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Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

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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 30/09/2005

..DAY 15

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THE COMMISSION RESUMED AT 9.03 A.M.

GARY JOHN WALKER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Applegarth?

MR APPLEGARTH: Thank you, Commissioner. Mr Walker, yesterday you were giving some evidence about the anterior list and the outpatients waiting list. Just by way of summary, during your time in the Surgical Access Team, the collection of data from the hospitals continued, didn't it?-- That's correct.

There's a distinction between collection of that data and its collation?-- There is a definite distinction, yes.

And in terms of the collation, for reasons that we don't need to go into in much detail, I don't think there was a manual process that had to be undertaken in the Surgical Access Team?-- That's correct.

There was a failed attempt to use the computer system, some module was created for it, but that didn't work?-- Yes.

And that process of manual collation was a very time-consuming process for officers in the Surgical Access Team?-- Yes, and also in the hospitals.

And the point's been made by you in a few places in your statement that has been also made by Mr Zanco in paragraph 24 of his statement, that the data that was being collected and collated was unreliable in some important respects?-- That's right.

Now, Dr Buckland comes on the scene - comes into head office, having worked out in the hospitals and the zones in 2002 as General Manager Health Services. Correct?-- Yes.

And he meets monthly - or regularly with the Surgical Access Team?-- That's correct.

And you appraise him of these problems?-- That's correct.

The problem that the data that's being collected and collated manually is unreliable?-- Yes.

And that it's occupying an inordinate amount of the time and resources of a team that doesn't have enough resources anyway to produce these monthly reports?-- I think he would have got that message.

From you, from Dr Cuffe, that was the message, wasn't it?-- Yes.

That was the fact?-- Yes.

So in early 2003 the conclusion was received by the Surgical Access Team and Dr Buckland that the Surgical Access Team were better off spending their time and finite resources on developing a reliable system to collect reliable data rather than persist with the manual collation of dubious data?-- I'm not sure that Dr Buckland was actually specifically involved in the decision. Certainly it was a very informal arrangement within the Surgical Access Team that we continued to collect the data. My understanding is that, as I said yesterday, it simply went off the radar and we took the opportunity not to dedicate extra resources or continuing resources to it.

Because the resource - the priority that you were receiving from on high, from the government, is that your attention should be directed at the elective surgery waiting list?-- That is correct.

But just to round off this matter, there was some attention within the resources that could be given to the Surgical Access Team to try and get a decent computer system up, because in a year or two hence there were going to be new requirements to actually have this better organised and more reliable?-- Yes. Just in terms of timing - I'm sorry, Mr Applegarth, to butt in yet again, but those efforts began some years previous to the 2003.

There's a long history with computers, as we always know, and computer contracts?-- That's correct.

That continued with the new contract, or the new system having some problems as well, and contractual disputes and the like?-- Absolutely.

But in terms of what was happening, that was the subject of briefings to the Minister in terms of answers to questions, possible parliamentary questions, estimates hearings and the like?-- All of that, yes.

Can I just then go back to where we left off yesterday afternoon when I was asking you about the funds that you administered - by "you", I mean the Surgical Access Team and that bucket. In a sense you, the Surgical Access Team, were setting the price that you were willing to pay hospitals to perform services?-- We weren't actually setting the price. We were accepting the price that was provided to us by another unit within the office which - in other words, it was the latest, if you like, benchmarking price.

Okay. But I think we left off yesterday with you agreeing absolutely that these prices barely covered the costs?-- Yes, I agree.

And in fact in many instances they were below costs?-- I agree.

And that problem wasn't confined to just the last year or two.

That had been an emerging problem?-- Over the years.

The consequence is that you, the Surgical Access Team, are buying elective surgery services at, from your point of view, I suppose, a competitive price. You're getting it for below cost?-- That's-----

That wasn't your intention, but that's what happens?-- That was certainly the evidence.

And the consequence is that the hospitals have to pay for the gap between what you pay them and what it costs them out of their base funding?-- That's a fair summary.

So that would take money out of another bucket, the bucket there for emergency surgery or procedures or paying the cleaners, to actually pay for the cost of the elective surgery that you were being given to provide?-- That's fair enough.

Dr Buckland, when he became Director-General, if not sooner, was concerned about this funding problem?-- Absolutely.

The one that we've just identified?-- Definitely.

He was concerned about it when he was General Manager Health Services?-- He was.

Everyone was concerned about it?-- Yes.

Now, you have some role, I take it, in drafting cabinet submissions?-- Yes.

There might be some interplay with people within the Department and people in the Premier's in Cabinet from time to time?-- That's correct.

I'm happy to take you to it, but we're short on time this morning, but could I suggest to you that in Exhibit GW31 to your main affidavit you exhibit the Cabinet submission that was done in August 2004, and it addresses in a couple of important passages this problem of costs, that costs were - with increasing costs of providing elective surgery over the years, costs increasing, that this was a major problem?-- Yes. Yes, I believe I wrote those words.

You're welcome to look at it, but it gave advice that from some participating hospitals, inadequate funding of the elective surgery program is having a detrimental impact on overall budget integrity?-- Yes.

Now, were you and Dr Cuffe and the Surgical Access Team encouraged by Dr Buckland to state that problem in the Cabinet submission?-- Yes, that's correct.

Getting back to your role in the Surgical Access Team and the Department more generally, you're in the difficult position of having to meet the policy objective of getting additional elective surgery activity going, but there's pressure, as

we've seen, on the budgets of the hospitals. There's this competition, as it were, this tension between-----?-- It's certainly a conflict.

I don't have an economics degree, but in some cases the Surgical Access Team was a monopoly purchasing elective - additional elective surgery spots in hospitals. You controlled the purse, you were the one who bought the services off the different hospitals?-- That's right.

And as a monopoly, with whatever input you had, you effectively can set the price?-- Yes, but-----

I'm not saying you personally, but the system had the Surgical Access Team, with input from other people, setting the price that you were paying the hospitals for the elective surgery?-- Under direction from the government, yes.

Now, you can continue to pay out-of-date prices with the consequences we've just discussed before in terms of budget integrity, that's one choice you can make, correct?-- Yes.

Or the other is to pay current - or at least fairer prices for the elective surgery that you're buying?-- They are two options.

If you take the second option, to pay a better, a more fair price, then for each million dollars that the Surgical Access Team has to spend, you're going to be buying less activity?-- That's exactly right, or at least the same activity with a better price.

But the problem is you're buying less activity, and that means that - in rough and ready terms - there's fewer elective procedures being funded out of that million dollars?-- Sorry, I'm just a little bit-----

I'm sorry, it's probably my fault. I'm trying to go a bit fast. But if you pay a better price but you've still only got a million dollars to play with, all other things being equal there will be fewer procedures purchased?-- That's correct.

That would be inconsistent with the objective of the government of having as many elective procedures done as possible?-- That's correct.

And so the Department found itself in this scissors movement, that on the one hand the hospitals wanted to be paid a fair price for the elective surgery they're doing?-- Yes.

If they're paid a fair price you mightn't be meeting the government's objectives of getting as many surgical - elective surgical procedures done as possible?-- Yes.

Can we get back to the pots or the buckets, whatever they may be called. The pot that you're looking after is for certain specified surgical procedures?-- Yes.

And because there are these different pots, there has to be an issue of classification?-- That's correct.

And naturally you're protective of your pot. You want your pot only spent on things that you think should aid the objective that you have of funding elective surgery as you see it, as you understand the rules?-- Yes.

And the bureaucratic way in which one has a system that has different pots is to have business rules which try to explain to people in all levels of the system which pot a particular procedure is going to be paid out of?-- That's right.

Now, these business rules, they were the subject of varying interpretations?-- They were.

We haven't got all day, so I might have to generalise here to some extent. A big issue was whether the pot that you controlled should be available to people who entered hospital through emergency departments?-- That's a big issue, yes.

The first interpretation is that if someone is admitted via the emergency department, then that should be - and they undergo a procedure, that should be funded out of the base funding.

COMMISSIONER: Interpreting what?

MR APPLEGARTH: The business rules.

COMMISSIONER: Oh. Do we have those?

MR APPLEGARTH: Yes, we do.

MR DOUGLAS: They were put to Mr Buckland.

COMMISSIONER: Oh, right.

MR DOUGLAS: Dr Buckland, I should say.

MR APPLEGARTH: I'll come back to them, but we do have them. I won't go into them - I mean, I can at a convenient time, but I'll try to move things through as quickly as I can.

MR DOUGLAS: They're in evidence, Commissioner.

MR APPLEGARTH: Yes.

COMMISSIONER: Yes, all right.

MR APPLEGARTH: Now, that was one view, that if someone's admitted through the emergency department then undergoes a procedure, that should be funded out of the pot that's there for emergency surgery and other surgery?-- Yes, the base funding.

The other view - and I'll call this, for convenience, the hospital view, is that elective surgery funding that you

control can be used for certain cases where the point of admission is via the emergency department?-- Yes.

These are the two views that were-----?-- That's correct.

-----constantly in competition?-- That's correct.

By early 2003, if not a long time earlier, you were aware of that hospital view, if I can call it that?-- Yes.

Now, just to try and-----

COMMISSIONER: Are these business rules vague, or is there plainly one view correct? There's not much point in talking about different interpretations if one is plainly wrong.

MR APPLEGARTH: Well, your Honour - your Honour's been on so many Courts, things are open to interpretation. I think these things are open to interpretation.

COMMISSIONER: Well, if you tell me it is-----

MR APPLEGARTH: Yes, I think they are open to interpretation.

COMMISSIONER: All right.

MR APPLEGARTH: But just in trying to give some focus to the practical problem that people in hospitals would face, for example, someone presents at the emergency department with acute abdominal pain and they're seen and they're stabilised and they undergo some scope and it's found that they've got a growth, a polyp, or even a cancer - understand the type of hypothesis?-- Yes.

Rather than sending that person home and, "Come back next week and we'll put you on the list to have this removed", the decision might be made at the hospital for them to stay in hospital and have that growth removed in a day or two?-- Yes, that's a common scenario.

And that scenario, from the hospital's view, the hospital viewpoint was that in that type of case that removal of the growth should be paid out of the elective surgery pot, that is the hospital view?-- Some hospitals, yes.

Just another quick concrete example, someone turns up, say at a regional hospital on Sunday night to go to have the hip replacement on the Monday morning, they present Sunday night through the emergency department because that's the only place that's open?-- Yes.

And they're coded in as having entered the hospital system and being admitted through the emergency department?-- Yes.

Again at least some hospitals contended that that person should be eligible for elective surgery funding?-- That's right.

COMMISSIONER: I take it that wasn't your view?-- Once again, Commissioner, the rules - the rules were quite vague. We set up the activity targets based on coding practices that were in place back in 1996. The principle of the government has always been that if we give a hospital extra elective surgery funding, that should buy extra elective surgery. So if a hospital was coding this data back in 1996 such that every patient that came through the emergency department was an emergency patient, then that is what the expectation was in terms of the government principle.

That is, that person would not be an elective surgery patient?-- That's correct.

MR APPLEGARTH: When you say the government principle, that's the principle you understood and applied?-- Yes.

COMMISSIONER: As you understood it, that was Dr Buckland's view?-- Well, Dr Buckland and I had convergent views over a reasonably long period of time, he having come from the coalface, so to speak, and having a very good handle on the difficulties of day-to-day management of surgery.

MR APPLEGARTH: But-----

COMMISSIONER: You mean yes by that?-- Yes.

MR APPLEGARTH: You haven't worked - I mean, you may have worked in some hospitals in some administration role, but you haven't worked in a hospital in terms of the - that type of process of organising surgical lists and-----?-- No, I haven't.

So I think we've identified there's a classification issue when someone turns up Sunday night and enters the hospital through the emergency department. That's a classification issue?-- It is.

Then there's a reclassification issue. That is, when the hospital - someone tells them, or they think of it themselves, "All these people have been coming through on Sunday nights for the hip replacements on Monday. We're entitled to be paid for hip replacements out of the elective surgery budget. We will go back and ask for, or take the funding out of the elective surgery budget", as an example?-- As an example, yes.

That's the reclassification issue, or an example of the reclassification issue?-- Yes.

These debates - it wasn't just a debate between you and Dr Buckland, it was a debate been the Surgical Access Team itself, wasn't it?-- Yes.

And it was a debate between the Surgical Access Team and, if I can use this term, the hospitals, represented by the zones and the districts?-- That's correct.

COMMISSIONER: I thought you were saying you and Dr Buckland were at one on this view?-- No, Commissioner - well, in some cases we were, but on this particular issue my belief is that it was divergent, our views.

In what respect?-- Well, Dr Buckland believed that there was some of these admissions - my belief is that Dr Buckland believed this - that really were proper elective surgery patients at the end of the day, after the whole classification, or treatment process was undertaken.

But you were at one on the reclassification issue. Do I understand you to be saying that?-- No, I believe that-----

You don't say that either?-- -----we were divergent on that reclassification issue as well. That's the way it panned out. I mean, I didn't know at the time. It really panned out over many months of discussion and results.

All right.

MR APPLEGARTH: I'll try and do the panning out and the short history as quickly as I can, because it just provides a context.

COMMISSIONER: All right.

MR APPLEGARTH: Just to summarise, when you have the two bucket systems, you have to have all these rules to decide which bucket it's going to come out of?-- Yes.

And you have these contests about interpretation?-- Yes.

This issue about - these issues about classification, reclassification, they certainly pre-dated Dr Buckland's arrival into head office?-- Definitely.

They'd gone back to Dr Cleary who had a lot to do with this back in the late nineties?-- Yes.

He had views about reclassification, that as the system evolved you would expect a lot of reclassifications?-- Dr Cleary was in the hospitals by then, I believe, yes.

But it was an issue when Dr Youngman was the General Manager Health Services?-- It was.

This debate was had during his era?-- It was, yes.

And during his time - and I think it was in May 2002 - the debate was such that KPMG were commissioned to go and review this issue, amongst others?-- Yes.

And they looked into it, and amongst their findings was that there was this problem of elective procedures, particularly in regional hospitals, being done in the emergency department?-- Yes.

And there were problems with the way officers and administrators were coding matters?-- Yes.

The upshot of that was that there had to be a focus on getting people to improve their systems of coding so that something that was an elective surgery - hip replacement - was properly coded and treated so that it would be available out of elective surgery funding?-- I'm sorry, I didn't manage that KPMG process, I'm sorry.

Okay. Just generally looking at the - but KPMG found evidence that supported to some extent the hospital view that elective surgery was being done in emergency departments and being paid for out of the emergency department budget?-- Yes, I believe that's correct.

And they found problems with just the administration, the accuracy and reliability of what people were doing in terms of input practices?-- Yes, a variability of practices across hospitals.

Okay. Now, just getting back to the Surgical Access Team, or Surgical Access Service, in terms of the data that it relies upon, it's looking at figures that come to it from the hospitals in terms of amounts spent on elective surgery, amounts spent on emergency surgery, total surgery. It's looking at big pictures, isn't it, in terms of movements and trends?-- It is. That's a fair comment.

And in terms of your commentary over the years, the inferences that you draw about trends were based upon looking at things like how much of the total percentage of this hospital or overall is being spent on elective surgery?-- Yes, that's one of the areas that I focus on, the big picture.

Okay. But your big picture is a big picture built on these macro numbers, if I can call them that?-- Yes.

It's not from looking at what actually happens at the hospital and going through and looking at their files and doing that sort of process?-- Well, if I could just clarify that over the years our information systems have improved dramatically, so that now we can go down to a very fine level at the individual procedure level at a hospital - in a hospital.

But that refinement has been in recent years?-- Yes.

If we're talking - and we do the short plotted history, when you were agitating these issues about classification, wrong classification, what one makes of it, that went to the Health Services Council in about 2001?-- Yes, it did.

And your view didn't find favour?-- It did not.

Dr Youngman chaired that group?-- He did.

And it had a lot of people who were experienced in hospital management?-- That's correct.

Information officers from hospitals?-- I'm not sure that there were any information managers from hospitals there.

But it had zone managers?-- It had zonal managers, yes.

Now, Dr Youngman, during his time, Dr Buckland during his time, and perhaps even after Dr Buckland, whoever the General Manager Health Services was, was faced with these conflicting views about how the system should operate and how it is in fact operating?-- Yes.

There's the hospital view and - I don't want to personalise this, but it's easy-----?-- Yes.

-----to have a short phrase, there's the Walker view then there's the hospital view?-- Yes.

The Walker view is based upon those macro numbers, largely?-- Yes.

The hospital view is based upon what happens on the ground?-- Yes, and the overriding - there was always an overriding issue there about budget management. At the end of the day these things impact on budget management.

Anyway, there's the Walker view and there's the hospital view, and they're almost like parallel universes?-- Yes.

Or ships passing in the night. Whatever metaphor you like, they're operating on different information?-- Yes.

And different interpretations?-- Yes.

At the hospital level there are health information managers who go through and audit the system, isn't there?-- There are.

And they have to do that - I don't know if it's a good idea, but the Health Insurance Commission requires them to do it. It provides oversight?-- That's right.

So the audit function and making sure that the system's operating properly at the hospital level isn't something that the surgical Access Team or Surgical Access Service had to concern itself with directly?-- That's correct.

Now, post-KPMG in the 2002/2003 year, there was an understanding that people in the hospitals had to be better trained to ensure that things are properly classified?-- That would be a reasonable outcome from such a consultancy.

Well, do you recall that some people from the Surgical Access Team actually went out and helped explain and train?-- Yes, absolutely. That was a key part of our overall role, helping the hospitals.

Did you go out?-- On many occasions.

And you took your interpretation of how things should be done, obviously?-- Well, I'm sorry, I was never involved in actually advising people in terms of coding practices.

Okay?-- My role was very much about, well, what can we help - what can we do to help you to administer the overall program.

But in terms of training the officers who actually have to do the day-to-day work, that fell to other people from the Surgical Access Service to go and out train?-- Yes.

Okay. And they might actually adhere to the hospital view that if something qualifies as entitled to elective surgery funding, that they're not precluded from that because the point of admission was via the emergency department?-- That may be correct.

Well, that is the case, isn't it? That was a view that people held?-- Yes. I mean, my position at the time was that we shouldn't be providing this information to one or two hospitals. I mean, the - everyone should be aware of what the possibilities were.

But you took the view that hospitals that claimed funding from the elective surgery funding for people who'd entered the hospital and been coded as having entered the hospital through the emergency department were not obeying the rules if I can call it that?-- That's correct. That was my view.

And you thought that they were actually abusing the system?-- Yes, at the end of the day, yes.

And that view about abusing the system was based upon your interpretation of the rules and what you made of the data?-- Yes.

The macro data that you had?-- Yes.

Do you have the August - I'm sorry, the July 2003 paper that - it's in two forms. It's Exhibit 368; it is also Exhibit 394. It is the one dated 30 July 2003. It doesn't matter at this stage. I can give you a copy if it helps to work off it. This is a - I put in front of the witness Exhibit 394?-- Thank you.

MR DOUGLAS: Exhibit 394 is the memorandum but just as I hesitated yesterday, this particular document bears some handwriting which at no stage is it suggested this witness saw. I just make that qualification, Commissioner.

COMMISSIONER: Yes.

MR APPLEGARTH: Now, Commissioner I'm not sure whether you have a copy.

COMMISSIONER: Yes, I do.

MR APPLEGARTH: Thank you. Just quickly, if you go to the first page with the typing on it in the section "Background", what you identify there is that you say, "In order to identify those hospitals actively reclassifying, and to estimate its impact on funding and activity reporting, an audit process has been initiated based on information available electronically within the Queensland data repositories." Do you see that?-- Yes.

So, basically, your analysis was done at a desk in Charlotte Street?-- Yes. Just be aware, Mr Applegarth, that I didn't actually write this document.

But you cleared it, didn't you?-- Indeed I did.

Well, you must have agreed with it?-- Yes, I did.

You understood the process-----?-- Absolutely.

-----by which Mr Roberts came to write it?-- That's right.

Mr Roberts, had he worked in the hospital system?-- He had.

As an administrator?-- Yes.

In the organisation of lists and the like?-- That's correct.

Then you go on to deal with the criteria which we will perhaps come back to but the important thing is the dot point "Elective Status of Patient to Elective". Do you see that down the bottom of the page?-- I do.

And that becomes a big issue; that is the issue, isn't it?-- Yes.

As to whether someone who comes through the emergency department and is admitted into the hospital through the emergency department as a point of admission, the little old lady on Sunday night, falls within that category?-- Yes, that's right.

Okay. Just moving quickly through the document, you discuss the interpretation issue. Then I see at the bottom of - it doesn't have a numbered page but it's got the heading "2. Incidence of reclassification", et cetera. You have read the, "Key point - reclassification is spreading but is only being abused by a minority of hospitals"?-- Yes.

You took the view that reclassification was really an abuse?-- I did.

And that conclusion was reached without really any input and investigation from the hospitals who were allegedly abusing the system?-- Well, the terminology was chosen by Mr Roberts. I didn't change it.

Well, if you weren't comfortable with the term "abuse", you would have changed it?-- That's right.

You were comfortable with the term "abuse" because it coincided with your attitude?-- Yes.

Now, don't get me wrong, Mr Walker, there were some hospitals abusing the system it would seem. Nambour, as we see on the next page, proved to be a prime example, if you move to the table. Do you have that?-- Yes, I do.

Just the point about Nambour, to cut a long story short, that was investigated and Dr Buckland imposed a 600,000-dollar penalty on it?-- Yes, our recommendation was that the penalty should - should align with the volume of reclassified data, which from memory, about $1.5 million. Dr Buckland agreed that he would penalise Nambour to the tune of $600,000.

Okay. Just working through the documents, if you would turn over the next page under the heading "Funding Implication" about a third of the way down.

COMMISSIONER: Mr Applegarth, while you are moving forward so quickly, I don't really understand - and I'm not criticising your speed for one moment.

MR APPLEGARTH: I'm always encouraged, your Honour, to be speedy.

COMMISSIONER: But I don't understand the difference between your interpretation of abuse and what you're apparently criticising this witness for, for his interpretation of abuse. You said there were some hospitals abusing the system and you seemed to be critical of his use of the term "abuse."

MR APPLEGARTH: No, I will withdraw that. What I should say is that you - you thought, Mr Walker, that apart from cases where someone obviously was wrongly classifying or reclassifying?-- Mmm.

You thought that people who, for example, reclassified the Sunday night hip replacement entry through the emergency department were abusing the system?-- Well, "abusing" is a fairly strong word. I mean, I would have preferred that they were continuing their coding processes as they were back when our activity targets were established.

Okay. I will come back to these lists in a moment.

COMMISSIONER: You still haven't clarified your term of "abuse".

MR APPLEGARTH: Thank you. I think in the interests of expedition, I'll move on and perhaps - I don't think it is terribly helpful to have rival debates about abuse in terms of cross-examination so I think I can better - I better approach it from a different angle.

COMMISSIONER: All right. Whatever you like.

MR APPLEGARTH: Just working through the document, under the heading "Funding Implications" on the next page you did or Mr Roberts did an estimate of how much money would be involved and you see there $4.5 million?-- Yes.

And in brackets: "Assuming none of these cases are genuine planned elective admissions". Do you see that?-- Yes, yes, I do.

Now, that was an important assumption?-- That's absolutely right.

It was a big assumption?-- Yes.

Now, we see at the end of the paper before we get on to the attachments at the end there is a section about consultation?-- Yes.

The consultation process in preparing the submission was with you, with Mr Zanco and Simon Wenck, so it is an internal consultation within the surgical access team?-- That's right.

You can't say whether each of those, Mr Zanco or Mr Wenk, agreed with everything in this; they were just consulted?--

That's right.

We see that there wasn't prior consultation with any of these hospitals?-- No.

Why is that?-- Well, once again, there was an overview document. This was simply requesting approval to do a more detailed audit as I saw it.

Okay. Just to finish the narrative, what happens is that over the next month or two there's input from the hospitals through the zones, isn't there?-- There is.

Which explains the process as they saw it?-- Yes.

And explains the situation for these particular hospitals?-- Yes.

And the surgical access team found many of those explanations satisfactory?-- Yes.

Nambour obviously wasn't?-- No.

I think it boiled down to three out of the 10 were found not to have conducted themselves properly?-- Yes, that - I just need to but in if you don't mind. Just in terms of - you must appreciate that I was requested to destroy the document - destroy this document. I felt under, you know, quite a lot of pressure to be I suppose, you know, a little bit sparing in terms of how strong our recommendations in terms of where we were going with this would be at the end of the day.

We will come to it as soon as I can this issue about the instruction to destroy and where that came from and so on?-- Yes, but I'm just pointing out that-----

What I'm-----

COMMISSIONER: Just let him finish. Yes, keep going?-- Just what I'm pointing out is that I'm - that I may not have personally agreed with going down this path. It was about getting something together that may be accepted by the General Manager Health Services.

MR APPLEGARTH: Now, in terms of the practice of reporting to and making submissions to the General Manager Health Service, whether it be Dr Youngman or Dr Buckland, isn't it the case that, for example, during Dr Youngman's period it was made clear to the surgical access team that if there were to be submissions about these sorts of matters, that there should be consultation with the zones before a submission went forward?-- No, that's not correct.

I suggest to you it is?-- Well, I - I - my interpretation of the instructions were that where there was a major funding submission or in the case of the elective surgery business rules, then we were to consult with the zonal management

units, and in fact, finally, we actually were instructed to have the zonal managers sign off on those major funding submissions and for the elective surgery business rules.

But isn't it the case that both during Dr Youngman's time as General Manager Health Service and prior to July 2003, that instructions tell me - you may not have received it, it may have gone to Dr Cuff, that any submission that related to the performance, allocation or withdrawal of funds had to be discussed and endorsed by the Zone Managers prior to submission to the General Manager Health Service?-- Look, I recall something along those lines; however, at the end of the day I can assure you that what was accepted was major funding submissions only and the elective surgery business rules were the documents that were consulted with in terms of the zones and finally signed off by the zonal managers.

Now, you put this document - you clear it, it gets submitted through Mr Cuff and it goes to the General Manager Health Service and it's received in the office I think in early August?-- Yes.

And a meeting is set up with Dr Buckland?-- Yes, that is my understanding, yes.

Well, you were at the meeting?-- Yes.

Isn't it the case that Dr Buckland expressed his disappointment that you didn't consult with the hospitals before putting this document forward?-- I don't recall that, I'm sorry.

Well, what do you recall him saying about that, if anything?-- About the consultation issue?

Yes?-- I don't recall much about the consultation issue, I'm sorry.

COMMISSIONER: You mean you don't think he said anything about the consultation issue?-- I don't recall anything, Commissioner.

Does that mean you think he didn't say anything about the consultation issue?-- No, I don't know, I just don't recall.

All right?-- Any - any conversation about - about consultation.

All right. Thank you.

MR APPLEGARTH: I suggest to you he said words to the effect of, "Well, this is an important piece of information but it hasn't been through zones to see what they've got to say about these issues." Do you remember him saying words to that effect?-- I don't, I'm sorry.

That he expressed his disappointment you hadn't done prior consultation with the zones to see if they saw this as an

issue and how big an issue?-- I don't recall that, sorry.

Do you remember him saying that he thought without the input from the zones, that the document was unbalanced?-- Well, once again, it was simply a request-----

Do you remember him saying that?-- No, I don't.

And it was untested?-- I don't recall that.

And that - I just have to put these things to you, that being unbalanced and untested, that if it was obtained under freedom of information it would present, in his opinion, an unbalanced and untested view?-- That's simply what we requesting.

Sorry?-- That's simply what the submission was requesting, we were doing further work.

COMMISSIONER: No, you are being asked if he said that?-- Sorry, Commissioner?

You are being asked if he said that?-- No, I don't recall.

MR APPLEGARTH: I suggest to you that was the issue about freedom of information, this document in his view was unbalanced and untested and on that basis it was obtained under freedom of information, the department would have to explain as it were why it was acting on this or had this unbalanced and untested document?-- No, I don't recall that.

But what happened at the meeting though was Dr Buckland went through the document with you and was it Dr Cuff there?-- Yes.

And he took the matter quite seriously?-- I believe so.

You've got there, and we can probably put on the overhead, the table that we were looking at before. My learned friend Mr Douglas said that there was some writing on the document and there is writing on the front page but if you have got the same one that I'm looking at, there is writing beside that table?-- Yes, there is.

Do you remember Dr Buckland going through these particular cases of classification or reclassification?-- I have some - some vague recollection that that was the case.

And was he wheeling a pen so far as you can recall?-- I don't recall that, sorry.

And that, as you worked through it, he said that there were obviously some of these that needed to be looked at?-- Yes, that would be a reasonable interpretation.

And he asked you which of these had already had people from the surgical access team go out to them to provide training?-- I certainly don't recall that.

Did he mention that that might be a cause of the apparent

reclassification, that someone had been out and trained the hospital or given them an interpretation which then led them to doing a different kind of classification or reclassification?-- No, I don't recall that.

But it might have been said; you just can't recall it?-- It was one of those things that I think I probably would have recalled but it really, I suppose, brought into some sort of highlight my - my management of this issue over - over a period of time.

And when you look at the table down at QEII, Redcliffe there is an arrow on it, do you see that? The 325 is arrowed up to the next page?-- Yes, I do.

Do you remember that there was some discussion as you were working through with Dr Buckland these things that there was a misalignment there?-- I don't recall that, sorry.

And that there was discussion about Redcliffe and I think it was Dr Mattiussi and some specific issues in relation to Redcliffe?-- No, I don't recall.

And I think you've seen in recent dates through your lawyers it's suggested that someone took notes at the meeting as well?-- Yes.

Do you remember Ms Miller was taking notes?-- Yes, Ms Miller was there.

You have probably seen her extract or what's said to be an extract from her notes?-- I have.

And you disagree with that as a record of what was said? I'm happy to take you to them but you've seen those notes?-- I - I glanced at them, yes.

Well, did anything jump off the page as not being an accurate record of what was discussed?-- Sorry, once again, I glanced at them. I took quite sparse notice of them.

Okay. They seem to suggest that as a result of a discussion that there was an obvious problem or obvious problems with Bundaberg, Fraser Coast, Nambour, Toowoomba, QEII, PA Hospital. That was the upshot of the discussion that you had with Dr Buckland?-- Yes, I recall that I was asked to contact these hospitals and have serious further discussions with why this practice may have been occurring.

And Dr Buckland actually said that that would be done?-- Yes, he did.

That you would prepare a memo to be sent out and the districts were to be told that you were contacting them with his authority to discuss the changes in data?-- I believe that's correct.

Then you were to get feedback from them and go back to him for

the reasons for the shift?-- That would be a fair summary I believe.

There's some discussion about the business rules?-- There may have been. I don't recall.

And that they were to stay the same for the moment?-- There may have been. I don't recall.

And that everyone should continue to monitor the reclassification from emergency to elective?-- That seems quite reasonable.

And - but already at this early stage it was obvious, and Dr Buckland said, Nambour should be put on notice that there was going to be in all likelihood a penalty - a penalty for them?-- I don't recall if Nambour was being singled out in that regard.

But just looking at the list, it looks like it is the prime offender?-- Oh, it was absolutely blatant. One year there was almost none; the next year there was almost massive reclassfication.

So Dr Buckland took these issues quite seriously?-- I believe so.

You would have known from Dr Buckland and other General Manager Health Services they have people who look after their documents for them, they go from one meeting to the next and decisions are made, people take notes, people bring documents in, take documents away?-- Yes.

And you weren't to know perhaps until the last couple of days when we've all been better informed of these things what actually apparently happened to these documents after you left?-- Yes.

That this one that he wrote on was kept with in the General Manager Health Services area it seems?-- I understand that's correct, yes.

There seems to be some issue about whether the electronic copy was put on RecFind but there doesn't seem to be any issue that there was any electronic kept. That's your understanding of the evidence as it presently stands. We're still waiting for witness statements-----?-- Could you just give me that question again, I'm sorry, Mr Applegarth.

Our current state of knowledge from what we've been told in the last day or two from Queensland Health employees?-- Yes.

Is that it seems as though this document wasn't put on the RecFind system but it was nevertheless stored electronically?-- My interpretation of what I was reading was that it was actually put on RecFind but it was removed.

And, obviously, you and I can't say with when that happened?--

Indeed.

Okay. And our current state of knowledge is that it is still on the health information network?-- So it appears.

Now, after this meeting you consult with the zones?-- Yes.

When I say "you", the surgical access team goes out and consults with the zones?-- That's correct. As well as the districts; they were involved in all these meetings.

And that results, so it seems from stuff we have been given in the last couple of days, in the generation of another report for submission by Mr Roberts. You have seen that in the last couple of days?-- I have.

Does that accord with your recollection, that he'd produced a new document that took into account consultation with the zones?-- Yes.

In the interests of time, I think I should just show the witness the document and I wasn't going to propose to take the witness through it?-- I'm happy. I have seen the - I have seen the document.

I tender a document headed "Submissions to the General Manager Health Services 11 September 2003". Commissioner, I can't take that matter any further in terms of processes or provenance or the like but-----

COMMISSIONER: Well, I assume someone is going to identify it and I'll admit it on that basis. 395.

ADMITTED AND MARKED "EXHIBIT 395"

MR APPLEGARTH: Do you remember endorsing that submission by - that was drafted by Mr Roberts?-- No, I don't.

Do you remember whether it was walked in or sent in or what happened?-- I don't. I don't, I'm sorry.

During this time, September 2003 period, the southern zone or the central zone had been consulted about these issues of interpretation and the practice of classification and reclassification, aren't they?-- Yes, through the process you just described do you mean?

Yes?-- Yes.

And they respectively put in briefings to Dr Buckland to respond to these issues that we have been discussing?-- Yes.

You may have seen a day or two ago, it became Exhibit 384, there was the submission from the central zone?-- Yes, I saw

that.

And there was another submission that came from the southern zone?-- Yes, from Toowoomba Hospital possibly, if that's the one you're talking about.

Yes. Again, you're welcome to look at this but you know the one that I'm talking about, the one that is dated 8th September 2003?-- Yes, I believe I know what you're talking about.

I tender that briefing to the General Manager Health Services dated 8 September 2003 prepared by Lee Hunter, Elective Surgery Co-ordinator.

COMMISSIONER: Yes, that will be 396.

ADMITTED AND MARKED "EXHIBIT 396"

MR APPLEGARTH: Commissioner, could I just say I don't want to take time but those documents, as you probably saw yesterday, contain the debate about the interpretation of the rules.

COMMISSIONER: Yes.

MR APPLEGARTH: And the significance of someone having on their admission records at the hospital the fact that they entered through the emergency department, and a few days ago I took Mr Bergin through those - the dot points that the central zone took but I wasn't proposing to take the time of the witness to go through those points unless you think in fairness I should.

COMMISSIONER: It is a matter for you.

MR APPLEGARTH: You saw the points that Mr - I shouldn't say Mr Bergin, but the central zone made about the types of occasions in which someone may have entered the hospital and been coded as the point of admission through the emergency department but that they were, in his view and the view of the central zone, entitled to be funded out of elective surgery?-- Under the current business rules, yes-----

Under the then business rules?-- That's correct.

Those are the sort of examples that I have given you a couple of already, the person who goes through the emergency department as the portal?-- That's exactly right.

Someone who goes into the emergency department for a particular reason, while they're there something is spotted, "Oh, you've got a hernia. Stay in hospital, we'll fix that as soon as we can"?-- Yes.

And another point that the central zone made was that this apparent movement of classification, reclassification, was due to the improved training of administrative officers in the hospitals, that they were being told about the way that these things should operate and the fact that someone had an emergency department point of entry didn't preclude access to the elective surgery pot?-- It may have been an improved training issue.

So the zones, with all the feedback from their hospitals, were explaining why in their view in many cases people who entered the hospital through the emergency department and then later on went on to have a procedure were entitled to be funded out of the emergency - out of the elective surgery pot?-- Yes, that was their contention.

These weren't new arguments to you, were they?-- No.

Why didn't you put them in the 30 July 2003 submission to Dr Buckland?-- I can't answer that.

Is it because you didn't agree with them?-- No, I - I looked at the submission that Mr Roberts had prepared and I thought he'd - he'd done a pretty good job in terms of covering the issues.

But he's the new boy on the block, isn't he?-- Oh, no, he is one of the most experienced people in this area in Queensland Health.

Well, he didn't assist in putting into the 30 June 2003 submission what he understood to be the point of view of the hospitals about the appropriateness in some cases of classification and reclassification?-- But he did make the point that hospitals were interpreting the current business rules and he went into some detail in terms of, you know, where some of those interpretations were actually occurring. So he did go into some - some detail. If I can just enlarge on that very, very quickly. An overriding consideration that was covered by Mr Roberts in this submission was a request to have Dr Buckland re-affirm the achievement of a total surgery target. Now, this is - this is - that was in Mr Roberts' submission and I believe that I read it in his follow-up submission as well. This basically said, "You can do what you like in terms of reclassifying data as long as your total surgery workload at the end of the day did not diminish."

Okay. Well, we can come back to that topic but if we can just focus on one thing at a time. The debate, the longstanding debate, the debate as at August September 2003 was the proper interpretation of the then business rules?-- Well, it was an interpretation. Once again, people were interpreting the business rules differently.

And wasn't it the case, and please look at this, that a further submission came through prepared by Mr Roberts, cleared by you, dated the 8th of October 2003?-- Yes, that's correct.

Sorry, I will just put that in front of the Commissioner on the overhead. Now, the handwriting at the front you recognise to be Dr Buckland?-- Yes.

The initial B?-- Yes.

So there is another brief that comes in on this issue, and he says, "This brief does not answer the question asked. The question is does the assertion that the '02/'03 business rules do not include source of referral code of substance. If this is true, then the Surgical Access Team has no legitimate call." Do you see that?-- Yes, I do.

Now, that was harking back to a point that Dr Buckland had made on the central zone document - and just in the interests of expedition, if I can just hand up my copy, if I can get it back - when the central zone's point of view came in with their interpretation - and, sir, if you just scroll it down to the handwriting - Dr Buckland said this to Mr Cuffe and asked the question about, well, the central zone is saying this is the way the rules should be interpreted, that the entry code on the admission records don't determine the matter, and he is asking Dr Cuffe and the Surgical Access Team what have you got to say about this? Do you see that?-- He is. He is, yes.

So he is asking that question - I can't see the date on it - but does he get an answer?-- I don't know, I am sorry.

Well, he doesn't think he gets an answer because he sends the one we have seen a minute ago. He is not getting the answer?-- It would be highly unusual that we wouldn't respond to a request from Dr Buckland in the Surgical Access Service.

I mean, maybe these are questions for Dr Cuffe but did you understand in late September, early October 2003 that Dr Buckland was trying to sort out this issue, interpretation, to try and just find out who might be right?-- Yes.

And did it come to your attention that after the central zone people had put in their interpretation, in Exhibit 384, that Dr Buckland asked the Surgical Access Team, via Mr Cuffe, what they had to say about that interpretation?-- He did.

And do you remember what happened?-- No, I don't.

He asked again, we see, as the endorsement on the 8th of October 2003 document, that your latest brief didn't answer the question that he'd asked. Do you see that?-- Yes.

Well, you had cleared that brief, hadn't you?-- That's right.

You were aware of the question that he'd asked?-- I was.

You didn't answer it?-- Not to Dr Buckland's - not to his approval, no.

Well, where in that document - you are welcome to look at it - where at all on the 8 October 2003 document do you actually

address this issue of interpretation?-- I don't believe it has been addressed.

Well, what's your reason for not addressing the question?-- I can't answer that, I am sorry.

But maybe the central zone did have a point, that there was this competing practical hospital view and you didn't have a good answer to it? Is that right?-- That's possible.

So you didn't have an argument to put back against the central zone's interpretation?-- That's possible. I don't-----

You couldn't think of an argument?-- That's possible.

Well, do you recall?-- No, I don't.

In any event, in October Dr Buckland's got the task on his hands of trying to sort out this - I won't say 100 year war, but the ongoing issue about the business rules and their proper interpretation, correct?-- Yes.

And in October 2003, there is - I won't call it a declaration of peace, but there are new business rules generated?-- That's right.

Commissioner, these are already an exhibit, but if I could hand them to you, just if it helps?

COMMISSIONER: What exhibit number is it?

MR DOUGLAS: I have armed you with a copy, Commissioner, this morning. It is Exhibit 348.

COMMISSIONER: I have got it, thank you. I have it now.

MR APPLEGARTH: Yes. The witness may not have one. You are welcome to have a look at this.

COMMISSIONER: No, I have one, sorry.

MR APPLEGARTH: I am not sure the witness has. Just to refresh your memory on dates, these are the new business rules that are signed off by the zones and Mr Cuffe as general manager?-- Yes.

In October 2003?-- That's correct.

And they do a variety of things. We can read them when we've all got some time, but they try to address the qualifying criteria?-- Yes.

Is your recollection that they - and this is on number - page 5 of 12 - they prohibit blocks of records being adjusted retrospectively?-- Yes.

And the idea there is to encourage proper practices in the first place of classification; that you can't come back and

ask for bulk reclassification?-- That's correct.

Now, you weren't happy with this resolution, were you?-- I think that's probably a fair comment. Mr Roberts, in his original submission of the 30th of July, made really quite specific recommendations in terms of how this problem of interpretation by the districts could be sorted out once and for all.

Okay, but leaving aside Mr Roberts, leaving aside you, your boss had signed off on these new business rules?-- Yes.

But you weren't happy with them?-- I think that's a fair comment.

Hence, your private submission of the 15th of October 2003, the one that's annexed to your statement which has those interesting marks on it about confidential briefing and so on?-- I am not sure the two things were related.

Well, you must have known in October 2003 that there was, in effect, a resolution in process of this debate attempt to have business rules that reached some awkward compromise?-- Yes.

That had the endorsement of both your line manager and the zones?-- Yes.

You still weren't happy with that?-- I wasn't happy with it, no.

That's why you do this private/confidential submission to Dr Buckland?-- My recollection of the private communication with Dr Buckland was purely in response to him asking for the former document to be destroyed.

No, but if we look at the substance of that document, it is arguing the toss about classification/reclassification, isn't it?-- Yes, it is.

You wanted to continue to advance your point of view?-- I was worried about the long-term viability of the program, yes.

COMMISSIONER: Mr Applegarth, this document of the 8th of October, did you want to tender that?

MR APPLEGARTH: I did, Commissioner, I neglected to.

COMMISSIONER: Right. That will be Exhibit 397.

ADMITTED AND MARKED "EXHIBIT 397"

MR APPLEGARTH: Now, the meeting that you had in February 2004 with Dr Buckland - you gave some evidence about it yesterday-----?-- Yes.

-----do you recall that? There is some very brief discussion about a document that a member of his staff apparently had seen on your desk?-- Yes, that's what Mr Cuffe - sorry, Dr Cuffe informed me, that someone from his office, yes-----

Don't need to go into the background, but just in terms of how much that featured in your discussion with Dr Buckland in February 2004, it really hardly rated a mention, did it?-- I was surprised that it was very sparse, yes.

Yeah. Well, there was some discussion about some document that had been seen on your desk by a member of his staff and he didn't seem to be too concerned about it?-- That's correct.

And you can't remember the word "destroyed" being used?-- No. I introduced the meeting, you know, by explaining why I wanted to speak to him privately and spoke about the two issues that he had brought up, as I understand it, with Dr Cuffe.

So the first thing about some document was a brief discussion-----?-- Yes.

-----as you explained yesterday and again today. Then you move on to the second topic?-- Yes.

And then you have an amicable discussion about other matters?-- Well, we had a very lengthy discussion about a new job that he wanted me to do.

Okay. So it was far from a confrontational meeting?-- Absolutely.

The new job that he wanted you to do was what?-- Was to take on the entire reporting and monitoring responsibilities for all the new election commitments provided by the election, the government.

There is a discussion about a new bucket of money and what was to be done with it?-- Right.

And meeting election commitments?-- That's right.

That was the discussion, and you were being offered this position?-- I was being offered the role.

Okay?-- On top of the surgical access role.

And after you discussed those important matters, then you had a personal conversation about your families?-- Absolutely.

Young children?-- Yes.

I think you had had a child?-- That's correct.

I think I might have asked you before, in that meeting on February 2004, you don't recall the word "destruction"

being used?-- No, I don't recall that.

Now, in terms of the - I will find my piece of paper. I am nearly finished, you will be pleased to know, Mr Walker?-- Thank you, Mr Applegarth.

Just in terms of this issue of, you know, directions and destruction and things that have emerged in the last week, to be fair to you, you have never accused Dr Buckland of destroying the document?-- No, I haven't.

Despite some media headlines to the contrary about "document destroyed", and so on, that's never been your allegation against Dr Buckland?-- No.

You were never told by Dr Buckland to remove the document from the system, let alone destroy it?-- I was not.

He dealt with the document in your presence?-- He did.

He addressed the concerns in it?-- He did.

The concerns in relation to individual hospitals?-- He did.

He didn't order you to stop writing about classification or reclassification?-- No, he did not.

What he wanted was you to consult with the hospitals and the zones so he could get the total picture, including the picture from people on the ground?-- I believe that to be correct.

And he in fact acted on that July 2003 briefing in subsequent meetings with the Surgical Access Team?-- Can you just enlarge on that? In what respect?

Well, the further briefings, further meetings, this issue of whether there were abuses by individual hospitals or widespread abuse of classification/reclassification was an issue that was-----?-- It was ongoing, absolutely.

-----addressed within the organisation over the following months?-- Yes.

He didn't try to shut down the resolution of these issues?-- No.

And the upshot of that process was that these views about interpretation led to new business rules that at least sought to address the concerns of the Surgical Access Team?-- Well, I don't agree with that point, I am sorry.

Well, they didn't satisfy you?-- Well, there was a fairly clear number of points that Mr Roberts put forward, as I said, that could have addressed this very, very clearly.

But putting yourself in Dr Buckland's position, he has got to try and resolve Walker view versus the hospital view and he, with the zone managers and your line manager, makes a

decision, and implements new business rules?-- Yes, in effect which were very, very much the same as the previous years.

Because they still permitted some people sometimes who came through the emergency department to get access to your pot of money?-- That's correct.

And that's what really rankled with you?-- Well, I am not sure that I took it personally but, as I said, my long-term worry was for the program.

Well, you still take it personally. You still - you still are complaining about it, aren't you?-- Well, if the fund - if the funding pool is still being eroded, of course I should be worried. It is a government priority, after all.

Okay. But if the hospital view was correct, as per the central zone, southern zone view in mid-2003, we're not talking about erosion, we're not talking about reporting, we're actually talking about districts who actually are entitled to the money accessing it. If your view was wrong and if they were right, there wasn't a reporting of the system through this process of classification?-- Well, if I can just take you back to what I mentioned before, that this reclassification is not such a big issue and would not have been such a big issue had Dr Buckland reaffirmed a policy that was already in place, and that is that individual hospitals must achieve their total surgery activity target each year. In other words, it took away the incentive to reclassify data between funding streams.

Do you remember my question?-- No, I don't, sorry.

If the hospital view, as articulated by the central zone and the southern zone, was correct in mid-2003, then rather than reporting the system, hospitals that classified or reclassified patients who had elective surgery but came through the emergency department were accessing funds to which they were entitled?-- Yes.

Just on a discrete issue, yesterday you gave some evidence or you were asked some questions about a Commonwealth funding. If we could just deal with that briefly. Commonwealth funding, in terms of timelines, was given to elective surgery in around '96/'97 when there was a new health agreement, correct?-- Yes, I believe that, although the funding that I was speaking to with the Commissioner yesterday was actually in place prior to that. There was part of the original 30 or $33 million as part of the funding program that the surgical project inherited, a proportion of that money was Commonwealth funding.

Okay, but the Commonwealth money - I think you said it is 33 million - was a one-off payment and actually wasn't about the performance of elective surgery but was to assist the States to set up reporting requirements?-- I don't recall saying that, I am sorry.

I know you didn't say that; I am suggesting that to you?-- Could you suggest it again?

That that initial Commonwealth payment in about '96/'97 - I think you gave the figure of 33 million-----?-- Yes.

-----was a one-off payment that wasn't actually for the performance of elective surgery but was to assist the States, not just Queensland, but Queensland got 33 million to set up reporting requirements?-- No, that's not correct. That was a permanent payment that that 33 million remained in the bucket, if you like.

But not in your bucket?-- Yes, in my bucket.

Well, the 33 million, I suggest to you, was the Commonwealth's contribution to the underlying elective surgery, not the additional State funding to increase elective surgery targets?-- No, I am sorry, my understanding is that that 33 million was - of which a proportion was provided by the Commonwealth, essentially began the elective surgery program. That is purchasing activity over and above what was traditionally done in base budgets and that was a permanent addition to this program.

Commissioner, I think obviously my instructions are different from the witness and I won't take the matter any further. These things obviously can be ascertained. I don't propose-----

COMMISSIONER: Presumably in a document that identified what it was for.

MR APPLEGARTH: I am sorry?

COMMISSIONER: Presumably in a document that identified what it was for.

MR APPLEGARTH: Yes. Your complaint a minute ago was Dr Buckland didn't do what the Surgical Access Team was suggesting it should do, of stressing the need to achieve both elective surgery targets and total surgery targets?-- At the end of the day, that's correct. He did not follow up with - well, a previous instruction to district managers that they must actually achieve that total surgery target.

Could you look at this document - I have only got one of it, so I might just put it on the overhead. Do you recognise that to be a letter from Dr Buckland - memorandum from Dr Buckland to district managers about elective surgery and total surgery targets? And if the gentleman could scroll to the end the last sentence on the page and the date below it. "As a result I would like to stress the need to achieve both the elective surgery and total surgery activity targets in 2002/'03."?-- Yes, I wrote the document.

And Dr Buckland signed it?-- That's correct.

Well, he seemed to be on your wavelength?-- He was at that stage - a month later I wrote another memo in similar vein, this time actually pointing out what the end of year positions for each hospital may in fact be, and he asked me not to send that out.

And that would be documented somewhere, would it?-- I am not sure that I have seen it in any of the documentation that has been presented so far. I have it on - in my files.

Just putting things in context, this classification/reclassification-----

COMMISSIONER: Excuse me. You say you have it in your files. You could produce that? You have it here with you today?-- I don't, Commissioner, but I could produce it, yes.

Thank you.

MR APPLEGARTH: The upshot of this issue about classification/reclassification in mid-2003, looking at the attachments to that submission, it seems as if there were contentious 1,585 cases - of that order?-- Which submission, sorry?

The July one - the attachment to it?

COMMISSIONER: Which attachment?

MR APPLEGARTH: Attachment A, in terms of figures, we have got weighted separations by category, but in the middle of the page that's converted to a figure of 1,585?-- That's correct.

That's, as it were, individual patients?-- That's right.

Now, this issue, 1,585 - I mean, it is a big number but it is an absolute drop in the bucket compared to the number of patients who go through the Queensland public hospital system in a year, isn't it?-- That's right.

Commissioner, I am conscious that I have - I could spend a lot more time talking about some broader issues.

COMMISSIONER: I am sure you could.

MR APPLEGARTH: I would very much like to and I do have further cross-examination on this.

COMMISSIONER: Go ahead then.

MR APPLEGARTH: I am sorry?

COMMISSIONER: Go ahead.

MR APPLEGARTH: I was just conscious that I gave an estimate yesterday of an hour and I have exceeded that.

COMMISSIONER: I am used to your false estimates,

Mr Applegarth.

MR APPLEGARTH: As long as I am not treated like Robinson Crusoe.

COMMISSIONER: No, no, you are not.

MR APPLEGARTH: Just if I can deal as briefly as I can, Mr Walker, with some of the broader issues that you make in some of these submissions, in doing the trend analysis and the like, you're basing things upon matters going back to 1995?-- Most of the analysis that I have produced, certainly for the Commission, began in 1997/'98.

Okay. But whether the figure be 1995, '97, '98, that makes certain assumptions about the reliability of that data, at the starting point, doesn't it?-- Yes, it does.

That things that were being classified and sent up to you as large numbers concerning the amount of emergency surgery and the amount of elective surgery were based on reliable data?-- Yes.

But we know, don't we, courtesy of KPMG, and many other places, that that isn't so?-- Yes, that's right. I mean, we rely on the data provided by the hospitals through the major data collection, the hospital morbidity data.

Now, Dr Cleary, he had something to do back in about 1995 with this process of classification and the whole - the system we have been talking about?-- Yeah, he was one of the instigators of setting up the program.

And didn't he make clear his view that there would be, in the nature of things, reclassifications of some order as the system improved?-- I don't recall him making that but he is a very broad-minded individual. He could easily have taken into account those sorts of things.

Leaving aside his view, you have got a new system, people being introduced to it, people perhaps not being properly trained?-- Mmm.

You would expect, in the first couple of years, for the recording to improve?-- Yes, absolutely.

As it has?-- Yes, data quality has certainly increased.

These issues about the appropriate use of funds, you have dealt with it in your various submissions on a global level, haven't you; making inferences from percentages and percentages of elective surgery total surgery?-- I have.

Correct? But on the local hospital level, I am sure you would agree that there is highly qualified people who audit patient files to make sure that people are properly classified?-- Yes.

Commissioner, I am reminded I didn't tender the memo of 23rd April 2003.

COMMISSIONER: All right. That will be 398.

ADMITTED AND MARKED "EXHIBIT 398"

COMMISSIONER: I don't have it.

MR APPLEGARTH: It is on the overhead projector.

COMMISSIONER: Thanks.

MR APPLEGARTH: Commissioner, I think I have dealt sufficiently with this topic for my purpose of cross-examination. I mean, I don't want to stand up for any more minutes pretending to be an expert in these areas when there are real experts, so can I leave it on that basis? The only other matter in terms of the completion of my cross-examination is that you will appreciate, from what my learned friend Mr Douglas said yesterday, that there are people being interviewed about things about who said what to who about documents.

COMMISSIONER: If something arises out of that, then you can cross-examine further. Subject to that, you have finished your cross-examination?

MR APPLEGARTH: Yes, thank you.

COMMISSIONER: Anyone else want to ask questions? Mr Douglas.

MR DOUGLAS: Yes. Commissioner, subject to Mr Walker producing that document that follows the last Exhibit, I have no re-examination.

COMMISSIONER: All right. Thank you.

MR DOUGLAS: May Mr Walker, subject to that, be excused?

COMMISSIONER: Yes. You will produce that in due course, Mr Walker, I take it?-- I will, Commissioner.

Thank you. You are excused from further attendance?-- Thank you.

WITNESS EXCUSED

MR DOUGLAS: Commissioner, as you know, the next witness is Dr Aroney.

COMMISSIONER: Yes. Is he here, Mr Andrews?

MR ANDREWS: He is, Commissioner.

COMMISSIONER: Right.

MR ANDREWS: Commissioner, while Dr Aroney is coming to the courtroom, there is some other business that can be attended to.

COMMISSIONER: Yes.

MR ANDREWS: A statement of a witness Martin Rollings, dated the 2nd of September 2005, has been circulated to the parties and no party requires Mr Rollings for cross-examination.

COMMISSIONER: Right.

MR ANDREWS: I tender that statement.

COMMISSIONER: Martin Rollings.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: That will be Exhibit 399.

ADMITTED AND MARKED "EXHIBIT 399"

MR ANDREWS: I can tell you what Mr Rollings' statement concerns, Commissioner. He's an Information Services Unit Manager of Queensland Health, stationed at Bundaberg. He's deposed to searching computer memory for the catheter audit that was done with respect to the peritoneal dialysis patients at that hospital.

COMMISSIONER: Yes.

MR ANDREWS: He's determined that one form of the document was created on 10 February 2004 and remained unchanged to 31 March 2004. He can't say in what form the document appears between 31 March and 20 October, but on 20 October it was in a different form.

COMMISSIONER: Right.

MR ANDREWS: These matters are of particular significance with respect to what information was given either to Dr Keating or to Mr Leck about Dr Patel's success rate, or lack of it, with respect to catheter patients.

COMMISSIONER: Yes, thank you.

MR ANDREWS: I have another statement for tendering.

COMMISSIONER: Yes.

MR ANDREWS: That is the statement of Helen Charmaine Beh, B-E-H, dated 30 May 2005. Dr Beh is the Chief Executive Officer of the Australian Orthopaedic Association. The parties have had that statement circulated and none require

Dr Beh for cross-examination.

COMMISSIONER: Right.

MR ANDREWS: Her statement deposes to the history of the Australian Orthopaedic Association's dealings with Mr Hanelt - Dr Hanelt, the Director of Medical Services at the Fraser Coast Health Service, in respect of the briefing of Drs North and Giblin, and in respect of the report that they created.

COMMISSIONER: All right. Thank you. That will be Exhibit 400.

ADMITTED AND MARKED "EXHIBIT 400"

MR ANDREWS: Thank you.

COMMISSIONER: Yes?

MR ANDREWS: I know that Dr Aroney is here. I spoke with him. Dr Aroney, would you please come to the witness box?

CONSTANTINE NICHOLAS ARONEY, RECALLED AND FURTHER EXAMINED:

MR ANDREWS: Commissioner, Dr Aroney appeared on 10 and 28 August.

COMMISSIONER: Yes.

MR ANDREWS: His statement is Exhibit 263.

COMMISSIONER: Yes.

MR ANDREWS: He has been examined and Queensland Health was not in a position at the time to continue cross-examination of him.

COMMISSIONER: Yes. You are now, I presume, Mr Farr. You are, sorry.

MR FITZPATRICK: Yes, Commissioner, we are, although the order of cross-examination has been agreed.

COMMISSIONER: I see. You're going first?

MS KELLY: Commissioner, Dr Aroney is my client.

COMMISSIONER: Yes.

MS KELLY: There are two matters - or three matters which have arisen out of evidence that has been given since Dr Aroney was last in the witness box that I'd seek your leave to ask him to refer to - to give evidence about.

COMMISSIONER: All right. Yes, certainly.

MS KELLY: Dr Aroney, have you prepared a brief supplementary statement - a two page supplementary statement overnight?-- Yes, I have.

And in that supplementary statement do you address some matters arising out of the evidence of Dr Scott?-- Yes, I do.

Can you take the Commissioner to that, please?-- First - the first issue is that Dr Scott's comments in his evidence - he stated repeatedly that baseline activity at the Prince Charles Hospital had been 57 cases per week in the cardiac catheter laboratory, and that testimony is repeated in several paragraphs. Now, I actually have access - I worked, of course, in the cardiac cath laboratory for 14 years at the hospital and have had access to those activities. Dr Scott was saying that there was no cut, that when the cutback was reduced to 57, that this was what the baseline activity was and that there'd been a temporary increase. In fact if one looks at the baseline activity in the years 2002, 2003 and 2004, and if you base it on 48 week year, which would be the usual way of assessing such activity, in 2002 the baseline activity was 80 cases per week, in 2003, 77, and in 2004, 77. If you base it on full 52 weeks' activity, which is not done, then it's 73, 72 and 71 cases per week. Baseline activity has not been 57 cases per week, I don't believe, in the past 20 years. So his statement that there was no cut, and that 57 baseline activity, is totally incorrect and is misleading the Commission. This cut was a severe cut of about 20 cases per week, a draconian cut which, in my view, led to a major increase in the waiting list and would have contributed to further deaths or heart attacks on that waiting list, and in my view, as I stated previously to the Commission, I believe this cut was punitive to the hospital because of our speaking out about long waiting lists. So this, I believe, is totally inappropriate.

Dr Aroney, was there some further evidence of Dr Scott given since you were last here which you want to address?-- Yes. The other issue Dr Scott made in his statement since I was here was that he said that there was no second cut of activity. Now, the second cut was that proposed on 1 January 2004, and I'd written to the Premier of Queensland about this in December 2003, and that cut entailed that patients - that cardiologists could not proceed with immediate treatment of severe coronary lesions except in emergencies, but must rebook patients for a second procedure, and cardiac booking staff were directed not to schedule elective stent angioplasty cases from 1 January 2004. Now, this did in fact occur, and in fact this was a reason why we went public, because a meeting of cardiologists asked me to go public about this acrimonious cut at that point. This was in the middle of the financial year

on 1 January. We presumed these cuts would continue for the whole six months until the end of the financial year, and management of patients, we felt, was going to be impossible with this degree of cuts, and it was only after we went public and I met with the Premier's senior advisor, Mr Dignam, in early January that these were then taken away and these cuts were reversed after that period and money was given to proceed with cardiac procedures. In fact some extra money was given. So Dr Scott is totally incorrect that this second round of cuts did not occur. It did occur, and it was only due to our disclosures that this was stopped.

Thank you. And thirdly, the evidence of Dr Cleary, Dr Michael Cleary, who was the administrator at the Prince Charles Hospital in relation to a petition which was circulated to reverse a decision to dismiss a hospital specialist, do you have something to say about that?-- Yes, I had said in my evidence that there was a petition to save a hospital specialist who we believe had been bullied and was being threatened with dismissal, and that the petition was obtained by all the senior staff members of the hospital. Dr Cleary's submission states - or stated that there was no - that he knew of no such petition, and that Ms Podbury also knew of no such petition, when we know the petition was taken to them. I have a copy of this petition. I'd like to tender it for evidence, and it's signed by approximately 15 members of the senior staff. Dr Cleary maintained that he knew exactly what was going on in the hospital, and this is a major petition occurring at his hospital, and the fact that he's denying it ever existed, to me is unbelievable.

COMMISSIONER: All right. Do you want to tender that?

MS KELLY: Yes, thank you, Commissioner.

COMMISSIONER: At that will be Exhibit 401.

ADMITTED AND MARKED "EXHIBIT 401"

MS KELLY: Commissioner, Dr Aroney's just been provided by Mr Andrews two statements dated yesterday, 29 September, produced probably by Queensland Health, I suspect. They are statements of Dr Michael Cleary - a supplementary statement of Dr Cleary, and a statement of Dr Paul John Garrahay who is the Director of Cardiology at PAH. Both of these statements are in response to evidence given earlier by Dr Aroney. I understand from Mr Andrews they haven't as yet been tendered, but perhaps if they can be marked for identification, I can put them to Dr Aroney so that he may respond to them.

COMMISSIONER: You can put them to Dr Aroney anyway.

MS KELLY: Okay. Thank you. Would you have a look at these

two statements, please?

MS DALTON: Commissioner, I don't have a copy of these statements, and I think I'm probably the only other person with an interest in Dr Aroney. Could I perhaps have a copy of them so I can follow it?

COMMISSIONER: Yes, you should have.

MS KELLY: I'm sorry, we only have the one copy provided to us.

COMMISSIONER: I think Queensland Health is getting one.

MR FITZPATRICK: Yes.

MR ANDREWS: Yes, Commissioner, I regret that one was received this morning and one yesterday. They came to my attention only this morning-----

COMMISSIONER: It's not your fault.

MR ANDREWS: -----and in the time available I recalled only that Ms Kelly's client would have an interest. I forgot that Ms Dalton's client-----

COMMISSIONER: Ms Dalton's got them now. Yes?

MS KELLY: Dr Aroney, if you can - would you like me to wait, Commissioner, to allow Ms Dalton an opportunity-----

COMMISSIONER: Do you want an opportunity to read them first?

MS DALTON: I'll just follow along, Commissioner. It's all right.

COMMISSIONER: Okay.

MS KELLY: Dr Aroney, can you turn first to the statement of Dr Garrahay? Is that how you pronounce it?-- Yes.

Garrahay? Do you see at the last pages of Dr Garrahay's statement a reference to the hidden - the alleged hidden waiting list for Category 3 patients at Princess Alexandra Hospital?-- Yes, I do.

What do you say in relation to that?-- Well, my assertion had been that there was several hundred patients on a hidden Category 3 waiting list at the Princess Alexandra Hospital. This was very clear to us at the Prince Charles because the Prince Charles had been confronted with evidence that there were no patients waiting on Category 1 or 2 lists at PA, and therefore all of our urgent patients - and we had over 200 - should be therefore transferred to PA for treatment, and in fact in the submission from Dr Cleary, MIC12, there's a letter from Dr Buckland stating this, that there was zero Category 1 patients, and I think two Category 2 patients rather than the several hundred at Prince Charles. Of course, Commissioner,

this is - the people on the south side of the river are not a different human species and suffer from the same degree of heart disease as we do on the north side of the river, and the patients on the south side were in fact categorised inappropriately to a Category 3 list. Misclassified, if you like. There's been a lot of talk about classification of lists today and yesterday, but these patients were misclassified and put on an elective list, and this was the reason, over a 12 month period, why patients were then transferred, in the full knowledge of Queensland Health of this misclassification, to the Princess Alexandra Hospital, and that those patients on Category 3 presumably were put further and further back. We have no knowledge of what the death rates were on that Category 3 list. So to say that there was no hidden list is clearly untrue. Dr Cleary's statement, MIC, from Dr Buckland doesn't mention any Category 3 patients, and we know they existed. It's a fact, and those numbers should be able to be obtained from Queensland Health exactly how many there were. We understood there were several hundred.

And indeed both Dr Garrahay's and Dr Cleary's statements to which I've drawn your attention today deal with a workshop which was conducted in November 2004 to deal with the discrepancy between the classifications on the one hand of Princess Alexandra, and on the other hand Prince Charles and Royal Brisbane. Is that right?-- That's correct. Because of the major discrepancy, it was felt that a workshop should occur. Dr Buckland had in fact stated publicly in The Courier-Mail in October 2004 that Prince Charles was inappropriate in its classifications, and that PA was doing things appropriately. So a workshop took place, and indeed the workshop totally corroborated the classification process which was occurring at Prince Charles and the Royal Brisbane, and that Princess Alexandra has been brought into line now with appropriate categorisation. Dr Cleary denies any knowledge of this misclassification through the whole 2004 period whilst these transfers were occurring, whereas we'd had many meetings with him to explain the situation, which he rejects in his statements.

Thank you, Commissioner. I've nothing further.

COMMISSIONER: Mr Farr?

MR FARR: Mr Fitzpatrick is looking after the Queensland Health end-----

COMMISSIONER: Sorry.

MR FITZPATRICK: That's all right, Commissioner. We'd agreed for my learned friend Ms Dalton to precede us.

COMMISSIONER: Do you need more time too look at those documents?

MS DALTON: Not those two. I've managed to look at those, but

is there another statement from Dr Aroney or has he given that testimony orally?

COMMISSIONER: He just gave that testimony orally.

MS DALTON: I wouldn't mind looking at the last Exhibit, Exhibit 401, before I start.

COMMISSIONER: Certainly.

MR FITZPATRICK: Could I then look at it, please, Commissioner?

COMMISSIONER: Yes, certainly.

MR FITZPATRICK: Sorry, Commissioner, I might have misheard, but I understand Dr Aroney to say he prepared overnight a two page supplementary statement.

MS KELLY: He just gave it orally.

COMMISSIONER: He gave his evidence orally.

MR FITZPATRICK: Could I see a copy of the supplementary statement if it's been tendered?

COMMISSIONER: It hasn't been tendered.

MS KELLY: It's just in rough form.

MS DALTON: It hasn't been tendered.

COMMISSIONER: It hasn't been tendered.

MR FITZPATRICK: Oh, I see. Thank you.

COMMISSIONER: If you'd both like some time to look at this, I'm happy to adjourn.

MS DALTON: No, no, it's all right. Thank you, Commissioner.

COMMISSIONER: I'm not trying to hurry you.

MS DALTON: That's all right.

COMMISSIONER: You don't believe me.

MS DALTON: Not feeling at all intimidated so far.

COMMISSIONER: That's good.

CROSS-EXAMINATION:

MS DALTON: Dr Aroney, my name is Jean Dalton and I act for John Scott. I'd like to try and get some picture in my mind, if I can, of the broad structures out there at Prince Charles, say from 2003 through to the time you resigned at the beginning of 2005. You were at that time the Director of the Coronary Care Unit?-- That's correct.

Now, tell me if I'm wrong, but that unit was focused on interventional cardiology, so it would deal with people that came in acutely with unstable angina?-- Yes, all patients coming in with heart attack, unstable angina, unstable heart rhythms are admitted to the Coronary Care Unit of the hospital. It's where the intensively sick coronary patients are first transferred.

Acute admissions either for angina, heart attack or fibrillation - unstable rhythms?-- That's correct.

And you yourself specialise in procedures to deal with that, being - and again tell me when I'm wrong, but angioplasty, stenting, and the use of these implantable defibrillators. Is that a good description?-- No, I don't implant defibrillators at all.

Is that the electrophysiologists?-- That's correct. No, I'm trained as a cardiologist, so I handle all aspects of these patients' care, the diagnosis of chest pain, the management of all cardiac conditions, not just acute coronary syndromes, arrhythmias, syncope, patients with heart failure and chest pains, heart patients with heart murmurs. We have to take on allcomers, so we're trained as general cardiologists, and I've had subspecialty training in interventional cardiology, which is implantation of stents and management of acute heart attack. So when you have an acute heart attack, I will be the person who takes you in and unblocks your artery.

All right. I understand, of course, that your training began in a general way and you got more and more specialised as you went along, but you appreciate what I'm trying to do is get some picture of the delineation of responsibilities and things as at 2003/2004. So at that time you were doing stenting, caring for unstable angina, caring for admissions with a arrhythmia, but not actually implanting the defibrillators?-- Yes, and for all general admissions to cardiology and to the cardiology ward and in the cardiology outpatients.

As Director of the Coronary Care Unit-----?-- We had all these responsibilities.

Who is "we"? Can you just talk about yourself?-- Well, I'm saying that the cardiologists at the hospital didn't just do one or two things.

But I'm asking you about you, and the Directorate of Coronary Care Unit, you see?-- Yes.

We'll get wider?-- My responsibility-----

But I'm trying to find out what you did?-- Right. My responsibilities were to do all the things I've just told you. I would go to the Coronary Care Unit, see the patients, I would go to outpatients and see patients who were waiting for six and nine months. I would go to the general ward and look after my patients in the ward. I would go to the cath lab and do these angioplasty, angiography procedures.

And so in terms of procedures, your procedures were interventional, but they were carried out in the cath lab?-- Yes.

This is going to sound - by use of a catheter?-- That's correct.

The cath lab itself had a separate director?-- Yes, that's true.

That was Darren Walters?-- Yes.

So he was in charge of the cath labbing. He was doing wider things. He was doing angiograms and angioplasties and the cath lab was doing atrial septal repairs by catheter?-- Darren and I were doing the same things. I did the atrial septal closures.

You were doing that too?-- Balloon valvoplasties. I did the first once of those. Darren, in addition, did implantable defibrillators, so he also did some of the electrical work, but we did the same angioplasties and worked in the cath lab as he did.

So although it's set up as two separate directorates, they're working pretty closely together?-- Yes.

Dr Galbraith was working as a Director of Cardiology?-- He was Acting Director of Cardiology.

That's right. Was it Dr Betts?-- Dr Bett had resigned due to ill-health about a year previously, and there was no full-time Director. There was an Acting Director.

No-one wanted to take it on. Is that right?-- I wouldn't say that. I would say that the hospital - we had asked the hospital to advertise internationally and to ask for a new Director, and that a salary be proposed for that, and there was said to be no funds for a new Director of Cardiology because Dr Bett was still there and therefore there was no new funds for a new salary. So that was a reason why there was no new full-time Director.

So Dr Galbraith was acting?-- That's correct.

You wanted to take it on, didn't you? You wanted to be the Director of Cardiology?-- No, I did not.

What, never?-- Never did I want to do that job. No, I'm a clinician. I love my clinical work, my research and my medical student teaching, and the administrative side of the work is not something that I enjoy at all.

Dr Galbraith's a senior cardiologist out at Prince Charles still, isn't he?-- Yes, he is.

He - you trained under him. You were his registrar?-- Many years ago, yes.

And you respect him?-- Yes.

And he knows you well?-- Yes.

And Richard Slaughter works out there in cath lab, doesn't he, doing angiograms?-- No, he doesn't do-----

Amongst other things?-- No, he doesn't do cardiac angiograms, no.

He looks at them?-- He looks at them.

He specialises in - I'm going to use some very non-technical language, but visualising, short of surgery-----?-- He's a radiologist.

Yes?-- Yes.

So he looks at the angiograms?-- Yes.

He's got a new 64 slice CT scan machine out there at the moment?-- Yes.

It's be the best in Queensland, wouldn't it?-- Mmm hmm.

Would it be the best in Australia?-- Yes, I think it would.

Have you seen it?-- Yes.

Do you know how much it cost?-- No, I couldn't tell you.

Are you interested in that sort of thing?-- Well, I am, but I'm not working at the hospital at present so-----

COMMISSIONER: Should we be interested in this sort of thing, Ms Dalton?

MS DALTON: I'm a little bit interested in it.

COMMISSIONER: Well, maybe, but is it relevant to anything that we have to solve here?

MS DALTON: It might become relevant.

COMMISSIONER: All right.

MS DALTON: Bear with me, Commissioner. Dr Walters - Dr Darren Walters is now the Director of Cardiology?-- Yes.

Is that right? He was a bit of a protege of yours?-- Yes.

He's younger than you, and a very good cardiologist?-- He is.

He was the first speaker at the meeting of the cardiologists that took place on Sunday, the 15th of February 2004, at Prince Charles, wasn't he?-- Well, I chaired the meeting and made introductory remarks. I spoke for about 10 minutes and then he spoke about acute coronary syndromes.

He was the first speaker?-- He was the second speaker actually.

After you, I suggest?-- Yes.

It was after that, was it, that you say Dr Buckland hopped up and mentioned a profanity?-- Yes.

To intimidate Dr Walters?-- I think to intimidate the entire membership of the meeting, actually.

Dr Walters wouldn't be intimidated by anything like that, would he?-- I think we were all intimidated by the Director - or Acting Director-General standing up and speaking in this manner.

Dr Walters wouldn't be intimidated by anything like that, would he?-- No, I disagree.

And was it part of Queensland Health's policy to punish Prince Charles, particularly with a focus on you, to promote Walters after that to be the Director of Cardiology, do you think?-- I have stated that I believe that the Queensland Health punished the hospital, as I've just stated, by cutting activity because of the disclosures that I had made.

Do you care to comment on the proposition I put to you?-- Well, in order to promote Dr Walters? I'm glad that Dr Walters is Director of Cardiology. I've always supported that he should get that position. He's a superb cardiologist and good administrator.

He is, and he is closely associated with you and known to be closely associated with you, and he was promoted by Queensland Health recently, probably to be the youngest Director of Cardiology?-- He was the obvious choice.

Not you?-- I didn't want the job, although I'd been nominated for it by the other cardiologists, Queensland Health rejected that nomination. I didn't seek the job.

Which other cardiologists?-- There was a meeting of cardiologists, about 10 of them, in October or November 2004

where they asked me to be the Acting Director because Dr Galbraith had resigned, and I said, "Look, I'd be happy to take it on as an interim measure", but that I didn't seek the position, and I doubted that Queensland Health would accept it because of all the acrimony which had been occurring, and indeed they didn't accept it. So I wasn't at all surprised when it was rejected.

We'll come back to that. Now, Dr McNeill, Dr Keith McNeill, is the head of transplant at Prince Charles, and the transplant unit works closely with the cardiology unit?-- Yes, it does.

I see Dr McNeill's name on the petition there in respect of Darren Walters?-- Mmm hmm.

Because he's very much involved in a broad way with what's going on in cardiology at Prince Charles?-- Yes, although he's not a cardiologist. He's originally trained as a respiratory physician and has gone into transplantation, and gone into predominantly lung transplantation, which is also involved with heart transplantation as well.

And he's also very involved in the organisation for funding for and administration of paediatric coronary care out there, isn't he?-- I couldn't tell you about that. I don't know that - the answer to that.

And John Dunning, do you know him?-- Yes.

He works for Dr McNeill, doesn't he, doing pulmonary endarterectomy?-- Dr Dunning is a cardiothoracic surgeon.

Yes?-- Who works at the hospital and does lots of different operations including the one that you've mentioned.

He's a bit of a prize for Queensland, isn't he? He did all the pulmonary endarterectomies in the United Kingdom before coming here?-- So I believe, yes.

Done about 1200 more than anyone else in Australia. Do you know that?-- Yes.

In fact, there is only one other person in Australia that does it down at St Vincent's?-- Mmm-hmm.

Do you know that?-- Yes.

Apart from California, he has probably done more than anyone else in the world?-- Yes.

And you know there was considerable funding put into Prince Charles to allow his employment and to allow all of that to be taking place up there?-- Yes.

Doesn't seem very consistent with the idea that Prince Charles is being punished, does it?-- Oh, this is an entirely different issue. A transplantation in particular is a politically very attractive thing to fund because young people are giving life-saving procedures that make the headlines whereas patients die on routine cardiac waiting lists commonly despite this funding proceeding. And so, the transplant unit is very well funded and people who work in that unit almost become spokesmen for Queensland Health has Dr McNeill has done at times, because the funding is so good and the unit is well funded, and that's appropriate. So you're talking about two entirely different issues: the funding of a transplant unit, which is politically a very visible, and the funding of routine cardiac work, which was deplorably treated by the administration.

All right. And you'd accept, wouldn't you, that it is not just Prince Charles that could do with more money for interventional cardiology. The PA could do with some more money too?-- Yes, I accept that.

Townsville could do with some more money?-- Absolutely.

Cairns could do with some more money?-- Yes.

In fact, one of the things you say is that it is all very well to set up centres out at PA, Townsville and Cairns but unless there is going to be adequate funding, they're not even going to get the throughput to mean that the people working there are going to be competent to do the procedures?-- Yes.

So it is not just Prince Charles that's missing out, it is all the cardiac centres, in your view?-- I think it is all the centres in Queensland. I mean, Rob Stable said that Queensland is 20 per cent underfunded for health. Twenty per cent, and this has been going on for years, a billion dollars a year. Why is Queensland the poor man of Australian medicine?

That's right?-- Someone should be held accountable for this degree of underfunding, don't you think?

That's right. He said it was $20 million underfunded and when he got the job he was told that it was a performance criteria for him to cut another 100 million out of the budget?-- Yes.

Yes. And you talk about people ringing your registrars at Prince Charles from regional hospitals and saying they've got acutely sick people?-- Happens all the time.

And your registrars have to say, "Look, I'm sorry, we don't have a bed"?-- That's correct.

It is not because your registrars don't think that the people ringing up are insincere and that the patient doesn't need to come to Prince Charles, is it?-- No, not at all.

They just can't do anything about it?-- Yes, we don't have the beds to take these patients.

You call them the meat in the sandwich?-- Yes.

And you are generous enough to extend your thinking in that regard to the administration, or at times you are, at Prince Charles Hospital and realise, I think you say, they're the meat in the sandwich too in relation to a lot of funding decisions?-- Yes, they have been.

Does it not occur to you that there is another - another layer of the sandwich, Dr Aroney, and that people like John Scott might well understand that Prince Charles cardiology needs more funds but they can't get it through either the Minister or the cabinet budget review?-- Yeah, I could understand that is happening, although that was not admitted to us directly from the administration. In fact, we were told repeatedly by Mr Scott or Mr Scott in the media said repeatedly that there was no problem, that there was - there was no major issues, that - that we were well funded, that funding was increasing when in fact all these cuts were occurring.

No, funding was increasing over all, wasn't it?-- The activity was not increasing. Activity was being cut. As I have pointed out, there was three major cutbacks.

Funding was increasing?-- I presume - presume it was, presumably going to administration.

The funding for the procedures was increasing and you know that, Dr Aroney, don't you?-- Look, I know that our - we were

being cut back on three occasions. I - I wasn't a business administrator at the hospital. I was being asked on the 1st of January to stop putting stents into acutely sick patients which I knew was untenable and I couldn't operate a coronary care unit and treat patients adequately, so I reject your statement that funding is increasing and that's giving me activity. I don't - I deal with patients and I was being told I couldn't treat them. That's - that's the - that's my only answer to your question. I am unable to-----

We will come to each of those supposed cuts in detail and I think you've agreed with me that funding for cardiology services all over the state - interventional cardiology services all over the state was woeful I think you said?-- It was.

And Queenslanders are more obese than the rest of Australia; do you know that?-- Yes.

We smoke more than the rest of Australia; do you know that?-- Yes, yes, yes.

And we've got a high indigenous population compared to other states in Australia?-- Absolutely.

And there's enormous problems with rheumatic heart disease in indigenous communities?-- Yes.

And if we can fund some prophylactic antibiotics for them, that would be very, very useful, wouldn't it?-- It would.

Do you know how much of the Queensland Health budget is dedicated to doing prevention for cardiology related things like that?-- I think it's a small percentage.

Mmm, one per cent. And did you know that before Dr Scott took over as the Senior Executive Director of Health Services he was in charge of that very program?-- Yes.

So he'd be well aware of the-----?-- Yes.

-----woeful underfunding of that, wouldn't he?-- Yes.

And you'd agree with me too that if we do not address these matters like obesity and smoking and rheumatic heart conditions, no government anywhere in the world is going to be able to pay for the stents and the defibrillators and the angioplasties that we are going to need?-- I agree. In fact, I publicly wrote a letter to the editor of The Courier-Mail complementing him on the antismoking stance that he took. So I'm on the public record congratulating the government on their smoking stance.

Did you write a letter to Dr Scott congratulating him in bringing in the new antismoking rules?-- No.

No. If we move out of cardiology and into radiology, oncology or renal dialysis or colorectal or methadone funding, we will

find underfunding in all of those places too, won't we?-- I'm sure we will.

Yes. And it is all right, Dr Aroney, isn't it, to be an advocate for your particular speciality or your particular interest but you have to be responsible about that, don't you? Would you agree with me about that?-- Well, I have been an advocate for all areas of cardiology. My letter to the Premier involved seven issues across the state, including issues of heart failure, of congenital heart disease, of the problems at the Royal Brisbane Hospital. I wasn't restricted to one particular area at all. But my expertise is in cardiology; I can't speak on other areas of health.

But you were advocating for cardiology then?-- Absolutely.

And Russell Stitz was no doubt advocating for colorectal surgery at the RBH and on and on the list would go, wouldn't it?-- Mmm.

Did you see Dr Scott's statement in the financial year for 2004? All of the bids came in for new funding for the year totalling $200 million and he had a budget of $32 million to deal with it?-- Mmm .

Did you appreciate prior to reading that that the figures were of that order?-- I imagined that that may be and it is very interesting to see all this coming out now that Dr Scott has left the system. None of this was occurring or made public whilst Dr Scott was in the system.

Do you really think that he would have stayed in the system very long if he'd been telling people like you things like that?-- Well, if people like Scott and Stable had been standing up for health in this state, it might be in a better state than it is now.

Why do you say they weren't standing up?-- Because they weren't going public on this 20 per cent underfunding of health, which has only become known to people now. We've all known it's been underfunded for years but they weren't prepared to stand up whilst they were in a position of power. They were only prepared to stand up now when they're out of the system.

Have you got any idea about the conditions of their employment, terms of their employment or the requirements of the public service act, Dr Aroney?-- Well, I presume that they may have been sacked but that's on their conscience.

Uh-huh.

COMMISSIONER: On the other hand, they don't have to in a radio interview say how good the Queensland Health system is, Ms Dalton.

MS DALTON: That was the television.

COMMISSIONER: Television, so that's even worse.

MS DALTON: You and I had a discussion about those answers. Now, Dr Aroney, tell me what you understand by bullying, what's that mean?-- Well, bullying to me is - in the context that we're talking about, is the intimidation of a person to retract from their position or to keep quiet-----

What-----?-- -----by - by various means, whether it be verbal or written or other means.

And what do you understand by media bullying? That's a term you used?-- This is where public officials go into the media and make statements about - in this context about hospitals, saying that they're doing things inappropriate when we know now that they were doing things which were entirely appropriate. I consider that to be media bullying and it occurred repeatedly last year.

Could you have a look at this document, please. I will hand one up for you, Commissioner. This was your - as a result of your contact with the media, was it?-- Yes, it was.

Just before the meeting of 8 January 2004?-- Well, more relevant, it was after our - the cardiologists had asked me to go public because of this second round of cuts which would have led to untenable management of cardiac patients and so we were forced to make this public disclosure, yes.

You would have been concerned to be responsible about what you said to the media of course?-- Yes.

Maladministration you say?-- Yes.

Is that correctly attributed to you?-- Absolutely.

You thought that was a responsible thing to say?-- Definitely.

It wasn't just underfunding; it was maladministration?-- It was maladministration because Dr Scott had received a letter from the cardiac unit, a submission from the cardiac unit, signed by Dr Galbraith and others stating that we needed increased funding, a big increase in funding and activity only a month before this second round of cuts came in. So rather than the increase which we were looking for, these draconian cuts were put in place which would have led to an extreme crisis in cardiac care. I consider that maladministration.

And you say that, in this article - I don't want to misquote you. You talk about three patients having died on the waiting list?-- Yes.

Was that responsible to say that?-- Yes.

Responsible for you?-- Yes, it was.

You had no first-hand knowledge of the care of any of those patients, did you?-- No, I received reports from the other

cardiologists at the hospitals, my registrars, the booking clerks, who all tell me about these patients who are either on waiting lists or waiting to get into the hospital because of a lack of beds.

Well, not the general situation. These three patients that you chose to talk about in the media, you had no personal knowledge of them, did you?-- I - I cannot specifically recall. I don't think they were my specific patients, no.

Well, have a look at this document. I'm showing Dr Aroney Exhibit 9 to Dr Cleary's statement, which is Exhibit 301C?-- Yes.

Just bear with me. That it's recorded there, isn't it, that you stated that you didn't have direct knowledge of the patients referred to in the media. Do you see that?-- Yes.

That's true, isn't it?-- I think that is true.

In fact, in relation to one of them, you weren't even sure which patient was being talked about in relation to the patient from Hervey Bay?-- No, I was well aware of the patients. Dr Cleary may not have been.

It says, "Dr Aroney was not clear if this was the patient the district had previously reviewed or if it was a different patient"?-- No, he's confused, it is not me.

So does this mean it's inaccurate?-- Yes.

"This could not be followed up at the meeting but was followed up by Dr Phillips." But it was a meeting that you were at with Andrew Galbraith and Dr Cleary and Dr Phillips. And they seem to think you weren't clear on which patient it was, but you'd reject that?-- I reject that.

This also records, doesn't it, that in relation to the patient from Lismore, the patient's treatment was planned within the recommended time frames but the patient died before receiving treatment within the recommended time frames?-- The patient died whilst waiting to be transferred to the hospital. Now, the recommended guidelines of which I am the principal author of the Australian guidelines, give a time of 48 hours for people who are sick. Now, this 48 hours is, if you like, a - an upper limit of what the ideal should be. The sicker the patient is, the earlier they should be transferred. And a very sick patient such as this should be transferred immediately.

You don't know anything about that patient, Doctor?-- No, we do, we've got lots of details the patient-----

You don't?-- We received - we received-----

Stop saying "we", Doctor. I'm asking you?-- The hospital - the hospital receives information about the patients and realises that they are very sick and this patient

was very sick.

Who realised?-- And required-----

Who realised that? Who realised that?-- It was the - it was-----

Who realised that?-- The booking - the booking clerks and the cardiologist who was contacted about the patient realised that.

Which booking clerk at which hospital?-- Prince Charles Hospital.

Which cardiologist?-- The cardiologist who was looking after the patient.

What's that cardiologist's name?-- Look, you're asking me something that's happened 18 months and expect me to tell you now.

You didn't know at the time?-- This is 18 months ago and you expect me to answer you.

You didn't know at the time?-- I - do I have to know the name of the cardiologist looking after them? Is that important to this-----

It certainly wasn't you?-- No, it wasn't me.

You didn't know about the patient at the time?-- I was told by the cardiologist that these patients were very sick and should have been transferred immediately.

This patient?-- Yes.

Not "these patients"?-- Yes, this patient.

And you were prepared to go to the media?-- Yes.

Not knowing about - first-hand about any of these patients?-- First-hand, I'd have to be at Hervey Bay. Is that what you expect me to have done?

Would you have reviewed the charts?-- These patients, these patients, and there were many of them, were occurring on almost a weekly basis. We put them - the three most recent examples up, but this was occurring very frequently. This is why we were in so much trouble and we were asking for more funding.

COMMISSIONER: But, in any event, for these three patients, you relied on what other cardiologists had told you?-- That's correct.

I think I will take a short break now.

MS DALTON: Thank you.

THE COMMISSION ADJOURNED AT 11.18 A.M.

THE COMMISSION RESUMED AT 11.35 A.M.

CONSTANTINE NICHOLAS ARONEY, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Ms Dalton?

MS DALTON: Thank you, Commissioner. Dr Aroney, just before we leave this article from The Courier-Mail in the beginning of January 2004, what is it that you say is the difference between your going to the media and putting your opinions about maladministration, in your opinion, and deaths that you have no firsthand knowledge of and media bullying. What's the difference?-- The deaths I did not have firsthand knowledge of but they were given to me by my close colleagues.

COMMISSIONER: I can't see anything wrong with that. I can't see why - you keep putting that he didn't have firsthand knowledge of. I don't see anything wrong with consulting his college and getting information from-----

MS DALTON: Part of the evidence before you is that Queensland Health goes into those three deaths-----

WITNESS: Further to that, Commissioner, the Thompson Report states - and can I quote it to you - about this exact issue of the first patient at Hervey Bay - you haven't even mentioned the other two patients - about the first patient: "The Director of Cardiology and the Clinical Nurse Manager, Catheter Lab both separately commented that the patient's clinical condition as outlined on the referral letter would indicate the need for immediate transfer to a tertiary centre for ongoing care." Immediate transfer. Thank you.

COMMISSIONER: Yes, Ms Dalton, I have made my point.

MS DALTON: All right. Well, I think before the witness made his point, I was going to say to you that there is some evidence attached to Michael Cleary's statement, which you will no doubt come to read, which is the investigation by Queensland Health, and it is certainly at odds with the conclusion-----

COMMISSIONER: So it might have been, but I can't see how that shows any lack of good faith or care on the part of Dr Aroney.

MS DALTON: Oh, well. Dr Aroney, page 13 of your statement in these proceedings, you explain how you accused Mr Bergin, who was the Queensland Health manager of the central zone - told him that the Cardiac Society would hold him accountable for the deaths that were occurring on the waiting lists?-- Yes, I said that at a meeting of staff at the Prince Charles Hospital.

Do you really think that's a fair or responsible thing to do,

to say to an individual that they are personally responsible for deaths that are occurring on waiting lists?-- Yes, I do, and I will give you the reasons why. We were told at that meeting that there would be a major cutback at the Prince Charles Hospital. We had then about a dozen presentations by senior staff from all over the hospital showing how that would impact upon care on all aspects of the hospital, and would have major deleterious effects. At the end of that, Mr Bergin said despite everything that was said, that these cutbacks would go ahead.

That's what you call the first round of cutbacks?-- That's correct, and I then - and I then told him that the Cardiac Society - as a representative, I would hold him personally responsible for these cutbacks if they led to further deaths. Nothing else was going to have an impact on this person and it didn't. I mean, they still went ahead with these cutbacks.

Well, they were cutbacks to Prince Charles and increases at Princess Alexandra?-- That's correct.

And overall, that had the effect that there were more procedures performed for Brisbane and the area immediately surrounding it?-- I don't know about that-----

No, you don't, do you?-- -----being an increase at all. All I know is that there were major cutbacks at our hospital, and the people on the northside of Brisbane, and all the people draining that, including Bundaberg and the whole central coast, suffered as a result of that cutback. In my view, a clear cutback. You can call it what you like, reallocation. The funds for PA should have come from an increase at PA. PA desperately needed the money and needed improvement but that shouldn't have been taken by ripping the guts out of Prince Charles Hospital, which is what effectively happened.

But you accept, don't you, that in fact what happened was that more procedures - because of the reallocation of funding, more procedures were performed for the greater Brisbane area and the areas that drain into it?-- I don't accept - I don't - I have no knowledge of any overall increase and I would be very surprised if there was.

All right. Well, you don't know?-- No.

No. And the patients who used to be referred to Prince Charles from the PA catchment were dealt with at PA after this reallocation, weren't they?-- There was some patients who were transferred there, who I think couldn't get into PA, and therefore they were coming to Prince Charles, and there was already a huge hidden waiting list at PA which weren't being dealt with, and the irony was, this hidden misclassified waiting list was used as a reason to transfer patients across to PA, and this went on for 12 months. And we have statements from Buckland, MIC12, stating that there was only two patients waiting at PA and "therefore send all the Prince Charles patients across", when he was hiding the category 3 list which had been misclassified.

Just focus on my question: do you know that - as a result of these reallocation of funding away from Prince Charles to Princess Alexandra do you know that as a result of that Prince Charles didn't have to deal with patients from the PA catchment zone and that they were dealt with at PA, so that Prince Charles had less patients to deal with? Do you know that?

MS KELLY: I object to the loading in the question. The witness has repeatedly said - taken issue with the claim in the question that they were dealt with at PA. The witness's evidence has been that they were put on a list at PA. And so it is clear that he has answered the question in that form three times now, and I object to the question continually being put to the effect that they were taken from one place and dealt with somewhere, when the discrepancy between the witness and the questioner is clearly what "dealt with" means.

COMMISSIONER: He is an intelligent witness, though. He can answer it. Yes.

MS DALTON: Do you remember the question, Dr Aroney?-- Yes. Some patients who came from the PA catchment were transferred to PA where they should have been done in the first place, and the reason why they were coming to Prince Charles is that they couldn't get into the PA. So it is a crazy situation.

Well, they were both underfunded?-- Oh, desperately.

Yeah. Now, you also accuse - were happy to accuse Gloria Wallace of being personally responsible for deaths on waiting lists?-- No, what - this arose out of the meeting in July 2004 when we were suddenly told, after our major submission to the health department that we were desperately underfunded across Queensland, and the specific part of the Prince Charles needed increased funding. In full knowledge of this, Gloria Wallace told us at this meeting that we were being cut from 80 to 57 patients per day.

You told her she was condemning patients to death?-- I did.

She-----?-- That this decision was - was - was doing this, yes.

You have no qualms about making the statement to her personally?-- Absolutely not.

Or my client?-- Not at all.

Did you really think about the substance of that? You would have to be a sociopath or something, wouldn't you, not to care if people were dying on waiting lists?-- As far as I am concerned, the Queensland Health bureaucracy was acting in a sociopathic manner.

Don't hide behind general terms. Do you think Dr Scott is a sociopath? Is that what you are saying?-- I believe the

actions taken by Dr Scott, Buckland in causing these cuts were sociopathic, yes.

We will come to the meeting of the 8th of January 2004. Now, you say that you had rung up Dr Scott or he had rung you to organise the meeting and he was quite cordial to you on the phone, is that right?-- Yes.

Then you arrived at the meeting and there was an onslaught, was there, from him at you?-- That's correct.

And, what, you were intimidated by that?-- Very much so.

How long did it take you to recover your equilibrium?-- I don't think I recovered during the meeting.

Don't you?-- No.

What, you just sort of sat quietly there shocked?-- Yes, I did.

Didn't get angry yourself?-- I was very taken aback. I don't think I got particularly angry, but I was extremely taken aback, and I did make comments refuting some of the statements he was making, such as cheap shots about my comments about deaths. So I was angry in that regard.

But you were, what, taken aback, shocked, couldn't recover your equilibrium? You sat there quietly not able to pursue the agenda you had come to pursue?-- No, I was happy to pursue the agenda about increasing funding but there would be no talk of that. The - very early on in the meeting it was very clear that the cuts would go ahead, that the decisions that had been made would proceed, and that's where it was left. There was no possibility of Queensland Health recanting.

And, what, certainly would have been obvious to Mr Bergin, who was there at the meeting, that you were taken aback by the onslaught?-- I would think so, yes.

He would have noticed that you didn't recover your equilibrium?

COMMISSIONER: Whether he would have noticed or not is a matter for Mr Bergin, Ms Dalton.

MS DALTON: All right. What about Dr Galbraith then? He knows you well. He would have noticed, would he, if you were intimidated?-- He-----

COMMISSIONER: Maybe Dr Galbraith was looking the other way or scratching his nose.

MS DALTON: He may have been in the bathroom.

WITNESS: He made comments to me after the meeting that that was a very hot meeting. That was his immediate words to me

after the meeting.

MS DALTON: So you were very angry in that meeting and you expressed that very vigorously at Dr Scott?-- I reacted to Dr Scott's comments.

Do you want to answer my question?-- No, I did answer it. I reacted to his comments.

Very angrily?-- Angrily, yes.

You gave as good as you got?-- That's your opinion.

Do you think anyone else at the meeting might have that opinion?-- You would have to ask them.

And you weren't intimidated at all, were you, Dr Aroney, by what went on? You were there on an equal footing with Dr Scott and you got angry with him and he got angry with you?-- No, I was very intimidated by Dr Scott. I went to the meeting. This was the first time I had been approached or even met Dr Scott. I was cordially asked to discuss the problems before that by telephone and I thought for the first time Queensland Health are going to listen to what's happening and stop this ridiculous rounds of cutbacks, and I really approached the meeting with much optimism, and I was very taken aback when Dr Scott launched into me at the meeting to intimidate me to shut me up. Obviously angry about the public disclosures and seeking to keep me solely from them onwards. That was his clear approach at the meeting. That's my belief.

That's what he was saying when he said, "If you come after us with shots, we will come after you with shots, too."? He was talking about, "You go to the media again and we will go to the media."?-- Well, that's his statement.

That's what you understood?-- Yeah, that's his view of that statement.

That's what you understood by it?-- I understood exactly what he said, that he was going to come after me and I was very taken aback by that.

COMMISSIONER: Come after you in what way?-- Well, he didn't - Commissioner, he didn't say.

What did you think he meant by that?-- I have known of other people who have-----

Don't tell me what - what did you think he meant by that?-- I thought he was going to come up with - with some - attack me in some way. I mean, people who work in the system are vulnerable, you know. We work long hours. They can say that you - that you are working inappropriate hours, you are claiming overtime you are not doing. Some trumped-up charge can be brought against you.

All right?-- This has happened to other people.

You thought it was going to be a personal attack on you in some way?-- I felt that that was possible.

All right.

MS DALTON: Then you had a press conference, did you?-- Yes, I did. I was - I was very taken aback by this and I thought the only way to respond to this intimidation was to go public with the intimidation.

What was all this business about Mr Bergin pretending that he was in the bathroom so he wouldn't have to tell the truth about the bullying?-- After the press conference, several journalists spoke to me about what was going on. One of the journalists asked me why - you know, why - told me after the meeting, "Mr Bergin wasn't there during the bullying, he was in the bathroom." And I said, "No, that's not true. Mr Bergin was there for the entire meeting.", and the journalist told me, "No, Bergin had said after the conference that he was in the bathroom." So that's where that evidence comes from. I was told that by a journalist after this press conference.

But Mr Bergin wasn't in the bathroom during the meeting, was he?-- No, he wasn't in the bathroom. He was there for the entire meeting.

And Dr Galbraith wasn't in the bathroom?-- No.

He was there for the entire meeting?-- Yes.

He is not a liar?-- No.

Neither is Mr Bergin, to your knowledge, is he?-- Well, if he said he was in the bathroom, he is a liar, yes.

Now, the last time you gave evidence here, the Commissioner asked you about whether you felt intimidated and you say, "I personally haven't felt too physically intimidated." Do you remember saying that?-- Yes, I do.

You have never been physically intimidated?-- Not physically.

COMMISSIONER: He said he didn't feel physically intimidated.

MS DALTON: Sorry?

COMMISSIONER: He said he didn't feel physically intimidated.

MS DALTON: He said he hasn't felt too physically intimidated.

COMMISSIONER: All right.

MS DALTON: You never have, have you?-- I said - I said not too physically intimidated. I was intimidated at that meeting, I can assure you of that.

And your evidence has been, hasn't it, that you decided that you had to leave the Prince Charles Hospital really for heroic reasons, because what you were saying was damaging the hospital?-- Yes. There is no question that everything that was happening had brought to bear a lot of pressure on the hospital, particularly this punitive round of cuts down to 57, and I felt, and I think others felt, that my continued outspoken talking about waiting lists and deaths, that the major problems we were having had resulted in that punitive cut. The attitude of the department and Scott, and so forth, hadn't changed and was continuing. Neither of these two investigations - neither the first investigation on the three deaths or the Maher report had been released and, in fact, the Health Minister Nuttall had stated only weeks before that the Maher report may never be released because of confidentiality issues. That was in The Courier-Mail. So I felt very upset that neither investigation may be released, that the administration was going on its merry way, the cuts were continuing, and that we were achieving nothing, and the hospital was suffering. And, in fact, I - I was - I knew that the hospital was being punished for what was going on. I also felt that my working at the hospital under those circumstances was not - was not going to be something that I was going to look forward to under that administration.

I will ask you to have a look at this document. It is exhibit 20 to Michael Cleary's affidavit, which is Exhibit 301C in these proceedings. Have you seen these minutes before?-- Yes.

These are the minutes of a meeting where you resign, or foreshadow resigning from the Prince Charles Hospital on the 3rd of November 2004?-- No, I didn't resign at that meeting. I was on leave at that meeting. I didn't resign.

When had you gone on leave?-- From around July 2004.

All right. You foreshadowed resigning then?-- No, I didn't.

All right. The meeting-----?-- I didn't resign until April.

The meeting is to-----?-- Of this year.

The meeting is to try and ascertain when you might be coming back from leave?-- There was - I think there was a lot of agendas at that meeting.

Well, was that one of them?-- One of the agendas was talking about me coming back and working in the cath lab, and that there were overseas doctors who were available to take our place, and that had been mentioned at a meeting only I think a month before, and it was mentioned again at this meeting. A very intimidating comment because overseas doctors had never sort of been used as locums in our cardiology unit in the time that I had worked there. So this is the first time this was ever raised.

This is Mrs-----?-- Ms Wallace stated this.

Yeah?-- And she was saying if you don't come back, that this is an option. And, of course, I was talking about the cut to 57 per week and I told her at the meeting - and it is minuted in here somewhere - "There is no point in me going back to work when there is a cut of 57 a week. There would be no work for me to do. I would be sitting on my thumbs. There is already another three interventional cardiologists there. Why do you want us to come back when you have made a cut of 20 cases per week? I can only do about 10 a week." So this was a ridiculous nature of this meeting.

She certainly wanted you to come back from leave and work, didn't she?-- She - at the meeting she stated it several times, and I told her that if the cuts were retracted, that I would be pleased to do so, but they weren't.

But not if the cuts weren't retracted?-- That's correct.

Really, those cuts were not your business, were they? They were cuts that were made by the administration and your reaction to that was to say, "Well, I don't agree with them, so I am not going to continue to work here." Even though the administration was saying to you, "We need you to work here."?-- A cut of 80 to 57 cases per week in the lab where I work is my business. This was the biggest cut we had ever seen at the hospital. For the life of me, I can't see the reason of it. Scott has lied repeatedly that this was a cut, and I have showed you the base line activity, it was 77 to 80 a week for the past four years.

We will come to that?-- So it was my business and we felt very strongly that this was absolutely untenable and couldn't go ahead and I wouldn't return under any circumstances unless those cuts were removed.

But you knew that the administration wanted you to come back and that the administration was saying, "If you won't come back, we're going to have to find other people to do the job."?-- Yes.

So you knew that you were leaving them short-staffed?-- They weren't short-staffed because-----

By continuing?-- Because they had made the cuts so they didn't need me in the cath lab.

Well, they were going to get someone else?-- Yes. Ridiculous, isn't it.

If it is true it is ridiculous, Dr Aroney?-- Mmm.

And at this meeting you raised, didn't you, your views again that the reallocation of funds from Prince Charles to Princess Alexandra was wrong and you didn't agree with it?-- Yes.

Ventilated all that again?-- Yes, because it was continuing all year based on the fallacious assumption that there was

zero patients at PA and that they could be transferred across, and Cleary said he didn't realise this until January of this year, which is ridiculous because he had been made aware of it repeatedly previously, and there is letters to him we have from October about the categorisation meeting detailing this, you know, four or five months before. In fact, he knew it in January, and my letter to the Premier on the 16th of January had outlined the ridiculous of this misclassification. So all of health bureaucracy realised what was going on and yet this continued for 12 months.

But it is ridiculous in your opinion?-- Yes, it is, and in the opinion of the other senior members of the cardiac unit, Dr Walters and others.

Probably not in the opinion of the clinicians over at the PA?-- No, the clinicians in the PA were getting extra funding and they needed it.

Anyway, you were told that there was a clear commitment to increase funding and resources within Prince Charles, and you were asked if you plan to return to work at all?-- Yes. I mean, I was on long service leave. I had never taken long service leave in my entire 14 year period at Prince Charles. Am I not entitled to take long service leave?

I am not suggesting-----?-- I had taken - I had taken the approved time to give that leave and I was taking my leave and here I have an acrimonious meeting with the district - with the hospital manager insisting I come back, not take my leave under these terrible circumstances where there has been major cutbacks to the hospital, and I told her I refuse to come back unless the cutbacks were withdrawn.

Okay?-- It is as simple as that.

Okay. Have a look on page 3. See about point 5 of the page, "Gloria Wallace asked Dr Aroney given the above comments, he planned to return to work at all. Con Aroney advised 'I have not made a decision. I will continue to take leave until there has been a turnaround.' Dr Aroney indicated he had previously been given unanimous support from the cardiologists and was prepared to continue to advocate the patients. He also indicated he had been prepared to return if he was offered the position of Director of Cardiology." So you were after that position, weren't you?-- No, I wasn't after it. I told you that the cardiologists had invited me to return about two - I can't remember, three weeks before that. I wasn't - I reluctantly said I'd accept it as an acting position only for a couple of sessions per week until a full-time director was advertised for. And that I would return under those circumstances and Queensland Health rejected that unanimous decision by the cardiologists.

It's not-----?-- That was the statement I made, nothing more than that.

It's not what you told the meeting, is it? You said, "Look, I'll come back if you make me Director of Cardiology."?-- No, that's not true.

That's what it says?-- Well, that's an incorrect assessment of what was said. That is not true, and you can ask Dr Tesar who was also at the meeting.

Over the last page you say if appropriate funding was made available you would no longer go public. See that?-- Yes.

Is that accurate?-- I'm sure it is.

And you were not willing to be gagged, and would not stop speaking out until major improvements were made. Is that right? Is that accurate?-- Yes.

"I will not" - "I will continue to speak out. I will not go away." Is that accurate?-- Yes.

It's not true, though, to suggest that you decided that really for the good of the hospital - you'd better stop making the public statements and resign from the hospital for the good of the hospital. You were saying, "You give me what I want. If you don't, I won't return from leave, and be advised, I'll be continuing to speak out."?-- You've made about five statements there, and most of them are incorrect.

All right. Well, you tell me why?-- The issue of Director of Cardiology was never an issue, number one. Number two, I didn't put my resignation in until April of the following year. Okay? And I was going to continue to speak out while this ridiculous 57 cut - the biggest cut in the history of the hospital, which was going to have definite effects on further deaths, if that proceeded, and it did proceed in November of that year.

It was you, wasn't it, that was trying to stand over Queensland Health in relation to these matters?-- Well, that's your - that's fine. I - whatever you - however you'd like to interpret it.

Well, that's a fair interpretation, isn't it? You were saying, "Unless you give me what I want, I'm not coming back to work, and I'm going to continue to make public statements in the media."?-- "Unless you retract the draconian cut, which would lead to patient deaths", I was not - I was going to speak out, yes.

I wonder if the witness could have a look at this document, please. I'll hand a copy up for you too, Commissioner.

COMMISSIONER: Thank you.

WITNESS: I would like to know who's accountable for that cut. No-one has ever admitted to it, as to why it was made, why the cutback was made. Scott's denying there was any cut. Someone should be made accountable for this.

MS DALTON: All right?-- This was an absolute disaster for the hospital, and for the patients of the North Brisbane area.

You won't have seen this document before. In fact Queensland Health only gave it out yesterday. But you were aware, weren't you, as part of the February 2004 election funding there was $20 million allocated to boost elective surgery funding?-- This, interestingly, was announced after our public disclosures.

So are you aware that that happened?-- It happened after our public disclosures about how bad cardiology was, yes.

And cardiology got some of the $20 million?-- Yes.

And Prince Charles got some of the cardiology dollars?-- That's correct.

And the cath lab where you worked got some of those dollars?-- Yes.

And this is - there's a lot of toing-and-froing in the documents about how that was being spent, and see in April 2004, to reduce the waiting lists-----

COMMISSIONER: Where are you reading from now?

MS DALTON: I'm reading from this document that I've handed to you.

COMMISSIONER: Yes, whereabouts?

MS DALTON: I'm just reading from the date on the front page.

COMMISSIONER: I see.

MS DALTON: But I'll be coming to about point six on the first substantive page.

COMMISSIONER: Yes.

MS DALTON: There was a proposal to do some of the work privately in the Holy Spirit Northside, and that's just right nextdoor. It's part of the same hospital-----?-- Yes.

-----buildings, isn't it?-- Yes.

See under "Issues"? See down on the third paragraph? Just read that, and the next paragraph?-- I'm not certain who is being referred to here, and most of this is to do with cardiac surgery and cardiothoracic surgery, of which - and I don't do open heart cardiothoracic surgery. So I'm not certain who is being - no names are mentioned.

No?-- So I'm not sure what - who is being referred to.

No, and to be fair, you didn't resign until April 2005?-- I hadn't resigned at all.

But you'd gone on leave?-- I was on leave, which I'd foreshadowed well in advance.

No question you're entitled to the leave, but you certainly made public statements in the press that the reason you had gone on leave was that you were so appalled by what you considered to be the maladministration of cardiac funding to Prince Charles, didn't you?-- I didn't go and say that in public. I didn't say anything about my leave in public at all.

You didn't?-- At that time? Not at that time. Not at all.

Well, at any time. But you certainly made - you were making a point, weren't you? You were going on leave, which you were entitled to go on, but you were taking it because you were so upset with the funding situation at Prince Charles. That's right, isn't it?-- That's one of the reasons, yes. I was also - I felt under a fair amount of stress. I know other colleagues of mine had taken stress leave, which I'd never taken, for many months under similar circumstances. I did not take any stress leave. I took my routine leave. I've never taken stress leave, but other colleagues of mine, some of which you've mentioned, did take stress leave at or before this time.

Do you not think this individual in here is you?-- Well, I didn't resign. It says a person resigned.

We've discussed that?-- Yes.

But leaving that inaccuracy aside, do you not think this was you?-- I don't think it is.

All right. I'll take that document back, Commissioner.

COMMISSIONER: Yes.

WITNESS: There was another cardiac surgeon who had resigned at that time, and I presume it was him.

COMMISSIONER: How much longer are you going to be?

WITNESS: I can mention the name of that cardiac surgeon if you would like, but I presume that's him.

MS DALTON: I don't think there's any need to?-- Well, I think you're totally off the track there.

COMMISSIONER: How much longer do you think you'll be?

MS DALTON: I want to discuss these - the cutbacks with the witness.

COMMISSIONER: I thought you had, but all right.

MS DALTON: No, I want to discuss them individually. Look, I don't know. I might be another 30 minutes.

COMMISSIONER: All right.

MS DALTON: Dr Aroney, you know that as part of that extra $20 million elective surgery funding, you got extra money to be doing work in the cath lab at Prince Charles, don't you?-- Yes, we did.

And the extra money meant you increased the number of procedures you did?-- Yes. As I said, this happened during an election campaign - or after the election, after our public disclosures of the second cutbacks. These were then announced, promised by the government, and went ahead after the election. I don't think that none of this would have gone ahead if we hadn't made our public disclosures.

And that meant that the cath lab procedures increased to 80 a week?-- Yes, back to where they should have been, where they have been for the past four or five or more years.

Well, they'd never been that high, have they?-- Yes, they have. I tendered that information this morning.

Well, you didn't tender it. You gave some oral information. Where did you get those figures from?-- I've had access to the activity at the cath lab continually, as my work in the cath lab and as Director of the Coronary Care Unit.

Do you just remember them off the top of your head?-- I keep the information, and I've got it here.

In what form is that information?-- I write it down and I have - I have the exact numbers, and you can get them from Queensland Health directly.

So it's your personal, handwritten records, is it?-- Yes.

And the cutback to 57 per week, Dr Aroney, was when that funding money was lost in about June - that extra $20 million funding money was lost in June 2004?-- As I stated, the activity for the past four years has been between 77 and 80 per week. So cutting this back suddenly to 57 per week in November 2004 can't be due to a loss of extra funding. It's a direct cutback. There's no other explanation, and someone should be held accountable for this, and for the reasons for it. The tendered explanation is incorrect. What you're just saying now is incorrect.

Well, you say that, and you say that the reason it was cut back to 57 per week is in September 2004-----?-- The decision was made then. The cutback didn't apply until November.

Okay. The decision was made in 2004 - September 2004, was it?-- Mmm.

And that was John Scott punishing you?-- My view is it was either John Scott or Steve Buckland punishing the hospital and the people of Queensland for our public disclosures. That is my view.

Dr Aroney, you have no basis to suggest that at all, do you?-- I do have. I do have basis for that.

In fact even in your statement you say that the action was either due to "punishment" for bringing these deficiencies to light or to negligent mismanagement. You don't know what it was about?-- I believe it was punishment. There's - certainly Scott and Buckland aren't going to come directly out and tell me, "You are being punished and the hospital is being punished", but Ms Wallace told us at the meeting - and it is minuted at that meeting - when I asked her, "Why is the hospital being bullied about this 57 cutback", and her answer, and I quote, is that the cardiologists were not "politically savvy". Now, there's no other explanation for her to say that.

That's what Ms Wallace told you?-- That's what he told us, and she also told us she was the meat in a sandwich. It wasn't her decision, the decision-----

Where are these meetings?-- In the minutes of the July meeting. It's been tendered here as evidence previously.

The July meeting? The decision was made in September?-- September meeting.

MR FITZPATRICK: I think it's MIC19 to Mr Cleary's statement.

COMMISSIONER: Thank you, Mr Fitzpatrick.

MS DALTON: See, it's just - John Scott was on long service leave from July until October 2004?-- Yes.

It's a scandalous thing to say that-----?-- In his evidence - in his evidence that he's tendered he says that he was well aware of this 57 cutback, and in full knowledge that it occurred, in full knowledge. He says that in his documentary evidence.

I'm sure he knew it occurred, but it is a scandalous thing to say that it was done as a punishment to you.

COMMISSIONER: He didn't say a punishment to him. He said as a punishment to the hospital and the people of Queensland for the statements - public statements he had made.

MS DALTON: That's a scandalous thing to say about an individual when you don't even know that they're at work or not?-- I didn't see - wasn't sure it was Scott or Buckland or

some other administrator, but I believe that is a reasonable explanation for what has happened. That's my belief. As I say, these people aren't going to admit this directly to us, because it - clearly it's an illegal act.

Or it might be negligent mismanagement, it might be too?-- It may be negligent mismanagement. If it is, it is really, very negligent.

Well, you don't know?-- No.

No. And it's your opinion then, that it's negligent mismanagement?-- I've said it's my opinion it's more likely to be punishment, because I couldn't imagine a manager could be that bad.

Now, have you seen the evidence from Dr Scott that in 2003/2004 Prince Charles Hospital got 4.5 million extra cardiac dollars over baseline funding?-- Yes.

You've got no reason to quarrel with that, have you?-- No. As I say, I'm not a budget controller at the hospital.

You didn't concern yourself with those things. You're a clinician, you say?-- Yes.

And an extra - in that same time period, 2003/4, an extra $1.5 million for the sort of work you do, interventional cardiology. That's right too, isn't it?-- I think that was part of that 20 million extra which was given after the election.

No, separately from that?-- Well, I'm not - I can't tell you. As I say, I don't control the budget. I have no idea.

You don't know?-- No.

And you didn't concern yourself with those things, and Dr Aroney, that's all right, but if you're not going to concern yourself with the facts about the funding you're getting over baseline, you shouldn't be making scandalous allegations about punishment and reduction of funding, should you?-- I think I should, yes, because it impacts directly upon my patients.

You don't-----?-- Who I have ultimate responsibility for, more than I have for Queensland Health.

You don't think you should look into the facts before you make these allegations?-- The facts were clear. There was a cutback from 80 to 57 per week. Can't be clearer than that.

That's one fact, but you didn't concern yourself with what the funding was, what the baseline funding was, or what extra money you were getting and why?-- I told you there was some extra funding during the year after the election. I'm unaware of any other major funding. There was also, after the election, extra funding given for defibrillators, because one

of the deaths was due to an unnecessary death on the defibrillator list, and at least some extra funding was given for that purpose, yes.

Have you read Dr Cleary's statement where he explains all the extra funding above baseline that Prince Charles cardiology was getting over that time? Have you read that?-- Yes.

Your Honour, it's paragraph 79, 99, 109 and 110, for the record. You don't quarrel with any of that either, do you?-- As I say, I don't control or understand all the budget, no.

No. You wrote that long letter to the Premier and the Ministers which is the second exhibit to your affidavit - or your statement in this matter, and you wrote it in July 2004. Now-----?-- I'll just correct you. I didn't write it. It was a submission from the Cardiac Society to the Health Minister and the Premier.

Okay. Did you-----?-- But I was a senior author of that paper, yes, but it was a Cardiac Society admission. It was not a personal letter, which you seem to be implying.

It's fair to say, isn't it, that if you read it - the pages aren't numbered, but if you read it, it suggests a whole lot of new approaches and new ideas to resource cardiac care in Queensland, but it doesn't complain about what you say are two major cuts which have happened to date - by that date, July 2004?-- No. We were asked to make a submission about cardiac care in this state, and that is what it is. It's a submission as to improve cardiac care in the state, and that's what we did. We didn't specifically talk about Prince Charles cutbacks. We weren't asked to in that submission, and that - its purpose was to do - give general issues about cardiac care, and that's exactly what was offered. It took several months of work, asking for upgrading in funding in all areas, and our response a month later was a massive cutback from 80 to 57 cases per week. Unbelievable.

A few months later?-- Well, the meeting was about a month later, I think.

Have a look at - have you got your statement there? Can you look at CA3 to it?-- Yes.

This is the memo that documents what you call cutback number 2. Is that right?-- No, this doesn't refer to cutback number 2. This refers to other issues.

Not what you're calling the second round of cuts?-- No.

Well, have a look at the next one, CA4. Well, what CA3 does deal with, just to be complete, is that the catheter laboratory is over budget?-- Okay.

Doesn't it? That's what you're being told. The catheter lab's over budget?-- Yes, it's stating - I think it's stating that, and it's also stating that patients - and the reason why

I put it in is that patients being referred from within the central zone but from outside Brisbane north - for example, Bundaberg - are only to be accepted if they can be managed within our existing capacity. So in other words, anyone on the central coast has - is not treated the same way as someone from Brisbane, which I had never been told before. So we had to treat as second class citizens anyone outside of the Brisbane north area, and if you came from Hervey Bay or Bundaberg, you could only - it was less urgent to get these ill patients in. That's why this has been offered, which is, I think, totally untenable.

Yes, but the reason is that there's only funding for a certain number of procedures in the cath lab?-- That's the reason given, yes.

And you're over budget?-- Yes.

And now have a look at CA4 which is the next document. This is Dr Galbraith, isn't it, as the Director of Cardiology, writing in and asking for more money?-- Well, it's a committee of Galbraith, the Acting Director, Toby Shields, and Haley Middleton, stating that there was an urgent demand for an additional 188 procedures per year to address a current demand for just interhospital transfers, an extra 38 extra per year to address a waiting list, and this was written in November, and as I say, a month later the - we were then given - this second round of cuts came through, after this submission had gone in. So it seems every time we ask for more activity the result was a cutback. That was the response on two occasions. After this submission, and after my submission from the Cardiac Society in July. Each time we asked for greater activity based on lots of evidence, the hospital was cutback.

See the third page in with - fourth page in - fifth page in with the tables and the dot points under the tables? Can you read the last two of those dot points for me?-- "The patients from the southern zone", is this is that you're referring to?

Yes, just to yourself, yes?-- Yes.

And that's right, isn't it, that that was the effect of cutback number one, as you call it, that the patients from the southern zone were now going to the PA?-- That was one effect of the cutback, yes, one effect. The other effect was to cut our activity back dramatically at the Prince Charles, yes.

Now, I understand that there were still patients waiting in Brisbane, in North Brisbane and from the central zone, that couldn't get to Prince Charles. That was the case before cutback number one and after cutback number one?-- That's always been the case.

Yes, that's right. But what wasn't happening after cutback number one was that patients from the southern zone were no longer coming to Prince Charles. They were going to PA?-- Well, the ones that came to Prince Charles were being

redirected back at PA. As I say, a lot of these patients couldn't get access to PA, and that's why they were coming to Prince Charles. As you know, PA, apparently, had no Category 1 and 2 patients. They were all lumped into this ridiculous Category 3, which was a total misclassification, and has only recently been redressed.

So that while Prince Charles lost funds in cutback number one and they were reallocated to PA, it also lost the patients it would have treated with those funds, and they were moved to PA too?-- Some - it did lose some patients. That's correct, yes.

Did you read the evidence that 11 million extra dollars are given to cardiology in the 2004/5 financial year, and $17 million in each year after that?-- Yes.

And you'd say that that's completely inadequate still?-- As I say, I cannot make comments about the overall budget, and questions like that I cannot answer. All I can answer is what was happening at the coalface at the hospitals that I was working at - at the hospital I was working at.

Well, you know one of the things you say is 25 - this is back in July 2004 - 25 cardiologists employed by Queensland Health - and really, per population you say there should have been 75?-- Yes, that's in our Cardiac Society submission, and that's based on the UK taskforce numbers. Queensland has one-third of the number of cardiologists looking after public patients that it should have.

All right. That's your submission, that it should be 75?-- That's a Cardiac Society submission.

Now, each of those cardiologists is going to cost about 300,000 a year to employ. Is that right?-- If they're employed as a full-time cardiologist, yes.

I presume that that's what you're talking about, full-time cardiologists?-- Yes, some of them are employed as VMOs, as part-time cardiologists, for instance. So there's an option to go both ways.

Apart from the cost of employing the cardiologists, would you know - would you have any idea - it's about $800,000 a year to fund the work that the cardiologists will do when you look at the operating theatres and the anaesthetists and the machines and the consumables and the outpatient appointments and inpatient stays?-- No, that would depend on what the cardiologist is doing. For example, a non-invasive cardiologist in Rockhampton, who doesn't do any angiograms or operating, there wouldn't be any of those extraneous costs that you mentioned at all, but for a cardiologist like myself who is doing a lot of interventions, that might be the cost.

But you're talking 10s of millions of dollars a year to increase the number of cardiologists to the level you say or the Cardiac Society says it should be; correct?-- That's correct. I mean, there is no cardiologists in the public system between Nambour and Townsville for instance. There is one private cardiologist there. So if you're anywhere along that central coast area, you won't come in contact with a specialist cardiologist when you have your heart attack. The same was true in Cairns for at least a year where the cardiologists there all resigned from the public system, and those hospitals coincidentally have the highest rate of death in hospital from a heart attack.

All right. So just to put the cardiologists in place is tens of millions of dollars every year and the other things you outline in your long letter to the Premier would be of an equal magnitude, wouldn't they, in terms of cost?-- I think it is consistent with what Dr Stable said about being underfunded by about a billion dollars a year and I think cardiology would fit into that argument as you've suggested.

Well, do you accept then that the things that you're asking for in that letter just can't realistically be provided in the current framework where our society doesn't give that extra billion dollars a year to health?-- That's right. It can't be provided with the current funding, that's correct, and that was why the submission was put in, in an effort to improve cardiac care and to improve funding. Thanks, Dr Aroney. Thank you, Commissioner.

COMMISSIONER: Thank you. Mr Fitzpatrick.

CROSS-EXAMINATION:

MR FITZPATRICK: Thank you, Commissioner. Doctor, I'm Chris Fitzpatrick and I act for Queensland Health. Can I ask you before I forget some questions about Exhibit 401 which was a
HER HONOUR: letter produced from the Medical Staff Association to Debra
Podbury, the then District Manager at the Prince Charles. Doctor, the-----?-- It's a petition.

Thank you. Its covering page presents as a letter which bears the words "faxed 25 August 2005". To whom was the document faxed on that date, do you know?-- Oh, that's - that's my faxing to my barrister here.

That's your faxing to your barrister?-- That's correct.

Because you would be aware of Ms Podbury's evidence in the sense that she has told Dr Cleary in specific response to his question about whether she ever remembers receiving this letter?-- Mmm.

That she never did?-- Yes.

It appears to be signed by something approaching 50 of her then staff?-- Yes.

She must be very forgetful to not remember such a matter, mustn't she?-- Yes.

Or else, she's lying.

MS KELLY: Commissioner, I object to the question.

COMMISSIONER: Yes.

MS KELLY: The form of the evidence alleged is that Dr Cleary reports that he's asked Ms Podbury does she recall and she doesn't recall, according to Mr Cleary. That's the best evidence upon which this questioning is based.

COMMISSIONER: Yes. I don't think you can put that question.

MS KELLY: In my submission it is unfair.

COMMISSIONER: You can't ask people in any event to speak about the veracity of someone else, Mr Fitzpatrick. It is quite inappropriate.

MR FITZPATRICK: Thank you, Commissioner. All right. Commissioner, I will hand up - back the exhibit.

COMMISSIONER: Yes.

MR FITZPATRICK: Doctor, when you gave evidence on the 24th of August you set out to address what you described as a number of misleading statements made by Dr Cleary in his statement and his evidence to the Commission. Do you remember that?-- Yes, I do. I had received a transcript at 9 p.m. the night before I gave evidence.

Thank you. Thank you, Doctor. The first of the matters that you were concerned about was the differing numbers disclosed on the cardiology waiting lists of each of the Prince Charles and the Princess Alexandra Hospitals at a time when the transfer of cardiology patients from the Prince Charles to the PA was in contemplation?-- Yes.

On that date and again this morning you have described a process of miscategorisation in relation to the PA list?-- Yes, not only that, but a hiding of the category 3 patients.

Thank you. We will come to that. Can I just ask you to focus, please, on your use of the word "miscategorisation"?-- Yes.

By whom do you suggest the PA list was miscategorised?-- I have no idea whether it was done by the clinicians or whether there was some reclassification by the bureaucracy. You would have to ask the PA that.

Yes. You have never worked at the PA, have you?-- No, I have not.

You have no idea how their affairs are conducted, do you?-- I have some idea of how their affairs are conducted. I have contact with the doctors there and I have knowledge as Chairman of the Cardiac Society of great difficulties of patients getting into the PA-----

Yes?-- -----from - from other hospitals such as the Gold Coast.

Yes, thank you, Doctor. You would be aware then, wouldn't you, as Dr Garrahay has told the Commission in his statement, he being the head of cardiology at the PA for this last 11 years, that at the PA it is the cardiologists who assign the cardiac patients to his list? Did you read that in his statement?-- I only received the statement about 30 minutes before proceedings today.

COMMISSIONER: He said he didn't know that, Mr Fitzpatrick. He said he didn't know whether it was the cardiologists or some administrators had done that.

MR FITZPATRICK: Thank you, Commissioner. Doctor, I put to you that the situation at the PA Hospital as deposed by the director of cardiology there is that it is the cardiologists who assign patient categorisation there?-- All right. If you say that's the case, I will accept that.

Thank you. So to the extent that you assert in relation to the PA list a miscategorisation?-- Mmm.

That is a matter initiated by the cardiologists there; is that not - must that not be the case?-- I assume that to be the case.

Do you know Dr Garrrahay?-- Yes.

Does he strike you as a responsible clinician?-- Dr Garrrahay is a very experienced clinician. With regard, however, to the waiting lists at the PA, I think most cardiologists in Brisbane would agree that they were inappropriate at that time.

All right?-- And if he was responsible for that miscategorisation, then that was not a responsible action on his part.

All right?-- And, in fact, at a meeting in November of this year to discuss the categorisation, this was looked at-----

All right?-- -----and has been changed at the PA Hospital.

All right. It's the case, isn't it, that at the Prince Charles Hospital, they utilised the Queensland Health general elective surgery categorisation process?-- Yes.

In their cardiac list?-- Yes.

Now, you've told the Commission, I think twice, that as a result of what occurred at a seminar in November of last year, that the system of categorisation used at the Prince Charles was upheld; is that your evidence?-- Yes, it is. It was - there was a consensus reached. I wasn't at the meeting-----

No?-- -----but I understand there was a consensus reached and the model was very close to that being used by the Prince Charles Hospital and by the Royal Brisbane Hospital and that the Princess Alexandra Hospital were then brought into line with that model.

Yes. Do you know Professor Ward?-- Yes.

Do you regard him as a responsible-----?-- Yes.

-----clinician?-- Yes.

He was the facilitator at the seminar, wasn't he?-- I wasn't at the seminar.

No. Well, I suggest to you that he was and that he's produced a summary of key points achieved at the seminar, point 5 of which is that there was general agreement that the surgical waiting list categorisation scheme was not appropriate for cardiac procedures. In other words, the system utilised at the Prince Charles was inappropriate?-- The system used, which is a 1, 2, 3 system is very close to the current system upheld at the end of the meeting with urgent cases. Now, it has been refined, but what PA was utilising was something totally different or that they were categorising all patients as non-urgent and could wait for very lengthy periods of time, something totally out of the bounds of what was being used at the Royal Brisbane, the Prince Charles and all the other major cardiac hospitals in Australia.

You don't know how long patients at the PA were obliged to wait for their treatment, do you?-- No, we do know. They were put on a-----

Doctor, Doctor-----

COMMISSIONER: Let him finish?-- They were put on a category 3 surgical list. They were put on a category 3 list which means they have very lengthy waits which is totally inappropriate for patients with chest pain. These are the patients who die waiting for an angiography.

MR FITZPATRICK: Doctor, that's only meaningful if in fact the two hospitals meant the same thing by assigning people a category 3, isn't it? If in fact the two hospitals utilise deterrent categorisation processes, it doesn't follow that the PA patients were not clinically properly treated, does it?-- Category 3 meant the same thing at both hospitals as far as I'm concerned. Category 3 meant that the patients could wait

for a very lengthy period and it is the same at both hospitals and yet there was hundreds of patients in the PA on that list with only - with zero category 1 and there was 229 category 1 at the Prince Charles. There can be no doubt that there was a major miscategorisation going on.

You don't know that there were hundreds of patients on the PA list, do you?-- Yes, I do.

How?-- I have been told by many sources that's the case.

Yes?-- And I would like - I would love Queensland Health to present the data. It has never been presented to us but I have been told by many sources.

Yes. From whom do you suggest that the PA list was hidden?-- Firstly, if you look at the MIC12 document from Cleary, Buckland makes a statement there talking about waiting lists at PA, that they're zero category 1 and two category 2 and doesn't mention the category 3 patients and uses this-----

Surely-----?-- -----as an explanation to transfer patients. I would view that as hiding the category 3 list.

Surely, Doctor, that document to which you have referred was created in the context of a then focus on the capacity of the PA Hospital to take patients from the Prince Charles and treat them within a time which was clinically appropriate; is that not the case?-- I think that statement was a total incorrect statement used for the agenda to transfer patients and cut activity at PA and it was hiding the true waiting lists at PA. It was subverting justice.

Who do you suggest was hiding the category 3 patients at the PA Hospital?-- If you read the statement, Buckland was in that statement.

Buckland?-- They're not mentioned. It's Buckland's statement.

Who - who else?-- Well, it's obviously - it's come down again then to the Prince Charles. When decisions were made to transfer patients, it was stated that there were no patients and Cleary stated in his evidence that there were no patients at PA, and this was a reason given for the transfer. The PA can do anything like they like, send them all across. So this was misleading the Commission and it was - and it was - and Buckland's statement is totally incorrect.

Yes. You said in your evidence on the last occasion that the PA lists might be difficult to locate because it was kept in somebody's briefcase. Do you remember giving that evidence?-- Yes, that was common knowledge amongst the cardiologists that the waiting list was kept in Dr Garrahay's briefcase.

Oh, so it was Dr Garrrahay who was carrying the list around?-- That was - that was common knowledge at the time that this was all being discussed.

Well, you will have read in his statement that Dr Garrrahay expressly denies that allegation?-- I'm not sure exactly what he denies. It's rather ambiguous. He says he denies things but he doesn't say specifically what he denies, whether it was a hidden waiting list or whether the numbers he denies. You will have to ask Dr Garrrahay what is he denying? Is he denying it was hidden or is he denying that there were several hundreds.

Yes?-- My knowledge is, certainly, that there was a large number, I believe several hundred, and I have heard that from good sources. Secondly, it is clearly hidden as Buckland said in MIC12.

Dr Garrrahay says in paragraph 28 of his statement, "Dr Aroney asserts that there were several hundred patients on a hidden category 3 waiting list at PAH. I reject this assertion." At paragraph 32 he says, "The waiting list at PA is centrally managed by the Cardiac Catheter Laboratory secretary and is not carried round in someone's briefcase rather than written down so it could be obtained as Dr Aroney asserts." So he denies both of the things that you asserted when you were last here?-- That's correct.

I suggest to you what Dr Garrahay says is true?-- Well, you will have to ask him that and as to when those - when he was carrying them around in his briefcase because the timing may be different. It probably now is centrally addressed but in 2003, when most of this data was collected, I think you will find it was in his briefcase.

I did ask him-----

COMMISSIONER: Come on, you can't say that. For goodness' sake. You are here to ask questions, not to make statements to the witness. You must surely know that, Mr Fitzpatrick.

MR FITZPATRICK: Yes, thank you, Commissioner. Doctor, the Prince Charles cardiac service was established long before that at the PA, isn't that the case?-- Yes, it was in fact the only cardiac hospital in the entire state for many years prior to private hospitals beginning and then the PA became the second public hospital doing cardiac work and then Townsville became the third.

Yes. And it's still the province, the exclusive province of the Prince Charles Hospital to do very complex cardiac cases?-- Yes.

And not that of the PA?-- Well, PA is expanding, as it should do, and I have always maintained that the PA should be appropriately funded but that these funds should not be gathered by ripping the guts out of other hospitals.

No?-- But, yes, the PA is developing complex work at their hospital in recent times.

Yes. And the service at the Prince Charles in terms of

numbers of cardiologists, beds and so on, is much larger even today than that at the PA?-- I don't know the exact numbers of beds of cardiology at PA but I think that that would be true.

Yes. Doctor, what is your objection to the proposition that so as to ensure continued viability of the service at the PA Hospital, some of the Prince Charles patients should transfer there for treatment?-- That has been used as the - as an excuse for taking patients from Prince Charles. Now, in fact, what that statement doesn't take into account is that the Gold Coast Hospital has recently got a cardiac catheter laboratory and that that will generate a huge number of new patients who will then be able to go to the PA. And that was not taken into account when that statement was written and that would easily account for the increased numbers that PA would have to grow and, in fact, PA even recently has been unable to take some of those patients from the Gold Coast. I have had complaints from the cardiologists at the Gold Coast of difficulty in transferring patients from their unit into the PA because of lack of beds or access block. So - so there is - there is provision for these patients from the Gold Coast.

It would be necessary - what you seem to be saying is that the PA be adequately resourced to take the transfer?-- Yes.

Yes. You're not suggesting that the PA Hospital didn't have the capacity to take the transfer of the Prince Charles patients who were in fact transferred to it?-- No, I'm not but I am concerned that there were several hundred patients on this hidden waiting list who were then put back further than - because of this transfer and what's happened to those patients? Is anyone an advocate for them? What's their death rates? What are their numbers? These numbers have never been supplied to us.

Well, Dr Garrahay says in his statement that the PA Hospital was asked whether it had the capacity to take the transfer and it did?-- Mmm.

Now, you're not in a position to disagree with that, are you?-- No.

Can I just focus for a moment on the seminar held in November of last year. You will have seen the papers?-- I have only seen them this morning actually.

Yes. But the papers make it clear, for instance, the memo from Mr Bergin, the Zone Manager, to, amongst others-----

COMMISSIONER: What's the point of asking him about a seminar he didn't attend, the papers of which he has only seen this morning?

MR FITZPATRICK: Commissioner, I was going to simply put to the witness that if in fact the PA list is the ruse that he suggests, it is a rather elaborate scheme to have a half day

seminar to try and get to the bottom of-----

COMMISSIONER: Well, how do you know what the seminar was for? That's a matter for a submission and construction of what took place at the seminar-----

MR FITZPATRICK: All right. The documents say precisely what it is for.

COMMISSIONER: That's a matter of construction then. I think it is a matter for submission, not questioning the witness about something he doesn't know anything about.

MR FITZPATRICK: All right. I won't trouble the witness with it. Now, can we talk about a different topic which is the use of VAD device in the two paediatric cases that you have referred to in your statement?-- Mmm.

Now, all of what you know about those two cases has been told to you by someone else-----?-- That's correct.

-----isn't that so? Yes. On the last occasion you suggested that Dr Cleary's evidence was wrong and misleading, Dr Cleary having said in his statement that it was the obsolete Biomedicus device which was contemplated for use in the two P cases. Do you remember that?-- Yes.

Have you since seen paragraphs 14 to 24 of Dr Cleary's most recent statement?-- I saw it about 30 minutes ago, or this morning when it was shown to me, yes.

All right. You will see there that Dr Cleary lists the weight of the two infants in both procedures?-- Mmm-hmm.

That being less than 30 kilograms. And he asserts that the Thoratec, the current Thoratec device is simply unavailable to those weighing less than 30 kilos so that it was the obsolete Biomedicus device which was contemplated for use in those two infants. Do you accept that?-- Well, that's his statement. As I say, this information was provided to me by the cardiac surgeon Dr Pohnler. I showed him Dr Cleary's evidence and he said this was not correct, that the Thoratec device was to be used for one patient and the Biomedicus for another, and if you wish to ask Dr Pohlner directly, I would suggest you do that, but that was his evidence to me and I'm passing it on.

Do you accept as a general proposition that it is within the reasonable prerogative of hospital management to insist upon proper safety and other precautions being in place prior to the use of machinery by clinicians?-- Of course, yes.

The next matter concerned your evidence that the dates of death of patients 13 and 15 referred to in your statement were misstated by Dr Cleary in a briefing by him to his superior Dr Scott concerning the circumstances of death of these and other patients, do you remember giving that evidence?-- Yes.

Have you recalled that you told the former Commission that

that evidenced an attempted cover-up by Queensland Health of the true circumstances of the death of those two patients? Do you remember that?-- Yes.

Have you now reviewed Exhibits 27 and 28 to Dr Cleary's most recent statement?-- Yes, again, I saw these just this morning.

Do you now accept that the dates of death of each were accurately disclosed by Dr Cleary in his statement to his superior?-- I would have to take more time and look at these deaths and make sure they're referring to the same patient so I have only been given these this morning. It - on the face of it however, I accept that there may have been an error made, the dates were given to me by staff at the hospital and it's possible that those dates were incorrect that I tendered and I apologise for that. Notwithstanding that, these patients were still avoidable deaths in that if they had been transferred urgently, that they still may have survived.

To whom do you apologise if you have been in error?-- I apologise to the Commission and to Dr Cleary if those dates were incorrect.

Can take you back-----?-- Sorry, just to answer that, I had limited time to look at those dates. Dr Cleary's evidence was on one afternoon. I received the submission at 9 o'clock. I had the dates written in my - on my notes that night and I had to make a submission the next day about Dr Cleary's statement.

Yes?-- So I had very little time to corroborate the evidence and that's part of the reason why this occurred.

In those circumstances, it might have been imprudent on your part to accuse Dr Cleary of a cover-up as you did?-- Yes, it may have been but I also brought up several other points including the petition and several other points which I do - which do represent, in my view, a cover-up.

Yes. Can I take you now to your suggestion that you were bullied by Gloria Wallace?-- Yes.

You say at paragraph 39 of your statement that in a - in the context of a staff meeting on the 29th of September 2004, Miss Wallace, the then Prince Charles manager bullied the cardiologists by threatening to replace them with foreign doctors. Do you remember giving that evidence?-- Yes.

Dr Cleary at Exhibit 19 of his statement, which is Exhibit 301C before the Commission, has put in some minutes of that meeting prepared by Dr Radford?-- Yes.

Do you know Dr Radford?-- Yes, I do.

Amongst, no doubt, other attributes, do you regard her as a reliable minute-taker?-- Yes, I do, although the meeting went for one hour 15 minutes and the amount of minutes taken and that are reported are extremely brief for a meeting which went for almost two hours. So it can be said that the minutes are

a very brief precis of what was actually said at that meeting.

COMMISSIONER: I propose to adjourn now. How much longer do you think you will be, Mr Fitzpatrick.

MR FITZPATRICK: Probably about another 15 minutes, Commissioner.

COMMISSIONER: I will adjourn till 2.30.

THE COMMISSION ADJOURNED AT 12.58 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.31 P.M.

CONSTANTINE NICHOLAS ARONEY, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Well, while I am waiting for Mr Fitzpatrick, I should say that I have received another letter from the Premier, dated 30 September, with a copy of his letter to the Honourable Stephen Robertson MP. I will mark that as Exhibit 402.

ADMITTED AND MARKED "EXHIBIT 402"

COMMISSIONER: Yes, Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. I am sorry for my lateness.

COMMISSIONER: That's all right.

MR FITZPATRICK: Doctor, before the break you were - you expressed some concerns about Dr Radford's minutes of the meeting of 29 September last year. Was your concern that the minutes presented in abbreviated form, what occurred over nearly a two hour period, or that the minutes omitted key issues which were discussed over that period?-- The - yes, the minutes were very brief minutes of what was discussed over an almost two-hour period. I think there was only probably 5 or 600 words after a very lengthy discussion. So they were brief minutes and some of the discussion - clearly much of the discussion was not included in those minutes.

All right. Have you the advantage of a copy of Dr Cleary's statement to which the minutes are exhibited available to you?-- I have read it. I don't have it on me at present.

Commissioner, perhaps if these could be put on the visualiser so that everybody can see them. Now, doctor, this is the first of nine pages of minutes which Dr Radford took of the meeting, and you will see that she has headed it "Gloria Wallace - Key Issues", on page 1. Do you have that there?-- Yes.

And the key issues apparently identify for discussion "more leadership", "culture - where we go". I don't know what the next word is.

MR ANDREWS: "Collaboration and surgical program".

MR FITZPATRICK: I am indebted to Mr Andrews, and the final was "budget". Do you see that?-- Yes.

And there then is embarked upon a discussion by Ms Wallace of each of those topics. The first heading is "directorship", et cetera. Do you see that?-- Yes.

Now, I will just put up page 2 of the minutes, and you will see that I've highlighted, "Staffing is an issue. Difficult to plan around staffing. For example with Con" - that's you, I assume - "on leave"?-- Yes.

"Not knowing what long-term intention is. Need to trust people and plan. Has been told" - I assume this is Ms Wallace - "about possible locums from an agency in South Africa." Now, in that context, it seems that what Ms Wallace was addressing was the issue of staffing and that she was not, at least as presented in the minutes there, making a threat of dismissal against the senior cardiologists in her unit?-- What she was saying that there were doctors available overseas who were available to take our positions. This had never been raised in all the time of 15 years or so that I have been at the hospital that locums would come from overseas to replace us. The difficulty involved in organising such replacement using an overseas doctor would be enormous, and this type of - in the context of what was going on, I and others in the cardiology unit saw this as a veiled threat, if you like, that, you know, "if you didn't toe the line, that we had doctors available from overseas", and that's how we read it, and it was - this sort of thing again was repeated at the subsequent meeting which was mentioned before.

You took her comment as a threat of dismissal of the senior-----?-- Not - as a threat of replacement.

Replacement?-- I mean, this had never come up before.

No?-- A person who takes long service leave, this had never come up before that someone - they had overseas doctors to suddenly come over and start working for us. This was very - this was highly unusual. It never happened.

Yeah. Can we just scroll down a little bit more, please? Now, there is then on the same page noted some comments by you, "Con: Overseas graduates are unlikely to come and stay for years. They go out into private. We need to get our registrars into the system. Look around the table as to long-term people who stay, issues of succession planning." Well - that's "G" is Ms Wallace, I assume?-- Yes.

"There are issues of succession planning, her feedback is that the registrars are not enjoying their experience." Now, with all due respect, that appears to reflect the general theme that what was being discussed were legitimate issues of staffing the unit, not bullying and overbearing the senior cardiologists?-- Overseas trained doctors have come to other parts of Queensland, for example to Townsville, and stayed - and Rockhampton or other places - stayed for a short period, got their registration, if you like, and then immediately gone into private practice, or very early on, and therefore to

suggest that these overseas-trained doctors were going to be useful in this context or going to provide long-term staffing is not - is not a useful issue. A lot of these people will come in for brief periods and then leave the system. And I was making the point that several of the cardiologists at the table, including Dr Radford herself, had been there at the hospital for over 30 years, people trained in this country, committed to this system, and they are the sort of people and our registrars who are training would love to have the opportunity of moving into the system. And this is what I was pushing, that we should be offering jobs to our own excellently trained staff to come back into the system, not to be looking overseas. That should be a last resort.

I thought you were responding to Ms Wallace's suggestion that she had available some overseas locums who could come in?-- Well, that's part of the reaction, yes.

Yeah. Because the meeting then continued for some seven pages or so. Can I suggest that if in fact Ms Wallace had made a threat of dismissal, it would have terminated very peremptorily at the point at which the threat was made?-- There was no threat of dismissal. I don't claim that.

Thank you, Commissioner. Those minutes are already in evidence.

COMMISSIONER: Yes.

MR FITZPATRICK: Doctor, would you look, please, at this document? Perhaps it can be put on the visualiser, Commissioner, if that's suitable. I am sorry, Commissioner, I meant to hand up this one. Now, doctor, this is a letter from you dated the 9th of March 2005 to Ms Wallace?-- Yes.

It is your letter of resignation?-- Yes.

Would you look, please, at the second - at the third paragraph? Now, what you have done by this letter is to resign your position as a staff surgeon at the Prince Charles, haven't you?-- Staff cardiologist, yes.

Staff cardiologist. And what you then purport to do is to "offer to continue as an honorary visiting cardiologist with catheter lab credentialing." Now, is that the same thing as a VMO?-- No.

No?-- I am not asking for any money. VMO is a paid position.

And a VMO also has obligations to attend at designated times?-- Yes.

So what you were offering was to come into the hospital on an ad hoc basis to assist where required in difficult cardiac interventional cases?-- Correct.

And so you would insist on refusing payment for assisting in these procedures?-- Yes.

Why was that?-- I didn't want to continue to be salaried by the hospital. I wanted just to help my colleagues in difficult cases. I had already done several of these cases whilst I was on leave. My colleague, who was doing, for instance, myocardial valvoplasty procedures, technical, very difficult procedures, sometimes he would call me during the case, been unable to do the case and I would come over, drop my clinical work, come over assist with the case we accomplished twice successfully and then I returned to my private work. I wanted to continue to be able to assist my colleague in doing these difficult cases.

This assistance that you gave on two occasions, was that before or after your resignation as a staff-----?-- It was before. It was whilst I was on leave.

Yes, but whilst you were on the staff of the hospital?-- Yes.

Yes. Yes, I tender that letter, Commissioner.

COMMISSIONER: All right. That will be Exhibit 403.

ADMITTED AND MARKED "EXHIBIT 403"

MR FITZPATRICK: This is a copy now on the visualiser of Dr Cleary's reply to you. It is already in evidence, Commissioner.

COMMISSIONER: Yes.

MR FITZPATRICK: In the second paragraph, "Dr Cleary notes your request for ongoing privileges. I can advise that the process for you gaining privileges will be considered on a case by case basis for individual patients. If such needs arise, the process for considering and awarding privileges will be through medical administration." Now, can I suggest to you, doctor, that given the transition which you had made from a staff cardiologist to that which you were proposing, that that reply by Dr Cleary is entirely appropriate and unremarkable?-- Well, I don't see it as appropriate. I believe, firstly, privileges, as such, should have been automatic, in that the fact I had been a staff cardiologist performing these procedures very successfully at the hospital for the previous 14 years. The idea that one - during the midst of an urgent case where I have been called across to help these cases urgently, to have to go to administration to get permission on a case-by-case basis is a ridiculous impost upon patient care. So I consider this response to be totally unreasonable and that, essentially, is a refusal of my offer.

Well, it certainly is that, but you can't see that from the hospital's point of view it needs to exercise some control over people who are no longer on its staff from simply going

into an operating theatre and supervising a process for which the hospital administration at the Prince Charles is ultimately responsible?-- I think it is unreasonable, given that I had pioneered these procedures in Queensland, I had the greatest experience and still have in all of these three procedures, than anyone else in the State, and for them to put this restriction on was totally unreasonable.

There is no question about your credentials to do that which you were asking to do, but this is a question, surely, of privileging? You understand the difference between the two concepts?-- Yes, I do, and we will have to disagree on this point.

All right. Commissioner, that's all that I have.

COMMISSIONER: Thank you. Now, Ms Kelly, do you have any questions?

MS KELLY: Yes, thank you. Mr Andrews and I have agreed that I will re-examine Dr Aroney in his stead.

COMMISSIONER: In whose stead?

MS KELLY: In Mr Andrew's stead.

MR ANDREWS: If I have any further questions, I will ask them, but at the moment I anticipate that Ms Kelly will cover the field.

COMMISSIONER: Okay, yes.

RE-EXAMINATION:

MS KELLY: Dr Aroney, you were asked about the impact of smoking on the need for cardiology services. Prior to the first round of budget cuts, did you operate an anti-smoking clinic at Prince Charles Hospital?-- I personally was the Chairman of the Cardiac Rehabilitation Unit at the Prince Charles for about six or seven years. I didn't personally operate the anti-smoking clinic but it was a very important part of the rehabilitation unit, and I was involved in all aspects of cardiac rehabilitation, including anti-smoking, weight reduction and regular exercise. So I have been involved in these aspects more so than any of the other staff at that hospital for that period of time.

And prior to the - or contemporaneously with the budget cuts to which you have referred, what happened to that anti-smoking clinic?-- It disappeared. It was - it was told there was no funding for the clinic, funding was cut off and the nurse who was operating the unit very successfully, Sister Fung, actually left the hospital.

Yes, thank you. Now, you were taken to some minutes of a meeting which are MIC20 to Dr Cleary's statement, being the minutes of the 3rd of November 2004 meeting. Those minutes refer to the Queensland Health Code of Conduct at page 3. Would you turn to page 3 of those minutes? Or do you still have the minutes in front of you?-- I haven't got them in front of me here.

Perhaps if I can just read to you the relevant extract. "Ms Wallace also indicated that Dr Aroney would be in breach of this document", that being the Queensland Health code of conduct, "if he were currently working at Prince Charles and not on leave. For example, releasing into the public arena details of the hospital's waiting lists without approval." Now, have a look at this document, please? This is the Queensland Health Code of Conduct. Did you have reference in the course of the controversy between you and Queensland Health to the Queensland Health Code of Conduct?-- Yes, I had access to this, yes.

Yes. And did Ms Wallace, in the course of this meeting, direct you to any particular provision of the Code of Conduct in breach of which she said you were currently?-- I don't believe so, no.

All right. Can you turn to page 8 of that document?-- Yes.

Dealing with integrity. Is there anything in respect of that provision of the Code of Conduct which guarded your behaviour in your disclosures?-- Part of the obligations in paragraph (a) number 2 that - and I quote - "to advance the common good of the community they serve." Also "should ensure any conflict that arises between the employee's personal interest and official duties is resolved in favour of the public interest." Also, "that people should disclose fraud, corruption and maladministration of which they were aware." So I felt in respect to all of these issues that my disclosures were appropriate.

Thank you. And at point 4 on page 9?-- Point 4 on page 9 states "circumstances where public comment or debate is not acceptable includes a public comment amounts to a personal attack."

Did you feel in any respect that you had breached that provision of the Code of Conduct?-- No, I did not.

Was it asserted by Ms Wallace in this meeting with you that you had done so?-- She - as you pointed out, the minutes state that I couldn't be working at the hospital with my current disclosures.

Yes, all right. Thank you. And at page 12 of the Code?-- Yes.

Was there any provision on that page of the Code which guarded your conduct?-- This includes "The Whistleblower's Protection Act protects whistleblowers against reprisals and declares

reprisal misconduct a criminal offence."

Yes, thank you, Dr Aroney. Now, in respect of the matter in which Mr Fitzpatrick last questioned you, that is the refusal of your offer for voluntary services, since it was made clear through your public disclosure of those events, that is that your voluntary offer was refused, has anyone from Queensland Health hierarchy or from Prince Charles administration been in contact with you in relation to accepting that offer in retrospect?-- No, they have not.

Thank you, I have nothing further.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: I have no re-examination, Commissioner.

COMMISSIONER: You are excused, Dr Aroney. Thank you for coming.

WITNESS EXCUSED

COMMISSIONER: Now, Mr Andrews, I think we know the witnesses for Monday, don't we?

MR ANDREWS: Yes, Commissioner. Although my mind has just gone a blank as to the first witness. Scott Crawford.

COMMISSIONER: Yes.

MR ANDREWS: Who is an orthopaedic specialist who has seen a number of patients from the Fraser Coast region, and Dr Nothling is scheduled to appear at 2.30 on Monday.

COMMISSIONER: All right, thank you. We will adjourn now.

THE COMMISSION ADJOURNED AT 2.53 P.M. TILL 10.00 A.M. ON MONDAY, 3 OCTOBER 2005