use of the data because at the corporate level, for example, there were other projects, I think, spun off in cardiac, for example, because of the data issues and subsequently published in the MJA - I actually remember one of the papers. But clearly at the local level being able to engage people and give them a copy of the report, that was inhibiting.

If you can't engage people at the local level, that inhibits the ability to garner the evidence that goes to the top level for decisions to be made?-- For future reports, I would imagine so.

That's so because all the work is being done, essentially at least with patients-----?-- Mmm.

-----at the hospital level?-- Yes. The patients' satisfaction data was released, you might recall. I think 91 per cent of Queenslanders who responded to the survey actually reported very satisfied or satisfied with their hospital experience. That was only one quarter of measured quality.

Thank you. That can be returned.

COMMISSIONER: This might be a convenient time to adjourn.

MR DOUGLAS: It is. Unless there are some questions you want to raise, Commissioner, that's my examination.

COMMISSIONER: All right. Perhaps I will ask one question, and we can leave it to the others to ask questions afterwards. I just want to take you back to the credentialing and privileging scheme, professor. I take it that that was done initially at the local level; is that right?-- The credentialing/privileging was Australia done at the local level.

Right. And the renewal of credentialing/privileging would again be done at the local level?-- That is correct.

Were there any system in place by which you or people under you at the central office could ensure that that was being done and was pursued?-- Yes. In about 1998 I introduced the requirement that all Queensland Health facilities had to be accredited, either by the Australian Council in Healthcare Standards or a similar body. One of the critical issues for accreditation is to have credentialing and privileging of your medical staff in order that you can be accredited as a hospital, and that - the accreditation process required a revisit every three - three to five - they changed the process a little, but I think it was at the time every three years.

What I'm asking you is whether that was monitored?-- Well, it was - it was monitored through the accreditation process, whereby all-----

No, no, no. That's really putting the cart before the horse. Was there in short some way that that had been complied with? Did anyone check to see that that had been done?-- I am unaware of any other process other than through the accreditation.

But how were you to know that a person had been accredited?-- As Director-general right up at the top? No, I wasn't to know about individuals, no.

MR DOUGLAS: What about at the interface level between the hospitals and Charlotte Street? Was there some administrative process whereby once accreditation had occurred at a hospital level in respect of any particular clinician, that that - there could be a record of that sent to central office so they'd know that that person had been accredited, whether for the purpose of that hospital, or perhaps if they were to shift to another hospital?-- Well, of course they'd need re-issuing of clinical privileges depending on the role delineation of the hospital. There was no process for central recording, no.

COMMISSIONER: That's what I'm concerned about, and my question is assuming that Dr Patel, for example, was not credentialled and privileged, shouldn't that have been picked up by central office? Shouldn't that default on the part of the local level have been picked up centrally?-- There was no process for that, Commissioner.

All right. Thank you.

MR DOUGLAS: Thank you, Commissioner.

COMMISSIONER: I'll now adjourn.

THE COMMISSION ADJOURNED AT 11.31 A.M.

THE COMMISSION RESUMED AT 11.46 A.M.

ROBERT LYNTON STABLE, CONTINUING:

COMMISSIONER: Have those who want to ask Professor Stable questions agreed upon an order?

MR DIEHM: I don't know that we had.

COMMISSIONER: Beg your pardon?

MR DIEHM: I've not been party to any such conversation, Commissioner.

COMMISSIONER: I'd really be very grateful if counsel would in future, as I've asked you before, agree upon an order of questioning witnesses.

MR DIEHM: Yes.

COMMISSIONER: Who wants to then ask Professor Stable questions?

MR DIEHM: I do have some questions.

COMMISSIONER: You do? Anyone else?

MS GALLAGHER: I have two very short matters.

MR ALLEN: Briefly, Commissioner.

COMMISSIONER: Why don't you go first then?

MS GALLAGHER: Yes.

COMMISSIONER: You have two short matters. You go first.

MS GALLAGHER: Thank you, I will.

CROSS-EXAMINATION:

MS GALLAGHER: Professor, my name is Gallagher. I appear for Dr Nankivell. Some of the evidence you've given this morning has been - in response to questions by Mr Douglas, have been that to some extent your actions and those of your Department were dictated to by the politicians. That's correct, isn't it?-- By legislation the Department is subject to the government of the day and the Minister of the day.

Well, from that what I wanted to ask you was whether or not within the Department the politicians had the ability to dictate, for example, where hospitals would be located or remain operational?-- That is definitely a political decision.

Does it then follow from that that the facilities available, the care available, the number of practitioners available at certain centres were matters dictated by the politicians?-- By the mere fact that they provide the budget, yes, because obviously if there's no budget you can't employ a lot of staff. But it never - I can never recall an instance, except through the budget process, when we were directed to open an extra three intensive care beds at 600,000 each or something like that. I can't recall where some politician would say, "You need another surgeon" or another this or another that, no.

I suppose to be fair to you, it's probably easier to be more specific. I'm speaking particularly, for example, of Hervey Bay?-- Mmm hmm.

Was it the case that there was ever pressure brought to bear, if you like, to ensure that that particular hospital, for example, had a very short waiting list?-- Oh, there was

enormous political pressure. I mean, I was abused by politicians because - I mean, one example was the Medical Board wouldn't register a doctor, and a politician rang me up and abused me, and I had to keep saying, "The Medical Board is not my responsibility. You'll have to speak to the Medical Board." His response was, "Don't give me that. They'll do as you tell them." I said, "I'm sorry, they don't." But politicians have been very rigorous in trying to get their local hospitals fully staffed, and there's a lot of pressure to have those - them fully staffed-----

COMMISSIONER: You're asked in particular, though, about Hervey Bay?-- Well, I don't recall - I certainly recall, Commissioner, that prior to the election in 1998 we were directed to open the Hervey Bay Hospital, and my advice to the then Minister was, "We don't have a budget for it", and he said, "It doesn't matter. We'll fix it after the election." That was a major concern, because that was premised on closing a fair bit of Maryborough Hospital, which subsequently caused pain for the next Minister. But Hervey Bay, that's the only - I'll try and recall if there's any others - but certainly Hervey Bay, that was a very clear direction just to open beds before the election in '98 and hang the expense.

MS GALLAGHER: Do you recall any similar pressure in respect of waiting lists at Hervey Bay?-- Not specifically Hervey Bay, no.

COMMISSIONER: Who was that Minister?-- Early 1998 was Mr Horan.

MS GALLAGHER: Commissioner, might this document please be put on the image intensifier?

COMMISSIONER: Yes, certainly.

MS GALLAGHER: Dr Stable, do you recall attending at Bundaberg in November 2001?-- It was actually - the meeting you refer to was Monday, the 3rd of December, I think.

Thank you. Do you recall being handed this memorandum by Dr Nankivell that day?-- I don't recall receiving the document, no, but I certainly recall, whilst Cabinet was meeting at Hervey Bay, attending Bundaberg Hospital, as was my practice at local hospitals, to talk to staff, yes.

Thank you. Could you please scroll slowly through the document so that the doctor has the opportunity to have a look at it? Do you recall seeing this document?-- Not at the time, no, but I've obviously since read it on the previous Commission's website because of the allegations made.

Indeed. Did you ever respond to the issues raised by Dr Nankivell in this document?-- Absolutely.

Thank you. I have nothing further.

COMMISSIONER: Thank you.

WITNESS: Do you want me to say how?

MS GALLAGHER: Thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Doctor, my name is Geoffrey Diehm and I appear for Dr Keating. I just want to ask you a couple of matters that emerge out of what you've said in your statement and your evidence concerning credentialling and privileging. The first of them arises out of paragraph 81 of your statement, and you say in there that, "As a senior medical officer and not a registered specialist, Dr Patel should never have been appointed to the position of Director of Surgery." What I wanted to ask you is that - is this appointment of a senior medical officer to the position of a Director of Surgery unprecedented as far as you're aware in Queensland?-- I think so. I was asked by Hedley Thomas, who has submitted-----

I'm not asking you about what Mr Thomas may have asked you?-- Well, I think it's important information.

COMMISSIONER: No, just listen to the questions and answer them, professor?-- I'm not aware of any other case, no.

MR DIEHM: Are you aware of any other case of SMOs being appointed as directors of other departments in the hospitals?-- Well, it is the SMO award, and the - emergency medicine is a new specialty, and in the early days I was a Director of Emergency Medicine, but I didn't have a specialty qualification. It didn't exist. In the history of Queensland Health there have been senior medical officers appointed as directors to some departments, but I - personally I cannot think of any case where a registrable specialist - a position which requires to have been registered as a specialist has been appointed director of that specialty, no.

All right. Well, that may be something slightly different, though, because you're talking about where a position requires that the person be a registrable specialist?-- Mmm hmm.

There has been evidence before this Inquiry, and more particularly so this Inquiry's predecessor, that it is in fact not an unusual occurrence for a director of a department within a hospital to be an SMO?-- A registered specialist or an SMO.

A senior medical officer?-- I think there's a lot of confusion here because under the award - and one of my

recommendations is that this needs to be clarified and separated out into two awards - is a specialist is a senior medical officer under the award. They're employed as a senior medical officer, but I wouldn't mind betting that when the Director of Surgery position at Nambour - at Bundaberg Hospital was first advertised and not filled, that it was actually advertised that they had to be registrable as a specialist in the State of Queensland. That is the standard advertisement that was used, and I never approved any variation for that for any specialist trained - any position which was clearly a clinical specialty.

COMMISSIONER: So your point is that the Director of Surgery should always be a registrable specialist in surgery?-- That is my position.

That's clear enough, Mr Diehm.

MR DIEHM: Thank you. Doctor, the next thing I wanted to ask you about concerned the matters you've referred to in paragraph 85 of your statement concerning the compliance with credentialling and privileging being picked up by the ACHCS process. Now, under that process - and you've made some reference to this towards the end of your evidence earlier this morning - there would be periodically, every few years - you may have mentioned this, but there's some variation in the number of years - but periodically there would be a survey of a number of different criteria within each hospital carried out. That's the process you're speaking of, isn't it?-- That's correct.

Now-----?-- By external reviewers, yes.

An external review. So external reviewers would actually attend at the hospital and carry out inquiries as to compliance by the hospital with various criteria?-- Mmm hmm. That's correct.

And one of those criteria is credentialling and privileging?-- That's correct.

Now, if the process that occurred in a relevant time period at Bundaberg was that there was in 2003 an external review carried out, and in that review the examiners inquired as to the status of credentialling and privileging and they were told that prior to 2003 and into the earlier part of 2003 the process had fallen into abeyance, into disuse, but that a new policy had been formulated and put in place and that the credentialling process and privileging process was being re-established, that would earn a tick in the box as far as the survey is concerned, you would expect, would you not?-- I was a surveyor for quite a period of time for the Council of Healthcare Standards, and I probably would have put a statement to that effect in the - that the process had not been undertaken, but there were commitments given to undertake it in the future.

All right. In any event, it would still result in a tick as far as the criteria for the survey, and indeed the indications then would be that the process was in place?-- I suspect so, but I can only speculate.

Yes, thank you. It wouldn't surprise you if that was the circumstance anyway?-- I would expect a qualification that they haven't been doing it because the process in fact is not just about what they're going to do, it's about what they've been doing, and if they haven't been doing it I would expect that to be in the report.

Yes. Thank you. That's all I have. Thank you, Commissioner.

COMMISSIONER: Thank you. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Professor Stable, John Allen for the Queensland Nurses Union. If I could also ask you a few questions about your evidence concerning credentialling and privileging, you mention in paragraph 83 of your statement that the policy on its face requires all medical staff other than junior medical staff to be credentialled and privileged, and you express concern that SMOs need to be considered further, as it now appears that they could slip between the cracks, and you mentioned in your evidence earlier this morning that in your opinion it was not clear in the policy regarding credentialling and privileging in relation to SMOs. You described it as a grey area?-- Mmm hmm.

Do you have a copy of the policy with you at all?-- I don't believe so, no. Let me just check.

Commissioner, could I ask if the policy, Exhibit 279, could be put on the visualiser? In particular, page 5 of that policy in Exhibit 279. For Mr Groth's benefit, I'll also be asking the witness to have a look at Exhibit 40 shortly. If we just see at the top left-hand corner under the heading, "Purpose of the credentials and clinical privileges process", you will see that there's reference to ensuring that all medical practitioners - and it goes on?-- Mmm hmm.

Then there's a Footnote 1 at the bottom of the page, and this, I expect, is what you may have been referring to. "The guidelines do not apply to junior medical staff such as interns, residents, principal house officers, registrars", and there's a different type of exception, "fellows appointed on a short-term basis as part of post-fellowship training". Now, leaving aside that last category, all the others are junior medical officers or staff in the sense that they're, as a matter of course, supervised by more senior medical

officers?-- That's correct.

Is that so?-- That's correct.

And do you say that there's a grey area in the sense that a senior medical officer could fall within that description of junior medical staff?-- Yes, the policy, as I recall, was written in the context of you're a specialist or you're someone under supervision. Senior medical officer, and, for example, senior medical officer in surgery is under supervision, but I think that probably is not clear, and to make it crystal clear, if they're not under supervision they should be credentialled, if there are going to be senior medical officers doing that sort of work.

But on its face, when you look at the terms of the footnote, you wouldn't describe a senior medical officer as being an intern, a resident, principal house officer or registrar?-- No, I wouldn't.

That position would be quite distinct to those?-- That's correct.

So on its face you wouldn't describe an SMO as being a member of junior medical staff?-- No.

Okay. If you could have a look, please, at Exhibit 40 which is the position description for the senior medical officer (surgery) job that Dr Patel was appointed to initially before being elevated to Director of Surgery. Have you had a chance to look at this position description previously?-- No.

All right. Perhaps if we just go through to "Primary duties/responsibilities" on the first page. You will see the third dot point, "Provide consultation services to other departments of the health service", the fifth dot point, "Supervise clinical care of patients by junior staff", the next dot point, "Involvement in educational activities involving junior medical staff" et cetera. Now, those primary duties and responsibilities are certainly not consistent with someone you describe as being junior medical staff. Is that so?-- Yes, correct.

Okay. So if we go down a bit further - no, I'll withdraw that. In relation to the type of position that he was initially appointed to, there was certainly no - he didn't fall - that is Dr Patel - within any grey area as to whether the credentialling and privileging process applied to his appointment as a senior medical officer. Would you agree with that?-- No, because I think in the document it's just not clear, having re-read it, and-----

COMMISSIONER: In what document are you talking about now?-- The credentialling and privileging document.

Looks perfectly clear to me, but all right?-- In that the intent was that a senior medical officer would be a specialist. We've now got somebody appointed not registered

as a specialist in the state to do specialist - work within a specialist category.

MR ALLEN: Well, if we could just go back to Exhibit 279 then, which is the policy, and again page 5. You've already been taken to the start of that paragraph 1 and the Footnote 1?-- Mmm hmm.

Do you suggest there's something else in the policy dealing with to whom it applies that on its face suggests that it would only apply to specialists?-- I read this in part of the 17 hours of interviews I did with counsel assisting, and it just struck me at the time when I looked at it briefly that there was some lack of clarity about senior medical officers.

COMMISSIONER: Can you point that out, because I can't see any?-- Well, Commissioner, if you could give me a copy of the document to flip through, I'll try and identify it.

MR ALLEN: Perhaps if the witness had the document in front of him.

COMMISSIONER: Yes, by all means?-- Whether I can do that now or not, I'm not sure. Commissioner, I can't see what struck my eye when I read it, perhaps except that the footnote in its definition of "junior medical staff" doesn't clarify where a senior medical officer sits.

It makes it clear that it's not in that footnote, doesn't it?-- Agreed, Commissioner, but they're not a registered specialist either.

No?-- And the breakdown was between registered specialist and other staff when the policy was first implemented.

Well-----?-- I mean, it may not be a point to anybody else. It was just something I noticed I thought could strengthen it.

Well, it's not a point to me.

MR ALLEN: Very well. You were taken to Exhibit 340, which was that e-mail from Mr Brad Smith in relation to the proposal of taking the measured quality report to Cabinet so as to gain FOI exemption. Do you recall being taken to that e-mail?-- That e-mail didn't mention FOI exemption. I don't think that e-mail did. But I recall being shown the e-mail this morning, yes.

You recall the topic. The ultimate public report which was published on the Internet is Exhibit 352 in these proceedings, and you're aware of the nature of that document?-- Mmm hmm.

And that was only published in about mid-2003, wasn't it?-- I think August 2003 is the forward that I signed.

Okay. And the public document which was then published was in some terms different to the original report which had been submitted to Cabinet in November 2002?-- There was a lot of

detail in the original reports. As to the exact differences, I can't specify them now. There was a lot of detail-----

I'm not talking about the 60 hospital reports which were never publicised, but the actual report which was then made public was somewhat different?-- That's my understanding, yes.

Okay. And one of the differences that's been pointed out by the Honourable The Premier in correspondence to the Commission was deletion of some reference to the ageing nursing workforce?-- I just don't recall.

You don't?-- No.

Okay. I'll see if I can jog your memory at all. In the original report which was submitted to Cabinet, and which is Exhibit JEC9 to the statement of Justin Collins, at page 48 of that report there was a section, "Workforce Management" which was dealing with the links between quality of services and skilled workforce?-- Mmm hmm.

And noting two high priority workforce issues for Queensland Health, being turnover of staff and age of staff, in particular in relation to the nursing workforce?-- Mmm hmm.

The draft report and the subsequent public report refer to the shortage of and difficulty in retaining nursing staff being noted both nationally and internationally, and the importance for Queensland Health to retain skilled and experienced staff?-- Mmm hmm.

Now, all that found its way into the public report which was eventually released. I just want to ask you about the following paragraph which was in the original report but apparently deleted before the public report was published, and it read, "Despite the problem of excessive turnover of nursing staff, the average age of nursing staff is increasing and there is a growing risk that a large number will reach retirement age within a short period of time which will result in the bulk loss of expertise."?-- Mmm hmm.

So that paragraph was highlighting the problem of the ageing nursing workforce and the need to retain and obtain suitably qualified nursing staff?-- Mmm hmm.

That's so?-- Well, from what you've told me.

All right. Do you have any recollection as to the reasons that may have underlay the deletion of that paragraph in the report that was eventually released?-- None whatsoever.

Were you aware of the process that took place between, say, November 2002 and August 2003 in relation to amendments to the original report?-- There were negotiations between Queensland Health, the ministerial staff and staff of the Premier's Department to finalise the report.

So was it three-way negotiations then?-- Yes.

Queensland Health, Minister for Health, Premier's Department?-- Yes. That's my recollection, yes.

And who undertook those negotiations?-- Well, would have been Justin or Justine Collins-----

I think we can assume it's Justin because it's Justin Edward Collins?-- Oh, okay. Thank you. Okay. Thank you for that clarification. My deputy, who was John Youngman, followed by Steve Buckland, had carriage of it because it was such an important matter to us to try and progress it and follow it through and get outcomes, but - so yes, they would have had carriage of it.

And in relation to the ministerial office, who was that - sorry, the Health Minister's office?-- The Health Minister would have been staffed in the Health Minister's office. I'm not sure specifically who would have been the primary people involved, but there were a number of staff in the ministerial office.

Do you recall at the time that the original report was being considered by Cabinet whether there was discussion of any sensitivity in releasing that report at that time because of ongoing enterprise bargaining between the Queensland Nurses Union and Queensland Health?-- I don't recall that discussion, no.

You don't recall that being even suggested as a reason why the report perhaps should not be released at that time?-- No.

Or being suggested as a reason for modification of the report as it was subsequently publicly released?-- No, I have no recollection of that.

Thank you.

COMMISSIONER: You have some questions, do you?

MR DEVLIN: Just on one topic.

COMMISSIONER: Yes, certainly.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Professor Stable, Ralph Devlin. I represent the Medical Board of Queensland. Specifically in relation to the Director of Surgery, the previous Commission heard three propositions relating to the reality at Bundaberg and I simply want to ask you whether you agree or disagree with these propositions, whether they are consistent with reality in the provinces as opposed to the big hospitals. The first of those is this, that a distinction should be drawn, it is said, between a large tertiary hospital in which a Director of Surgery would spend a lot of time teaching and the regional hospitals where there may be two full-time surgical staff and one of those is the, so it is said, unlucky bunny who ends up in the position of Director of Surgery as it were by default. In other words, ends up in charge of the paperwork and has the title. Do you agree or disagree with the suggestion that that is a reality in regional hospitals?-- I'd suggest it's probably a reality, yes.

Thank you. Next, it was suggested that because Patel was a locum, he did not have to be a specialist to be employed as an acting Director of Surgery until a replacement was found; do you agree or disagree with that proposition?-- I disagree with that proposition.

How would you express it then or have you already expressed your position on it?-- If he is to be employed as a specialist, then he should be a registered specialist under one of the specialists registration arrangements, of which there are a number, with the Medical Board. And if I make the point, this was a question asked of me by The Courier-Mail the week I left-----

COMMISSIONER: Please don't tell us what you told The Courier-Mail. Just answer the question?-- Well, the specific issue was would I agree to someone being employed as a

specialist if they're not a registered specialist and the answer then and now is no.

MR DEVLIN: How does that square, though, with the reality that some people who aren't specialists end up as directors? See, the example is given in evidence more than once that a Director of Anaesthetics in a regional hospital may not be a specialist but may have a real interest and skill in that area?-- Well, without knowing the - I mean, I just don't agree with that and if you give me an example and - then I can - if I can recollect it, but I can't think of any situation where someone can be a Director of Anaesthetics and not be a registered anaesthetist.

Well, can I ask you this then: in your time as Director-General, if we simply take it that this witness is speaking from a reality, you as Director-General were not aware of that reality?-- I was not aware of that situation, no.

Thank you. Finally, it is also - another proposition is put this way, that Patel was appointed as Acting Director of Surgery in the hope and expectation that he would seek and secure Australian specialists registration?-- Mmm.

Does that pass muster in your mind?-- No, he wasn't a registered specialist. He shouldn't have been in the position.

Thank you.

COMMISSIONER: Do you want to ask any questions?

MR BODDICE: No.

COMMISSIONER: Mr Couper, do you have any questions of your witness?

MR COUPER: There is nobody else left?

COMMISSIONER: No-one else - sorry, you weren't here.

MR APPLEGARTH: Commissioner, I have just arrived because I was told some there was evidence this morning which mentioned my client Dr Buckland. I haven't had much of a chance to talk to Dr Buckland; he is effectively between patients. My preference would be to obtain better instructions in case I need to ask any questions of Professor Stable but on the very little that I've been able to obtain so far, I could probably ask him some questions.

COMMISSIONER: You weren't even here, Mr Applegarth.

MR APPLEGARTH: I'm sorry?

COMMISSIONER: I said you weren't even here.

MR APPLEGARTH: No, but my junior was dealing with matters.

Could I have the indulgence of just a couple of minutes to speak to my junior about what was said?

COMMISSIONER: Yes.

MR APPLEGARTH: I don't expect any cross-examination of Professor Stable will be very long at all.

COMMISSIONER: Perhaps Mr Couper can ask questions while you're doing that.

MR APPLEGARTH: Thank you.

MR COUPER: Perhaps I can.

RE-EXAMINATION:

MR COUPER: Just a couple of things, Mr Stable. You were asked a question before the break by the Commissioner about whether there was a process of - whether there was a process of reporting as to whether credentialing and privileging was being done in the districts?-- Mmm.

Did the measured quality reports have any role to play in that exercise?-- It appears that it may have, yes, that - that, in fact, at district level they were required to report for - that there was credentialing and privileging but I would have to get the detail of that.

One would be able to discern from the measured quality reports of each district whether there was a category indicating whether credentialing and privileging was taking place?-- Correct.

And those reports obviously went to Corporate Office?-- Correct.

Right. The other topic I wanted to take up with you was this: you were asked some questions by my learned friend Ms Gallagher about a letter, a document from Dr Nankivell. I think you said you hadn't seen it but you knew what - the concerns expressed in it. You were asked whether you'd taken any steps to deal with them. Can we deal with that briefly. You attended a meeting at - of the clinical staff at the Bundaberg Hospital on the 30th of December 2001?-- Mmm-hmm.

At that meeting a number of concerns were expressed about staff shortages; is that so?-- That's correct, mmm-hmm.

As a result of that meeting, and I'll just briefly if I may, did you decide to allocate funds for two visiting medical officer surgical sessions and two visiting medical officer paediatric sessions per week and an additional operating theatre staff member full-time?-- I did.

All right. And did you in the following year substantially increase the Bundaberg Hospital budget for visiting medical officers obstetrics and an accident and emergency SMO by the sum of an additional $1 million?-- I did, mmm-hmm.

I have nothing else, Commissioner.

COMMISSIONER: Thank you. Mr Applegarth?

MR APPLEGARTH: Thank you, Mr Commissioner.

CROSS-EXAMINATION:

MR APPLEGARTH: Professor Stable, my name is Applegarth. I appear for Dr Buckland. I understand this morning you asked some questions about issues in relation to the classification of emergency presentations and the data collection, whether the matters were properly classified as emergency or elective surgery?-- I was.

I wasn't here for the evidence so you will have to excuse me, and I haven't had any notice from the Commission particularly about what this relates to but I'll do my best. That issue of classification has been around for some years, hasn't it?-- Of classification of elective surgical patients?

Yes?-- Yes.

There are issues about whether people are properly classified as being in the case of emergency surgery or elective surgery?-- Yes, there were definitions for what could be claimed as emergency surgery or elective surgery, correct.

I appreciate it is a highly technical issue but as the system evolved, there must have been some evolution of the system and people doing their best to apply systems to determine whether someone who initially presented as an emergency patient was properly classified on some subsequent procedure as being treated as an emergency patient or having received elective surgery; is that correct?-- There's a definitional issue which is quite - in my view quite clear about what's emergency or not, but - but there were allegations that people were being shifted into the elective surgery categories to optimise funding for the district, yes.

Those allegations were around some years ago before Dr Buckland became general manager of the health services?-- Oh, yes, the allegations have been round for a while, about categorisation and - yes.

When you say the allegations, was Mr Walker someone who made these allegations?-- He has been manager of the elective surgery program continuously I think since 1996, or 1995 I

think probably.

Do you recall back in I think 2002, before Dr Buckland became General Manager Health Services, that Queensland Health, when you were Director-General, referred these issues that had been raised by Mr Walker to KPMG for an external analysis?-- I don't recall that, no.

Do you recall what involvement, if any, you or Dr Youngman as General Manager Health Service had in relation to these issues, as you call it, these allegations?-- Well, they - they often came through - well, when they did come, they came through parliament and people claimed that people had been moved to make it look better, et cetera, et cetera. They were obviously allegations. I don't recall much in the way of allegations that emergency patients were being moved to claim money. Most of the allegations were about alleging taking people from category 2 and putting them in category 3 or things of that mode.

Now-----?-- But the deputy - I mean, John Youngman and then Steve Buckland had carriage of the elective surgery program, yes.

You would have expected them if and when they received any allegations to seek advice from other people within the department who were familiar with the process at the hospital level and in all other levels of the department?-- Yes, both of them had extensive experience at district level and hospital level but, yes, I would.

So apart from their own experience, you would expect them to seek out, for example, information from other people who had experience and knew something about these issues and the proper classification of people as either receiving emergency treatment or elective surgery?-- Yes, I would expect them to check the information before them and to seek counsel and, yes, come to a conclusion.

And I'm - I appreciate you probably had to deal with a thousand things a month. You're not saying that you weren't apprised of what was happening from time to time; you just don't specifically recall what happened in terms of reporting to you about these matters from time to time?-- Well, specifically, I was shown a document at about 8 o'clock this morning and asked - and told that I'd be asked about it. I don't recall having seen that particular document before and that document outlines - makes allegations about a number of hospitals that were allegedly moving patients on to the elective surgery ledger, if you like, that had been emergency presentations. But I did make the point that one of the things that struck me when I saw the document this morning was that was at a time when there was industrial action by specialists who were refusing to do elective work because of the indemnity issue and Nambour, for example, was hit particularly hard, PA as well through that industrial action, and I would want to satisfy myself that there wasn't an element of hospitals trying to look after sick people by doing it that way, but I

only saw the document, I believe, for the first time this morning. I had no recollection of seeing it before.

I take it it is a highly technical area in terms of how one interprets data and data year to year on elective surgery as against emergency surgery?-- Well, it is clearly defined now but you're correct in that what was included in base funding, what was due for additional funding, what should or shouldn't be included had been ongoing issues for at least 10 years - well, at least since 1985-----

Just on this specific issue, I have just been given the document as well, some issue about reclassification of emergency presentations as elective surgery, would you have expected Dr Youngman as General Manager Health Service and then Dr Buckland after him to seek advice from, for example - I'm instructed that there's a procurement council?-- There was. Yes, that still exists. It was - it was in existence when Dr Buckland was appointed, yes, and I believe it continued for a couple of months.

And you would expect-----

COMMISSIONER: Excuse me, when did it finish then?-- I can't recall, Commissioner.

But a couple months after Dr Buckland was appointed?-- Yes.

All right.

MR APPLEGARTH: In any event, you'd expect the General Manager Health Service to look at this document, look at the allegations that were raised in it and seek advice from appropriate quarters, not simply act upon this document alone as establishing the truth of the matter?-- It was up to the person to make an assessment themselves as to what advice they needed to get but it would be a very reasonable thing to do to go and get advice from other parties.

I take it from your experience as Director-General and even before that, often on these sorts of issues there are starkly divergent views within Queensland Health if I can use the term bureaucracy as to what one makes of data?-- Absolutely and, in fact, there's things that used to come up in briefs from relative junior officers who are pushing their own barrow but didn't understand the broader picture and, in fact, there were errors because of that.

That may be the case, not through any malice or incompetence; simply that they hadn't had experience at the hospital level-----?-- Correct.

-----as to how these things are handled at the hospital?-- Yes, correct.

For example, somebody who presents at the emergency ward but in the next day or two undergo some surgical procedure which is classified as elective surgery. It is a long question. It

is more about the experience of some people who interpret numbers?-- Well, it is such a complex issue but the bottom line is there are people working some of these programs who don't understand the operational, that's why I used to try and get clinicians into bureaucratic jobs so that they had that understanding on the front line.

Do you know of a gentleman called Mr Zanco, Z-A-N-C-O?-- Michael Zanco, I do, yes.

Do you understand he worked in the surgical access team?-- Yes, I recall that.

To your knowledge did he have experience of working in hospitals as well?-- He was the manager of the surgical access program at Royal Brisbane but he doesn't have a clinical background.

I didn't mean a clinical background. Before working in, I don't want to use an old phrase, the central bureaucracy, if I can use that, he'd actually worked in hospitals?-- He'd come from Royal Brisbane Hospital where I recall he was the manager of the elective surgery program.

Now, I may have asked you this question, I will only ask you one more time and I just can't remember your answer. Are you saying you can't remember a KPMG external review on this matter?-- I don't recall that, no.

Excuse me, Mr Commissioner. I have no further questions.

COMMISSIONER: Thank you. Mr Douglas, any questions?

MR DOUGLAS: No, Commissioner. May Professor Stable be excused?

COMMISSIONER: Is there any objections to that? You're excused from further attendance, Professor Stable?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: There are no further witnesses?

MR DOUGLAS: No, Professor Stable, it was anticipated, would take most of today.

COMMISSIONER: All right. We will now adjourn.

MR DOUGLAS: I believe there is a witness tomorrow. Ordinarily the Commission doesn't sit on Friday.

COMMISSIONER: Yes.

MR DOUGLAS: That's Dr Mullen I believe.

COMMISSIONER: Yes.

MR DOUGLAS: Thank you.

THE COMMISSION ADJOURNED AT 12.31 P.M. TILL 10.00 A.M. THE FOLLOWING DAY