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QUEENSLAND

COMMISSIONS OF INQUIRY 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF JOHN GRANT SCOTT

I, John Grant Scott, former Senior Executive Director, Health Services, Queensland Health, acknowledge that this written statement by me is true and correct to the best of my knowledge and belief.

1. What are the details of Dr Scott's formal qualifications and his working history (in brief)? For what period was Dr Scott employed, or otherwise engaged, by Queensland Health (herein, Dr Scott's "employment")? What positions did he hold with Queensland Health, and for what respective periods? What responsibilities attached to those positions?

1.1 I hold a degree of M.B.B.S. from the University of Queensland obtained in 1976. I also hold a Bachelor of Economics obtained from the University of New England in 1994.

1.2 I hold post graduate qualifications. I have a Diploma of Obstetrics from the Royal Australian College of Obstetricians and Gynaecologists obtained in 1980, (subsequently invited to examine candidates for the Diploma) and a Masters of Applied Epidemiology from the Australian National University. I was awarded a Fellowship of the Royal Australian College of General Practitioners in 1989 (subsequently appointed Censor for the Queensland Faculty and member of the Board of Censors of the College of General Practitioners at the national level) and a Fellowship of the Faculty of Public Health Medicine, Royal Australasian College of Physicians in 1994.

1.3 **Attachment JGS-1** is a copy of my Curriculum Vitae detailing my professional qualifications, associations, published works and committee and working group memberships as well as the positions I have held within the Department of Health and elsewhere for the past 28 years.

1.4 I commenced work as resident medical officer in 1977 within the Department of Health. Since that time I have worked within the health sector in Queensland in various roles. I have provided direct, one-to-one patient care in hospitals (in Brisbane and Toowoomba) and in private rural procedural General Practice (Ingham) for fifteen years.

1.5 I have worked in public sector management and senior administrative roles for ten years. For eight years I was State Manager Public Health Services overseeing population level services such as education campaigns to address childhood obesity, delivering immunisation programs that have taken Queensland's immunisation rates to among the best in the country, and delivering breast screening services that have given Queensland some of the best participation rates for women across Australia. I have continued

through this time to have a strong interest in the provision of medical services to rural and regional Queensland.

1.6 I acted as General Manager and Senior Executive Director of the Health Services Directorate from November 2003. I was appointed to this role in December 2004. My services were terminated by the Government on 27 July 2005.

1.7 In general terms, my responsibility as Senior Executive Director, Health Services ("SEDHS"), at Queensland Health ("QH") was to manage health services in Queensland through District Health Services organised in three Zones, and through statewide services in Public Health, Laboratory and Scientific Services, and Non-government contracting and community-based health service delivery. The Executive Directors for the statewide services reported to me. **Attachment JGS2** is a current organisational structure which shows the areas over which I had responsibility. The Public Health Services Branch, where I worked as manager, is also shown on the structure chart.

2. **The Commission has received evidence about longstanding concerns in public health as set out below (including, for example, the state's dependence on overseas trained doctors, bullying, lack of resources and unsafe working hours). Was Dr Scott briefed regularly by Queensland Health staff about emerging issues in Queensland' public health sector? In what ways was Dr Scott briefed, by whom and how regularly? Does Dr Scott consider that he was briefed effectively and comprehensively? How did Dr Scott apprise himself of emerging issues in the public health system?**

2.1 Queensland is divided into 3 zones for QH Health Service administration purposes. Each zone has one Zone Manager. Each Monday morning I had a 2 hour meeting with the 3 Zone Managers. Also present at these meetings were the Public Health Services Manager, the Pathology and Scientific Services Manager, and the Statewide Health & Community Services Manager. Issues regarding Queensland's Public Health Sector were discussed at these meetings.

2.2 In addition to the weekly meetings, I would receive additional briefings. These briefings would generally be in the form of a written briefing by a District Manager, although the information may have been written by someone other than the District Manager. Generally the briefings I received were of 2 types:

2.2.1 briefings regarding acute episodes such as an outbreak of disease or the escape of a patient with mental illness;

2.2.2 issues which were longstanding such as problems with overseas trained doctors and working hours. Briefings of this nature were generally provided to me to keep me informed as to what was happening with ongoing issues.

2.3 I believe this system of briefing generally worked well. The main difficulty that was experienced was that some individual District Managers were unwilling to report issues that arose within their districts either because they believed the issues to be unimportant or thought they would resolve them at

the local level. To a point this was desirable, but I did need to be informed if the issue had the potential to blow up. I instructed that we develop and report on a list of 12 matters to be discussed at each of these meetings to try to ensure they were orderly and complete concerning performance information; new initiatives by government, and ad hoc issues and our response to them – **'JGS3"**.

2.4 As well as formal briefings such as the above I received telephone calls and emails on a daily basis. QH published a card which should have been available to every District Manager which had my landline telephone and mobile numbers on it. I welcomed calls from District Managers if they had a concern.

2.5 QH has a tracking system which assigns briefings and submissions a number. This was to keep track of where the documents were within the system. My Personal Assistant has printed out a spreadsheet showing that about 8,000 such documents came to me in the 2004/5 year – **"JGS4"**. As well as this there were memos and letters addressed to me personally and an increasing number of emails received every day. Given the size of the job, the system was as efficient as any, but the volume alone meant that it was impossible to be aware of every issue as fully and as soon as desirable.

3. During Dr Scott's employment, did Queensland Health monitor media reports concerning public health. If yes, how was this done? If not, does Dr Scott consider that this should be done as a matter of course?

3.1 During my employment as SEDHS, QH did monitor media reports concerning public health. Each morning the Director General would meet with the Media Manager employed by QH. At that meeting the Media Manager would go through current media reports with the Director General. The departmental Liaison Officer was also present at this meeting. If an issue that arose in a media report appeared to be worthy of investigation, the Liaison Officer would take the matter up with the relevant District Manager. The Liaison Office would then let myself, the relevant Zone Manager and the Director General know the results of the inquiries. Persons were also employed within each of the zones who fulfilled a similar role to that fulfilled by the Media Manager employed in QH's Head Office.

4. What is Dr Scott's knowledge of the means by which Queensland Health briefed the former minister, Gordon Nuttall MLA, or his predecessor, Wendy Edmond? Would Dr Scott recommend any changes to the way in which Queensland Health briefs the Minister?

4.1 Both Ministers Nuttall and Edmond were briefed as and when issues arose. A briefing would occur if they called for a briefing on a matter or if the department thought they ought to be briefed. It is fair to say the department had a fairly low threshold as to when to brief the Ministers on issues – i.e., we would brief rather than not take the matter to the Minister. These briefs could be either written or oral.

4.2 When he became Minister, Mr Nuttall instituted a process whereby he was given weekly briefings in addition to the established process described

above. These briefings were generally given orally, although on occasions reports in respect of the matters on which the Minister was being briefed would be left with him. Present at these weekly briefings were the Director General, myself (as SEDHS), the Senior Executive Director, Strategic Policy and Intergovernmental Relations, the Senior Executive Director, Resource Management, the Senior Executive Director, Information Services, and the Senior Executive Director, Innovation and Workforce Reform – shown as the top layer of the organisation chart - **"JGS2"**.

4.3 At these weekly meetings we discussed problems, and other issues of concern to Mr Nuttall. For example, Mr Nuttall was particularly interested in capital works, elective surgery waiting lists and oral health services. The Minister would ask for weekly, monthly or quarterly follow up of these and other issues.

4.4 I was generally of the view that the system of briefing the Ministers worked reasonably well. Certainly if information was requested from me I always attended to providing it promptly and completely. I always tried to be responsible about briefing the Ministers with information that they had not sought but I believed they should have. The DG met with Ministers daily as a matter of normal routine. If something came up after hours or on the weekends I would contact the DG so he could tell the Minister or on media-related matters I would call the Minister's media adviser directly.

5. **Dr Nankivell made repeated complaints to Queensland Health about dangerous and unacceptable waiting periods for patients (see exhibit 212 – especially the attachments; and the transcript for 26 and 27 July 2005). His statement contains a letter addressed to the then Director-General, Dr Stable, outlining a number of concerns. Dr Nankivell's concerns were given some corroboration by Dr Pitre Anderson (exhibits 199 and 200; transcript 25 July 2005).**

(a) **Was Dr Scott aware of such complaints, or similar complaints and issues surrounding dangerous waiting periods for patients during his employment?**

(b) **If so, what are the details of that knowledge, and what steps were taken in consequence.**

5.1 I understand that the complaints made by Drs Nankivell and Anderson were made prior to my employment as SEDHS. I was not aware of those complaints having been made and had not heard of either of those doctors before the issues in respect of Dr Patel came to light.

5.2 I was however aware of complaints regarding waiting periods (including dangerously long waiting periods) for patients being made during my period of employment as SEDHS.

5.3 Various strategies were used to attempt to reduce waiting periods for patients. For example, procedures were put in place whereby a patient who was required to wait an unacceptable length of time for an operation at one hospital would, if possible, be transferred to a different hospital either within

the zone or more widely within the State if the operation was able to be performed more quickly at that hospital. Work was also contracted to the private sector when waiting times between the private and public sectors for particular operations were out of proportion. Efforts were also continually made to obtain more money. Funding was especially sought for areas where there were critical points such as gynaecological cancer services at the Royal Brisbane Hospital and Mater Hospital, and for intensive care beds at the Royal Brisbane Hospital and PA Hospital.

5.4 If an individual case was brought to my attention I would personally contact the relevant District Manager to try to achieve a satisfactory solution – e.g., if an MP contacted me on behalf of a constituent, directly or through the Minister's office. Otherwise the system relied upon individual clinicians, either within a hospital or say, a referring GP outside the hospital, to alert the Medical Superintendent of the hospital to a problem. If the problem raised concerned an individual, steps could usually be taken to provide care. If the matter concerned a class of patients it was more difficult.

5.5 Some classes of treatment – renal medicine/dialysis; oncology – for example – were under-resourced Statewide, in terms of money and staff and other resources. Sometimes waiting times cannot be addressed immediately because QH simply does not have the built capacity. This is an area requiring policy and allocation of resources over many competing disciplines. Further, there are often long lag times after steps are taken before any effect is seen in waiting lists.

6. **Numerous doctors have given evidence about low morale amongst doctors and nurses in the public system brought about by, inter alia, an inability to treat patients well (having regard to funding inadequacies), excessive rules, a focus on money rather than patient welfare, a perceived lack of responsiveness to clinical concerns, and a lack of a role for clinicians in management of hospitals: see, for instance, the evidence of Dr Thiele, Dr Molloy, Dr Jenkins and Dr Woodruff).**

(a) **Was Dr Scott aware of such complaints and issues during his period of employment?**

(b) **If so, what are the details of that knowledge, and what steps were taken by him to address the same during his employment?**

6.1 I was aware of complaints and issues of this nature during the period of my employment as SEDHS.

6.2 The primary issue of concern in relation to the majority of these matters stemmed from a lack of funding. The public hospital system was, in my view, under pressure due to not having enough money to address the demands of the system. This was not just a problem in hospitals but was an issue throughout the entire system. As a result of QH's Public Works program there was an improvement in facilities, however there still remained insufficient funding for patients to be treated as well in the public system as in the private system. This problem could however only be solved if more money was made available by government.

6.3 I accept that as government employees, doctors and nurses were subject to more rules than they would be subject to if they were employed in the private sector. These rules are however generally produced by government and are required to be enforced by QH.

6.4 I did have knowledge of concerns that there was a lack of a role for the clinicians in management of hospitals. QH has been implementing collaboratives to attempt to address this issue.

6.5 The idea behind collaboratives is to promote grouping of like clinicians to work together on defining quality in performance in their area of expertise. These collaboratives then look across the organisation to find examples of good practice that can be promoted and useful parameters to measure performance across the system.

6.6 QH has attempted to promote a culture of no-blame in order that clinicians will see the value of working collaboratively and will join with other like-minded clinicians. This approach has been promoted actively through the Evidence-based Practice section of the Innovation and Workforce Reform Directorate, led by Prof Michael Ward. Clinicians themselves choose the indicators that they believe best monitor their performance eg out-of-hospital mortality after myocardial infarct and then measure their performance against peers in an atmosphere of confidentiality. The eventual aim is to involve all clinicians and facilities in this process.

6.7 QH has organised collaboratives in the Cardiac, Renal, Cancer and Emergency Services areas to date and was looking to expand this approach to other areas in the future as clinicians hopefully embraced the process. Evidence, particularly in the cardiac area which has been running the longest and has been published in the Medical Journal of Australia, suggests significant improvements in survival post-myocardial infarct.

6.8 The Cardiac collaborative has been in place for approximately 5 years. The number of facilities involved has increased of recent times. The Emergency Services collaborative has been in place for approximately 18 months, the Renal collaborative for a little longer. The Cancer collaborative has recently been approved and is currently being developed.

6.9 QH's long-term goal is to encourage participation of all facilities and hopefully all clinicians.

6.10 At the national level a similar process is used and some of the larger QH facilities voluntarily choose to benchmark with national level peer organisations through a process called Round Tables. I am aware of facilities like PAH, RBWH, PCH and other larger facilities being involved in this process with very good results.

6.11 Before I left my position, the Health Services Directorate in QH was implementing a system of individual performance planning and review whereby Zonal and Statewide Managers, District Managers, Directors of Nursing and Medical Superintendents were to be engaged in a process of

individual performance planning and review with their immediate supervisors on a 6 monthly basis.

6.12 I believe Medical Superintendents and Directors of Nursing have a fundamental role in determining the culture and performance of particular facilities. Medical Superintendents should be both leaders of the local medical staff and also a conduit to and from the medical staff for management decisions and clinician concerns. Medical Superintendents need to be able to readily access performance information that can objectively identify problems with the performance of their facility.

6.13 It has been my observation that this interface between management and clinicians has been variable in its effectiveness across the state. In some locations, exemplary Medical Superintendents have created an efficient and effective culture of service delivery which provides an example for other institutions. In other locations, staff have lost respect for management and the decisions of management to some degree, simply because they have never been engaged in understanding decisions or in contributing to decisions that needed to be made by management. The implementation of a performance planning and review process was intended to give Medical Superintendents greater support in managing and improving these relationships.

6.14 Medical Superintendents and Directors of Nursing in performance management meetings would discuss not only hard target benchmarks in terms of operational plans but also address cultural issues and corporate values in order to promote a more open environment supportive of improved communication between clinicians and management. This process has been piloted in the Public Health Services Branch and has proven to be an effective way of involving all layers of the clinical team.

6.15 I believe, the current QH structure and the changes implemented as a result of the QH Strategic Plan for 2004 to 2010 showed that QH was improving the way it was providing services to Queensland patients. There is no doubt that there has been a serious system failure in Bundaberg but it is my belief that processes that have been introduced or are being introduced in QH in relation to patient safety and improving clinical performance will make a significant difference to the quality and safety of the systems QH provides.

7. **During the period of Dr Patel's employment at the Bundaberg Base, it is understood that Queensland Health had in place policy 15801 (ex 279) being the Credentials and Clinical Privileges Guidelines for Medical Practitioners July 2002. Under this policy, district managers were responsible for ensuring that an appropriate committee periodically reviewed the credentials and clinical privileges for each medical practitioner operating within the district. There is no evidence that Dr Patel was reviewed in accordance with the policy. Instead, it seems, he was given blanket temporary privileges provided without any form of assessment. It has been suggested this was because the Royal Australasian College of Surgeons would not nominate a surgeon for the task.**

(a) Does Dr Scott have any information that contradicts the understanding set out above?

(b) There are a number of surgeons in the Bundaberg and Fraser Coast areas who are Fellows of the RACS. Is there any reason why one of those surgeons could not have been utilised to review Dr Patel for credentialing and privileging, in lieu of a nomination from the RACS?

(c) There appears to be no attempt by Dr Keating or Mr Leck to consult with Queensland Health in Brisbane about difficulties experienced in complying with the policy. Was Dr Scott aware of any difficulties that districts were experiencing in securing appropriately qualified people for the credentialing and privileging committees? If so, was it only Bundaberg?

(d) What assistance was given by Queensland Health's head office to districts in relation to credentialing and privileging?

(e) What measures were in place to ensure compliance with the credentialing and privileging policy?

7.1 I do not have information which contradicts the above. It is my understanding, which is only hearsay, that the Royal Australasian College of Surgeons did not nominate a surgeon for the task of credentialing surgeons in Bundaberg and for this reason Dr Patel was not assessed.

7.2 As to (b) above, I have concerns with utilising a surgeon to review a doctor for credentialing and privileging if that surgeon has not been nominated by the College, as there are potentially issues of bias that could be raised if the candidate is not ultimately credentialed. Someone put forward from the College is recognised as being a person who will act without fear or favour and who has the formal recognition of their colleagues. I appreciate this is an ideal founded on principle, but credentialing is a practical matter of fundamental importance to the Colleges. Had I been made aware of any particular problem in Bundaberg (or anywhere else) I would have contacted the President of the Queensland College and organised someone to perform the credentialing whether as the College's formal nominee or someone who was informally recommended by him.

7.3 As to (c) above, I am not aware of any attempt to contact QH in Brisbane. After the issues with Dr Patel became known I looked at the Measured Quality documents from Bundaberg and they stated that the BBH was doing credentialing. I was not able to take that discrepancy any further from the documents. Larger facilities did not generally have difficulty implementing the credentialing and privileging process. I was aware, however, that at smaller facilities, there were sometimes problems properly constituting a credentialing committee. It is difficult to find enough members of the relevant specialty because in regional areas there is a small pool to draw on. Additionally, problems are encountered in finding suitable people who can assess the applicant doctor's country of origin training, and speciality qualifications, and who also understand the scope of practice of the hospital

where the doctor wants to work. This impacts on the ability of the committee to make informed decisions in relation to the credentials of the doctor, and the privileges offered to the doctor.

7.4 As to (d) above, at present there is no general assistance available - the districts have to ask for help. For a recent example, credentialing and privileging requires participation from the relevant professional college or body. Of recent times this process has been difficult to organise for surgeons in some regional areas as participation from the Royal Australian College of Surgeons has been difficult to arrange. To attempt to address this issue I worked with Dr Buckland who wrote to the Head of the Royal Australian College of Surgeons to ask if he could ensure that the College would participate in the credentialing and privileging process. He responded to this letter by saying that he would support the process but that Surgeons would not be representatives of the College - see **"JGS5"**. It would be a sensible change to have more formal availability of this type of assistance. The obvious place for that in QH Brisbane is under the direction of the Chief Health Officer, who is primarily liaising with the colleges as part of his role.

7.5 Ideally, the Credentialing and Privileging committee in each District should consist of staff with knowledge of the relevant Hospital's ratings under the Service Capability Framework devised by QH; knowledge of the services currently available in the facility and those available to support the proposed scope of practice of the applicant, and at least one College appointee in the speciality for which the doctor is applying to be credentialed. It should also have evidence to support the claims of the individual to previous experience and expertise. Where a practitioner is from overseas this may require follow-up either with previous employers or at least advice from an Australian-registered practitioner who has worked in and perhaps graduated from the area the applicant comes from and with knowledge of the level at which that unit functions.

7.6 As to (e) above, I believe that an individual clinician's performance is very much the responsibility of the facility in which they work and should be monitored at that level. QH Brisbane established guidelines and expected that they would be complied with at a local level. There was follow-up such as through the Measured Quality documents, referred to above.. To endeavour to audit this process in a more detailed way at a corporate level would require extra administrators and would also send a message to clinicians that they were not capable of managing their own performance and that of their peers.

8. **The Commission understands that Queensland Health had policies in place concerning complaint and incident management (Queensland Health Policy on Complaints Management 15184 issued July 2002 with accompanying work instruction outlining the roles and responsibilities of various persons; Queensland Health Integrated Risk Management Policy 13355 and accompanying work instruction initially issued on 20 February 2002 and reviewed and updated in June 2004; the Queensland Health Incident Management Policy issued June 2004). It has been suggested to the Commission that the complaints handling process has not dealt with matters in a timely and transparent manner and that there is a lack of feedback and**

follow up on complaints to the extent that it discourages staff and patients from complaining in the first place.

(a) What are Dr Scott's comments as to these matters?

(b) How many sentinel event and serious adverse risk reports did Dr Scott receive from Bundaberg Hospital, when and from whom? What were they and what did Dr Scott do about them?

(c) What action, if any, did Dr Scott take in response to data concerning patient safety issues that emerged in the Bundaberg Hospital Measured Quality Process Report and when?

(d) Which, if any, Bundaberg matters did he refer to the Medical Board, Audit and Operational Review or other appropriate external bodies?

(e) The Commission understands that:

(i) Under Queensland Health complaints management policy, there is a requirement for each district to provide an annual report (concerning complaints received and organisational improvements subsequently implemented) to the General Manager of Health Services, and to report generally on major risks to Queensland Health Audit and Risk Management Committee ("QHARMC");

(ii) Health Service Districts are not all complying with the annual report to the General Manager of Health Services requirement;

(iii) Aside from the provision of risk registers, there is no process for the Districts to provide ad hoc risk advice to QHARMC relating to specific complaints.

What are the details of Dr Scott's knowledge of the matters relating to compliance set out above? Did Dr Scott provide briefs to the Queensland Health Minister in relation to any of the matters relating to compliance alleged above? What steps did Dr Scott, take, or know of, during his employment, to ensure that the districts complied with the complaints policy?

8.1 As to (a), in QH the majority of these issues and complaints are satisfactorily resolved at the local level usually by Patient Liaison Officers. Resolution may require escalation to the facility or District Executive if the matter involves a decision on policy or funding. Sometimes complaints may not be resolved to the satisfaction of the complainant and they may then be referred to the Director-General, the Medical (or other relevant) Board, the Health Rights Commission, the Ombudsman or a range of other parties.

8.2 Complaints may also be escalated to the political level either through contact with the Minister or their office or through contact with other members of parliament. I would usually not be involved in patient complaints unless they are escalated to the latter levels (that is Ombudsman, Minister, etc).

8.3 I believe in most cases that patient complaints are best resolved at the local level. This is the approach adopted by QH. Escalating complaints to higher levels in my experience only serves to reduce the likelihood of a successful outcome, serves to make all parties more defensive, and is not in the best interests of a satisfactory resolution for the patient. Some members of QH staff are also trained as investigators and they are called on to investigate complaints where necessary. Issues of natural justice and due process then intrude, participants begin to consider legal matters and I can understand that this gives rise to a perception of a slow process where responses are guarded. I can see that people believe that this system is overly-bureaucratic. I can also appreciate the difficulties of the people who must deal with the complaints; who must attempt to afford everyone a fair hearing and protect everyone's rights. Often every party involved will only see their own point of view and almost necessarily will be disappointed by the process.

8.4 QH treats over 20,000 patients a day and employs 65,000 people, so even when the majority of complaints are dealt with well, there will still be some that are not. I think this issue needs to be seen in this context.

8.5 As to (b), Sentinel Event and serious adverse risk reports from hospitals were to be reported by staff at the hospital to the District Manager who should investigate both the specific incident reported and whether there is any pattern of adverse events emerging. If the individual event or a series of events is serious - say if someone had lost a leg - that information should come right through to me, via the Zone Manager, under the "no surprises rule". If the incident is not so serious, and is a one off, it can be dealt with at the local level.

8.6 With hindsight, this process did not work in relation to Dr Patel's time at BBH. The only matter that was brought to my attention was the case of the 15 year old who did lose a leg. That was reported by Dr Rashford to the hospital and, through the Zone Manager to me. When I received the report from Dr Rashford, I asked the Zone Manager for a report on how the patient had been managed in Bundaberg – see **"JGS6"**. I received a report from the Medical Superintendent at Bundaberg with covering emails from the District and Zone Managers two days later – **"JGS7"**. There was obviously a very unsatisfactory outcome for the patient, but nothing alerted me to a problem more significant in terms of Dr Patel's surgical skills or his management of patients after surgery. I agreed with the recommendations in the report from Dr Keating that patients with major vascular injury should be transferred from BBH to RBH as soon as possible after the patient was stable, and could see that the Zone Manager was dealing with implementing this change at both BBH and RBH.

8.7 As to (c), Measured Quality documentation was under the direction of Innovation and Workforce Reform Directorate - see "measurement system data analysis" - last dot point, fifth box under this heading in **"JGS2"** above. This was the part of QH that administered the process to the hospitals in the first place and then took the results back to the hospitals to discuss what needed to be addressed. Therefore I did not have the responsibility for

reading and responding to the Measured Quality documents for any particular hospital.

8.8 My role was further along the management chain in relation to these documents. The process began, I think, in 2001-2002. The first lot of reporting was in 2003. This report went to Cabinet. This had an undesirable effect from a management point of view because the documents became Cabinet confidential and thus were not able to be used to give feedback to the hospitals. I felt strongly that this type of feedback was very valuable for the hospitals and facilities from which it had been collected. I made strenuous efforts to achieve a situation where feedback from the 2004 process would be given back to the District Managers and Executives, although it was carefully done, through hard copy information only, on a restricted distribution. At the other end of the process, I encouraged the District Managers to participate fully in collecting the data and using it with their executives. I also fought for funding to support the analysis process and support for districts in interpreting the reports. In short, I think the Measured Quality process is one of the most important things QH was doing, partly I suppose, because of my background in epidemiology.

8.9 Measured Quality Reports have not demonstrated any significant variation in the performance of the Bundaberg Hospital to date but it is important to stress that the methodology, while offering a significant potential to compare facilities across the State, is still being developed and should be considered a work in progress. This approach to organisational performance monitoring would be considered to represent national level best practice.

8.10 As to (d), I did not refer any Bundaberg matters on. As explained above, I did not have any basis for concerns of that type until after January 2005. Between January and April 2005, Dr FitzGerald was conducting enquiries.

8.11 In early January 2005 I was acting as Chief Health Officer ("CHO") while Dr Gerry Fitzgerald was on leave. I undertook these duties in addition to my own duties as SEDHS. While I had performed this role previously in conjunction with my own role, it was a particularly busy time as the CHO was involved in coordinating a team of surgeons, paramedics, public health staff and anaesthetists to go to Aceh, Indonesia to assist in the wake of the Boxing Day 2004 Tsunami disaster and I was involved with this coordination work. This work required daily national teleconferences, meetings with staff members and Department of Emergency Services staff and was delivered at a fast pace.

8.12 I am aware that there is a phone message dated 10 January 2005 recording a call from me to Peter Leck - **"JGS8"**. I believe that this call related to the 15 year old male. I do not recall another phone call from him after that.

8.13 On 13 January 2005 Mr Peter Leck sent me an email regarding concerns he had about Dr Patel's surgical practice and suggesting an investigation by the CHO needed to be conducted - **"JGS9"**.

8.14 I do not recall when I first read the email, although I most likely would have responded on the same day that I read it - the 20th of January – **"JGS10"**. I

was present in my office on the days 14 to 19 January 2005 but was busy with arrangements for the deployment to Aceh as well as my normal workload. In general I respond to phone calls and letters in priority to emails. I expect that if someone needs me urgently they will ring - as stated above, District Managers have my phone numbers and my PA, as a matter of course, gave my mobile number to such people if I was out of the office and it was urgent.

8.15 In my emailed response to Mr Leck of 20 January 2005 - **"JGS10"**. I suggested he consider contacting the Senior Executive Director Innovation and Workforce Reform, Dr Mark Waters or Dr John Wakefield (whose patient safety branch is overseen by Dr Waters) if the CHO was not available. Drs Waters and Wakefield were leading the changes around international medical graduates and were also involved with broader initiatives around patient safety and complaints management for the organisation. I received the reply from Peter Leck shown in **"JGS11"**.

8.16 For completeness, I include further email traffic between Peter Leck and I about Bundaberg issues – **"JGS12"**;

8.17 I was on leave from 25 March 2005 to 3 April 2005. My memory is that when I returned the Director-General, Steve Buckland, had received Dr Gerry Fitzgerald's clinical audit of general surgical services at Bundaberg Base Hospital – **"JGS13"**. That report does make criticisms of the surgical outcomes at Bundaberg but there is nothing in it that rang alarm bells as to Dr Patel being incompetent or behaving in a way which justified his immediate review or removal. It seems I was asked to clear a ministerial briefing dated 15 April 2005 – **"JGS14"** relating to this issue on 15 April 2005. I do not recall this briefing, which doesn't mean I did not clear it. However, as a matter of course I signed briefings when I cleared them and sometimes made comments. The copy I have is not signed by me and has no comments from me. This briefing contains markedly different advice in relation to Dr Patel compared to the report from the CHO marked JGS13 – I cannot explain this difference. Thereafter I asked for a briefing as to issues surrounding the alleged cash payments to Dr Patel and the payment of his airfare to Los Angeles and received it on 18 May 2005 – **"JGS15"**.

8.18 I visited the Bundaberg Base Hospital on 29 April 2005, 20 May 2005, 7 June 2005 and 20 July 2005. At that stage Senior Queensland Health employees had been appointed to positions such as Acting Medical Superintendent and Acting Director of Surgery etc. I wanted to offer support to management and to staff and see for myself how the hospital was operating. I recall that I spent a lot of time speaking to staff in intensive care and the emergency department who were having particular difficulties at that time. I spoke to management and I spoke to staff generally. I would visit the cafeteria at meal times to access staff. I wanted to reassure them that they had the support of Queensland Health and to listen to concerns which they wanted to raise.

8.19 As to (e) above, QHARMC was a committee chaired by an independent chair. Amongst other things that committee would look at compliance with rules relating to finance and administration and would also look at the

compliance with rules regarding clinical performance. It was not the function of the committee to put in place new systems or to address complaints on an ad hoc basis. I am unaware of the requirement to provide reports of the nature referred to in paragraph 8(e) above.

8.20 The QH Minister would have been briefed on matters relating to compliance but generally only on an annual basis. Briefings would however go to the Minister regarding specific incidents on an ad hoc basis.

8.21 Memos were sent out to the districts informing them of the complaints policy. Such memos would detail what was involved with the complaints policy and what was expected in the enforcement of that policy. Complaints management was the responsibility of the Innovation and Workforce Reform Directorate. The risk register was the responsibility of the Audit and Operational Review Directorate. If it became apparent, for example, that a particular district was not complying with the complaints policy, correspondence would be sent to that district reminding them of what was required by the policy and of their obligations to ensure that the policy was complied with.

9. **It has been suggested in evidence that there has been a steady decline in the resources of public hospitals leading to an inability to treat patients. They have spoken of "access block" to surgery caused by shortfalls in terms of ICU beds, nurses, funding of consumables etc., and a shortage of beds generally in tertiary hospitals in Brisbane, and in some regions.**

(a) **Does Dr Scott have a view in respect of the adequacy of funding for public hospitals? If so, what are the details of that view? If the funding was, in Dr Scott's view, inadequate during his employment, what steps were taken to increase funding? What is the process for increasing funding?**

(b) **Does Dr Scott agree that there is beds in tertiary hospitals in Brisbane? If so, what steps have been taken to increase beds? What is the process for increasing bed numbers in Tertiary Hospitals?**

9.1 As to (a), the short answer is, yes.

9.2 Across the world governments and health departments are recognising that they are incapable of addressing mounting health care demands. This mounting demand expresses itself as increasing numbers of patients presenting for services with increasing waiting lists, in increasing costs for tests and medications, and as an increasing proportion of the state or country's gross domestic product being committed to health care.

9.3 The Queensland Health Statement of Strategic Intent released by the Premier last year identifies a need to respond to prevention of disease and the promotion of good health. This is different from simply treating existing disease. It also recognises a need to enhance community-based services and to form partnerships with private sector organisations and providers of services in order to improve the efficiency of health service delivery. All of these approaches were incorporated into District and other service plans and

carried an extra burden in relation to funding. However without this significant change in direction health services will become unsustainable in the medium term (as recognised in the Health 2020 document endorsed by Cabinet) especially in areas like mental health.

9.4 A brief description of the budget process used by government and QH is attached as **"JGS16".**

9.5 Sometimes, election commitments actually create further costs which place greater pressure on existing services. For example, funding an orthopaedic surgeon's wage will allow a surgeon to be recruited but unless an extra $1 million or more is made available to address costs incurred by the surgeon in doing their work, the result will be an extra cost for the facility in which the surgeon works. Further funding loads borne by the department result from programs that are proposed for funding and approved to go ahead but with funding to come from already existing internal departmental allocations. In effect, this means that the available departmental budget to address service shortfalls is reduced by the amount approved but not funded. In 2004-05 my advice was that this amounted to approx $75 million worth of work. Recently I was advised that the figure for unfunded approved work for 2005-6 stood at $120 million.

9.6 This process will ultimately result in small items not being funded and over a period of time these compound to become significant budget deficits which require significant amounts of money to address. A process completed within the last two months sought districts' advice on medium and high priority exposures for them that could result in less than optimal services (i.e., services that are safe and meet the needs of patients). The total funding required to address these deficits across the state (as estimated by the districts) was approximately $233 million recurrently for services and $35 million one-off for capital items such as new facilities or medical equipment.

9.7 Funding from the Commonwealth and State Treasuries is based to a large degree on past performance of Hospitals and other services using clearly defined counting methodologies. For example, some of the funding provided for hospital activity is based on the care required to be given to a patient that is relevant to their diagnosis-related group (DRG). A DRG is a planning methodology that has identified that a patient attending a hospital with a particular illness will, as a result of that illness, generally require a certain amount and level of care. For example, the DRG for myocardial infarct (heart attack) patients is telling of what sort of care is required for patients in this DRG and the average length of stay of a patient in the DRG and takes into account the costs of drugs, staff time and hospital-based services required to deliver that level of care.

9.8 The Commonwealth in particular expects that levels of service will be maintained (or enhanced if extra funding has been provided) and regular reports are required by the Commonwealth and the State on performance in areas of hospital admissions, vaccination services, breast-screening and elective surgery to name a few areas. Provided these levels of activity are delivered then funding continues to be made available. In effect this

arrangement requires that facilities continue to provide services at both the number and level of complexity that have been delivered in the past.

9.9 It was and is the case that more money is required to provide an optimal service. QH's budget is, on my understanding, largely determined on historical grounds. Additional money will be received from time to time. Often this money is unable to be utilised to meet needs which may be identified by QH as it will come tied to specific projects, often to fund election commitments. QH puts in submissions to the formal mid-year budget review for funding for specific projects. A bid is put to the Cabinet Budget Review Committee, which then decides whether the particular proposal would be funded. In 2004/05, QH put in 5-6 bids. It is my recollection that only 2 of those bids were successful in receiving funding.

9.10 The normal budget process is that each District puts bids in to QH for the money they need for the following year. The department will then review these claims and prioritise these bids bearing in mind the funds it believes it is likely to get from the budget. The Minister will receive the department's submission. The Minister may or may not ask for parts of such submissions to be changed. The Premier's Department also views submissions and again may ask for parts to be changed. The Budget Review Committee then looks at the Minister's submissions. It is not the case that the department or the Minister gets what they ask for - the health budget must compete with all other funding needs of the State.

9.11 Outside this yearly budget cycle, QH puts together proposals to fund various projects. These proposals are often at the initiative of the Department but can also be at the initiative of the Minister. The proposals are prepared in the form of submissions for the Minister to take to Cabinet. As above, the Minister, or the Premier's Department, may ask the Health Department to change the documents. Sometimes a QH proposal to fund a certain activity or achieve a certain goal is rejected in that the department is asked to delete it from the Cabinet submission. Other times the Minister will take the submission to Cabinet and Cabinet will reject it, or, say, direct that the initiative proceed but be funded out of existing resources.

9.12 Policy considerations at this level are properly the province of the government, not the department. It is the department's role to implement policy from this governmental level even if it is contrary to what the department has assessed and put up in the submissions to the Minister. That the department is not able to address issues does not mean that it does not regard them as important. It is sometimes difficult to implement policy in these circumstances and stakeholders may conclude that the department does not see their claims to funding as necessary, important or sincere -. see my statement below as to my dealings with Dr Aroney.

9.13 As to (b), I agree that there is a need for more beds in hospitals. This varies across the State. Statewide there is a shortage of beds in intensive care and neo-natal care. Other shortages are specific to particular hospitals at particular times, and from time to time includes tertiary hospitals in Brisbane. In some places there is not the physical space to put the beds into the hospitals. For example, on the Gold Coast there is no space for additional

mental health beds. As a result, beds in private hospitals are used with QH staff being sent to those facilities.

9.14 During my employment at QH, efforts were made to increase bed availability as well as just numbers. Money was put into intensive care and neo-natal intensive care in south east Queensland which allowed for the opening up of more beds. Bed numbers were also increased at the Robina Hospital and TPCH. As to availability, efforts were however focused on the number of patients being treated rather than the number of beds. This involves in part shortening patient stays in hospital, which of course, gives rise to potential problems itself. Contracting work out to the private sector effectively increases bed availability.

10. **It has been suggested in evidence before the Commission that:**

(a) **The waiting lists for elective surgery published by Queensland Health may be misleading in that they disclose the patients waiting for surgery, but not the people waiting to be reviewed to determine whether they need surgery (eg, exhibit 267, and see transcript 31 May 2005, especially page 550);**

(b) **In the aftermath of concerns being raised publicly about Dr Patel, Queensland Health sent a Medical Review Team to the Bundaberg Base Hospital. The team prepared a report which is Exhibit 102. It will be seen in paragraph 1.1 that the Team found staff were concerned that there was an excessive emphasis on elective surgery targets. There has been other evidence that elective surgery targets were very important to the Hospital's funding, that the management between 2003 and 2005 were keenly aware of this (see evidence of Dr Nydam and exhibit 72), and that Dr Patel may have received special treatment because he was instrumental in reaching targets (Annexure GF10 to Exhibit 225).**

Did Dr Scott have any knowledge during his employment that official Queensland Health waiting lists did not disclose patients waiting to be reviewed for determination as to whether they need surgery? If so, what are the details of that knowledge? Are there any impediments to the publication of a surgical waiting list which discloses the number of people waiting for an outpatients appointment, or alternatively the wait from seeing a general practitioner, to being assessed, to having surgery? Did Dr Scott, during his employment have any knowledge of deliberate efforts to minimise the number of appointments for review of patients prior to booking same for surgery, so that the number of patients appearing on official Queensland Health waiting lists would be minimised? If so, what are the details of that knowledge? Does Dr Scott agree that within Queensland Health there may be an excessive emphasis on elective surgery targets? How else might funding be distributed?

10.1 As SEDHS I had responsibility for those parts of the organisation that delivered elective surgery. I was responsible for those parts of the organisation that managed waiting lists and also for those parts of the organisation that delivered reports on which the information on waiting times was built.

10.2 QH maintained a waiting list for outpatients services for elective surgery - i.e., it was a list of people waiting for an initial, or second appointment with a surgeon prior to surgery or for a post-surgery consultation. QH also collected data at the facility level on the numbers of people waiting to see other specialists at public hospitals. None of these lists were published. The data was available and could have been regularly collated and published. It was from time to time collated for the use of the department and Ministers on request. The decision to publish is one for the Minister, not for the department. Information as to outpatient waiting lists was regularly used by the department to assess need and resourcing at a local level - for this purpose the numbers at a particular hospital or in a particular speciality were used, not the statewide figures. From time to time I recall that statewide totals were requested by the Minister to take to Cabinet including for Cabinet to consider the Waiting List Reduction Strategy and for budget purposes. I was not aware of deliberate efforts to minimise the number of outpatient appointments for surgery or otherwise.

10.3 The outpatients waiting lists were not published but they were not secret. Searches of Hansard reveal questions as to them and the general waiting times for outpatients many times over the last few years – **"JGS17"** is a collection made by some QH employees. Any General Practitioner referring patients to public outpatients would know this. Any surgeon working in a QH facility would also know that patients waited to get into Outpatients.

10.4 Overall direction at the state level was set by an elective surgery steering committee I had formed (comprising Zone Managers and the Executive Director of Statewide Health and Clinical Services Branch). I was not on the committee but the committee reported to me on average weekly. The committee did significant work to better streamline delivery of elective surgery, to better plan funding and to organise elective surgical waiting lists to better manage patients. The key objectives of this work were:

- To ensure category 1 and 2 patients were attended to within the prescribed timeframes.
- To use our resources efficiently and to ensure wherever possible patients were transferred between facilities if facilities had shorter waiting lists. We have also explored the use of smaller secondary facilities like Maryborough and Ingham that have excess capacity to take patients for minor surgical procedures and thereby to relieve pressure on major secondary and tertiary facilities.
- To explore how we could better prioritise category 3 waiting lists to ensure that those with the greatest clinical need were attended to first.
- To shift the focus of the programme from elective surgery to elective procedures to ensure interventions requiring a less invasive approach but delivering the same quality of outcomes were available to patients (eg funding early intervention through diagnostic procedures).
- To work with the AMAQ and specialist bodies to identify how we could contract out elective surgery procedures to the private sector.

Outcomes from the committee included:

- A proposal that was accepted by government to change the programme focus from elective surgery to elective procedures.
- A paper that was provided to the Minister's office and circulated within QH to promote discussion of procedures that might be removed from the category 3 list that weren't seen to be life threatening, such as tattoo removal.
- A paper that was provided to the Minister's office and circulated within QH on establishing an objective ratings-based set of criteria to identify people with higher clinical need who could be prioritised in the category 3 list - eg, employed patients with a disability that is surgically correctable and that would allow them to remain employed and supporting dependents.

Feedback on these issues went through District Managers to the committee but the operating procedures for elective surgery were very clearly and strongly reliant on Directors of Surgery and Medical Superintendents locally and heavily reliant on clinicians generally for the prioritisation of procedures.

10.5 In terms of information presented for national reporting, reports were prepared on the basis of nationally agreed criteria. There was no organisational direction that I am aware of to falsify elective surgery reports. I absolutely reject any formalised misrepresentation of information. I also did not have any knowledge of deliberate efforts to minimise the number of appointments for review of patients prior to booking the same for surgery, so that the number of patients appearing on QH waiting lists would be minimised.

10.6 QH's focus was to respond to category 1 and 2 patients within the agreed timeframes if at all possible. In terms of category 3 patients, it is important to recognise that Queensland is the only state that provides free public outpatient services. Elsewhere patients are referred to specialists privately. Attempts to utilise named referrals in order to have fulltime specialists use their option A or B entitlements to see patients privately have often met with inaccurate claims of cost-shifting or medifraud. Many private specialists also don't want public patients seen in their private rooms as they believe this sends a message that there is little value in having private insurance. There are of course also waiting times to see specialists privately.

10.7 QH has done a large body of work looking at all facets of the elective surgery process, much of which is ongoing but in the implementation phase. As an example we have explored models such as nurse practitioners working with specialists in outpatients (eg urology outpatients at PAH) to try to improve outpatient throughput. However, bringing more patients in to outpatients and booking them for surgery will then require that operating theatre throughput can be improved. More theatre time can be found in the private and public sectors, and more doctors can be available to use these theatres but at an extra cost. Work is underway in all these areas but until more doctors are available in the system, maintaining little or no waiting times will be impossible. Before then, and even with more doctors, more funding and workforce reform will be essential. For example, the surgeons assessing the patients in outpatients are the same surgeons who do the operations, so

dedicating more time to one or other activity takes time away from the other. There is thus a need for more staff and more funding.

10.8 In my view there is not generally an excessive emphasis on elective surgery targets. Elective surgery has been given an higher importance by political decisions that have made it a political marker of health system performance but clearly it is one of many important concerns. The funding for elective surgery is provided in response to the perceived need for elective surgery in a particular district. If it appears that that funding is inadequate for a particular hospital, attempts are made to increase the amount of funding. If a hospital is not utilising the full amount of the funding that has been allocated to it, those funds are redirected elsewhere. I do not have enough information on the views of District management in Bundaberg to comment on the views held there specifically.

10.9 Ideas that by performing more surgery, or more complex surgery, Dr Patel made money for BBH are misconceived. BBH received a certain budget for surgery, like every other hospital. That budget would not increase because Dr Patel performed complex surgery. Complex surgery is more expensive to perform than simple surgery. If Dr Patel performed complex surgery the BBH's surgical budget would disappear faster, but no further funding would be provided. Less patients could therefore be treated and waiting lists would increase. There was no profit or bonus to the hospital for performing complex surgery.

10.10 Dr Patel performed a lot of surgery. This meant that BBH did not lose funds because they couldn't provide the amount of surgery that their budget was based upon. But it did not mean they got extra funds. Nor did it mean they made a profit. The budget was based on the cost of providing surgery and this did not contain a profit component. To keep their surgery budget they had to do the work and meant they had to spend the amount budgeted. The only benefits of a high surgical throughput are non-financial - less people on waiting lists and staff more gainfully employed.

11. It has been suggested in evidence before the Commission that there is a medical workforce crisis (see evidence of Dr Lennox, Dr Jeanette Young, and Dr Fitzgerald). Did Dr Scott during his employment become aware of a medical workforce crisis? If so, what are the details of that knowledge? What steps in respect of addressing any medical workforce crisis did Dr Scott take or become aware of being taken, during his employment? Can Dr Scott recommend any further steps that would address this issue?

11.1 When I took on the role of SEDHS, clinical workforce shortage was (and continues to be) a primary issue for QH. This is generally a world-wide problem. The situation in Queensland is worse than other States in Australia because:

11.1.1 we don't have competitive award and incentive conditions, and

11.1.2 we are decentralised geographically.

Workforce shortages were a problem across the State, both in terms of filling particular positions (particularly in rural and regional areas) and with respect to particular specialties. OTDs are recruited partly as a response to medical workforce shortages when local graduates are not available.

11.2 When I became SEDHS, I was aware of problems in QH broadly and in the hospitals specifically through a combination of:

- Ministerial and other correspondence from and to patients complaining about the treatment they received at hospitals or other health services (from OTDs and non-OTDs);
- Briefings and emails raising concerns with me;
- Being advised of the difficulties associated with recruitment of appropriately trained people into specialist positions in hospitals;
- Being advised of the difficulties that QH has had with recruitment companies and in ensuring that doctors contracted had the appropriate skills for the positions to which they were recruited.

11.3 Innovation and Workforce Reform were developing departmentally-endorsed responses to workforce issues. This was not within my area of primary responsibility. One of my roles, however, was to track concerns in relation to problems that may not have been addressed at the system level and to ensure that we were working with other relevant parts of QH to address these problems. It was not, however, my role to manage individual cases. Instead I was required to be cognisant of any statewide problems and to know that QH was putting in place a response at the organisation level to address them.

11.4 Part of this process involved participating in wage and award negotiations. It became clear to me that QH could not be competitive in attracting quality local or overseas graduates if our rates of pay were not competitive. While comparisons are difficult it would appear that Queensland falls behind other major states in our rates of pay and our conditions. We also have no clear incentives to recruit staff to rural areas and none to retain them there. While SEDHS I participated in negotiations around the Visiting Medical Officer (VMO) Agreement and was instrumental in supporting active interest-based bargaining to determine what incentives will assist to recruit staff to QH in the lead-up to the next Enterprise Bargaining Agreement round. Ultimately decisions on what pay and conditions are offered to staff are taken by the Government through the Cabinet Budget Review Committee - see the process described above.

11.5 Any further steps that could be taken should be focussed on making pay and conditions more attractive for recruiting and retaining staff, and in promoting improved collaboration and, wherever possible, integration with the private sector. Incentives proposed for consideration by government are attached as **"JGS18"**. In the face of workforce shortage available resources must be used as efficiently as possible.

12. Is Dr Scott aware of a Queensland Health policy of discouraging the engagement of VMO's in favour of more staff specialists? If so, what are the

details of that policy? If so, what are the details of such a policy and awareness?

12.1 Visiting Medical Officers ("VMOs") are specialists who work in the public system on a part-time basis. These doctors have a private practice also.

12.2 VMOs are a necessary part of the public health system as they provide a service where no full time doctor can be located, where the workload does not demand the services of a full time practitioner, or where a practitioner cannot be recruited fulltime.

12.3 Apart from a suggestion made to me of an apparent move by the previous Director of Anaesthetics at RBWH to recruit fulltime staff exclusively, I am not aware of any organised approach to replace VMOs with fulltime staff. This certainly has never been the policy within QH.

13. **In or about August 2003, Dr Denis Roland Lennox (Queensland Health's then Acting Principal Medical Advisor) and others produced a report entitled *"Management of International Medical Graduates"* detailing concerns about Queensland's dependency on Overseas Trained Doctors, and changes which might be made to manage that dependency (see attachment DRL12 to exhibit 55, and exhibit 55 generally). The report ("the Lennox Report") was commissioned by a joint committee approved by Queensland Health and at least one early version of the Report dated July 2003 bears the Queensland Health logo. Dr Lennox has given evidence that the Report in its August 2003 version was complete (see the transcript for 3 June 2005).**

By an article published in The Courier-Mail on 4 November 2003, the Premier, the Hon. Peter Beattie, was recorded as saying in relation to the Lennox report, *"When this final report is completed as opposed to a draft, then obviously Cabinet will want to have a very close look at it...If the reports in The Courier-Mail and the draft report are sustained in the final report then we will need to change our systems and we will"* (copy to follow).

Did Dr Scott ever receive a copy of the Lennox Report in any of its versions? When was the Report finalised? What steps, if any, were taken to finalise the Report, after August 2003? What steps, if any, were taken to implement the Report? When did Dr Scott first become aware of problems presented by Overseas Trained Doctors and their integration into the public health system in Queensland? When were those concerns communicated to the Minister and what steps if any have been taken to address the concerns?

13.1 I did not receive a copy of the Lennox Report and cannot say when, or if, the report was finalised. I do not know what, if any, steps were taken to implement the report. These are issues which arose prior to my appointment as SEDHS, and before I began acting as SEDHS on 4 November 2003. I was aware in a general sense that there were issues raised by Hedley Thomas just prior to this and my understanding was that the Director-General had dealt, or was dealing with them.

13.2 As to when I first became aware of problems with OTDs, in the early to mid 1990's I was involved in the Doctors for the Bush Program which was an initiative of the Australian and State Governments and involved other groups such as the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and medical boards. The program was designed to recruit doctors from overseas to work in Australia in areas of need, working towards an Australian Fellowship with one or more of the Colleges.

13.3 When I was working on the Doctors for the Bush Program I became personally aware of a number of difficulties with OTDs at a range of different levels. For example I witnessed OTDs having difficulties with the English language. As with Australian-trained doctors, there are some OTDs who are clinically very good and other doctors who are not competent. There is a wide disparity in the level of training that is provided by particular overseas medical schools and there are basic cultural differences.

13.4 I cannot comment on whether QH was trying to address the issues with OTDs in the 1990s. I worked on that issue at that time with QH through the College of GPs as state Censor. This was a non-work-related interest springing from my time in rural general practice.

13.5 In terms of the performance of OTDs and the appropriateness of their qualifications, QH takes the approach that Medical Superintendents have responsibility for the performance of their staff. They have medical qualifications and understand the local issues associated with medical service delivery, understand how sub-specialties and specialties are differentiated and understand what is required to deliver a complete and safe service. Coupled with Credentialing and Privileging Committees, appropriate rostering practices, and local training processes in place for people who have identified skill deficits, these are the mechanisms at a local level to appropriately screen and monitor local and overseas-trained doctors.

13.6 QH is instituting programmes for the recruitment of new clinical staff, for assessing and reviewing the competence of medical practitioners (including those from overseas) being recruited to, or currently working within QH, and for identifying and correcting problems in terms of key competencies. These changes were instituted in response to recognised problems with recruitment processes (inconsistent contracts, lack of a clear process for determining what competencies the recruit had, no process for prioritising placements of available new staff, no parity with wage scales), a need to support international medical graduates in sitting examinations like the Australian Medical Council examination, and for remedial training in recognised areas of deficit in new recruits. The Centre for Overseas Trained Doctors at the Skills Development Centre at RBWH was the central focus for this process.

13.7 These changes were commenced in late 2003/early 2004 and were proceeding through a range of mechanisms, mostly coordinated by the Innovation and Workforce Reform Directorate, but also requiring input from the Resource Management Directorate. All of these changes were seen as keys to recruiting appropriate practitioners and to ensuring that they were supported in delivering services. While the focus was clearly on international

medical graduates all of these mechanisms will benefit local graduates as well.

13.8 The following are some of the problems which confronted QH:

- Under current awards and processes there is very little, if any, meaningful ability for facilities in rural and remote locations to offer incentives likely to attract medical staff to their areas ahead of facilities closer to the urban environment.
- There are issues associated with supervision of clinicians in rural areas as staff may not be available to supervise them, particularly if they are sole practitioners. People with the skills to travel to country areas to determine what level of care clinicians are providing usually are more than involved in clinical care elsewhere.
- A further issue is the ability of QH to manage OTDs who are recruited by recruitment agencies to ensure that when they take up a District position they have all the skills that are required to fill that District position. In the past the Districts have significantly relied on the recruitment agencies to properly screen OTDs. The challenge was how to assess the OTDs level of competence in the Districts or preferably before they were placed in a District. Originally QH didn't have any formal assessment process but developments through the Centre for Overseas Trained Doctors at the Skills Development Centre (SDC) at Herston were aimed at addressing this deficit.
- Assessing clinicians in the work environment and providing on-the-job training for new and older graduates in light of the shortage of clinicians in regional areas.

13.9 The IWR is also organising a process for enhancing patient safety through the Patient Safety Centre in IWR and District-based patient safety officers. The IWR is also rolling out and managing the PRIME database that gives a capacity to monitor adverse patient outcomes across the state (including a capacity to recognise low-prevalence adverse outcomes), allows clinicians of any variety to report adverse outcomes and clinical incidents by e-mail and allows for anonymity if this is preferred.

13.10 QH has also worked to improve recruitment and contracting of doctors through the use of panels of recruitment firms, standard contracts and centralised advice on recruitment procedures. Currently processes are underway to review contracts and by centralising recruiting approaches, to prioritise placement of applicants for positions in order to ensure urgent clinical need is met first. I have actively promoted and assisted these processes. A process for prioritising facilities in terms of access to available clinicians is currently being developed and should be managed through Zones to ensure clinical needs are consistently assessed and appropriately managed.

13.11 In Rockhampton and Bundaberg where no appropriate applicant was available (locally or internationally) I have agreed to above-award contracts to recruit suitable staff to permanent and temporary positions in order to ensure that appropriate services could be delivered. In the long-term this approach, and the issue of non-competitive wages generally, raises the

question of whether our approach to medical remuneration and conditions is appropriate or whether we need a major overhaul to introduce, for example, individual contracts to better address regional or individual differences with regard to what will attract and retain a practitioner.

13.12 In the briefing dated 18 February 2004 entitled English language testing for OTDs, I was supportive of the concept of doing English language testing. My only concern is ensuring that the testing process used is appropriate. As I have travelled throughout various hospitals, I have had two or three OTDs raise concerns that they could pass most of the segments of the test but they couldn't pass all of them. They were concerned that the IELTS test (used for testing English language proficiency) was too hard in areas like interpretation of difficult concepts culturally and was going to drive OTDs out of Queensland. IELTS is an English language proficiency test that is made up of a number of different modules. There are different modules testing written and spoken language and comprehension. Some OTDs were concerned that it might test comprehension of, for example, English literature when it was more relevant to test their comprehension of medical language. They suggested that while there was nothing wrong with their spoken and written English, when it came to comprehension in some areas they became concerned that they would fail.

13.13 Ministers Edmond and Nuttall were briefed on OTD issues. The following are worth noting:

13.13.1 There were a large number of written briefs and submissions to the Ministers on these issues. These submissions came through me in my time as SEDHS, and a large number of the briefings came through me. I cannot recall which briefings came to me and which didn't because sometimes the Senior Departmental Liaison Officer would request Ministerial briefings directly from Districts. The submissions came to me from departmental officers. I sent them to the Director-General who passed them onto the Minister. Briefings came from districts to me, and went directly to the Minister. Others were specifically requested and would not come through me.

13.13.2 Ministerial correspondence both inward and outward that came over my desk relating to concerns of individuals with OTDs or concerns of organisations or groups.

13.13.3 Direct discussions that I was involved in with the Ministers and Director-General.

13.13.4 Issues that were discussed regarding OTDs in meetings of the Ministers and Director-General with other bodies such as Rural Doctors Association of Queensland and the Australian Medical Association Queensland.

13.13.5 Other documents such as papers from Australian Health Ministers' Advisory Council (AHMAC) meetings or from the Australian Medical Workforce Advisory Committee (a sub-committee of

AHMAC) that were delivered to Ministerial office staff for their consideration and possible later briefing of the Minister.

14. **Dr William Kelley has given evidence of concerns with the Emergency Department at the Rockhampton Base Hospital in March 2005 (see transcript for 8 July 2005, page 2236). He also gave evidence of learning – on raising the issues with management – that a Report prepared by a Dr Peter Miller and others in June 2004 ("the Miller Report") had identified major concerns with the Hospital but had not been publicly disseminated. When did Dr Scott first become aware of the Miller Report? What, if any steps, were taken prior to 27 July 2005 to address the concerns raised in the Report? To whom was the Report published, and when? If a decision was made to restrict the publication of the Report, what factors informed that decision, and who made it?**

14.1 I first became aware of the Miller Report around November 2004, although I did not actually receive a copy of that report until approximately June 2005. In response to that report the district put together an implementation plan. I received correspondence from the district asking for my assistance in funding the reforms which came out of the report. In response I agreed to the necessary funding of $40,000 to respond to concerns raised in the report specifically the cost of a project officer to support the Medical Superintendent and other hospital staff in implementing the reforms and increased funding for the emergency department to be used for extra medical staff once needs were clearly identified.

14.2 I am not aware of any decision which was made to restrict the publication of the report. An executive summary of the report was provided to staff in the Emergency Department at the Rockhampton Base Hospital along with a memorandum from the District Manager attached as **"JGS19"**. The full report would have been provided to the Medical Superintendent and District Manager and I think that it is likely that the Zone Manager would also have received a copy.

15. **Exhibit 38 is a report by two orthopaedic specialists, namely Dr Giblin and Dr North, about Hervey Bay Hospital? Like the Lennox Report (exhibit 55), the Miller Report (exhibit 129), the Fitzgerald Report (GF30 to exhibit 225) and the Waters Report (see Mr Messenger's evidence - Transcript 25 May 2005), the Giblin/North Report was not widely disseminated by Queensland Health.**

How were decisions made during Dr Scott's employment by Queensland Health about the publication of reports obtained by Queensland Health? In what circumstances might a decision be made to refrain from publishing reports? Is Dr Scott aware of any other reports relevant to the Commission's terms of reference which have not been made public nor cited by the Commission?

15.1 From time to time, issues arise which require investigation within hospitals or other facilities. Generally the approach taken by QH has been to arrange an independent investigation of serious allegations or issues on the basis that transparency of process is important in reaching an appropriate outcome that addresses the underlying issues. Sometimes doctors from other hospitals

are engaged to undertake the investigations and report on these matters. At other times academics or members of Colleges, who may not be part of the public sector, are asked to conduct investigations and report on their findings.

15.2 The level at which an investigation is initiated and monitored and at which the final report is received depends on the seriousness and scope of the situation.

15.3 Generally the extent to which reports were published depended upon the purpose of the report. For instance the Miller Report was a report about the emergency Department at Rockhampton and the executive summary was circulated to the staff of the emergency Department. The Medical Superintendent, District Manager and, I think, the Zone Manager, received the whole report, as did senior officers in QH Brisbane, and in appropriate cases, their assistants.

15.5 In the position of SEDHS I would expect to see reports from important investigations but equally would expect each manager at the relevant level to respond appropriately to investigations overseen by them and to implement recommendations flowing from reports as they saw fit.

15.6 Once the persons who will be preparing the report have been decided, they are appointed by the Director-General under the *Health Services Act 1991* and are issued with terms of reference and a time frame within which to carry out the investigation and deliver the report.

15.7 To assist with the implementation of recommendations from some investigations I would receive requests for funding from the relevant District/hospital/facility. In this instance I would read the report and the accompanying submission and then discuss the suggested approach with the relevant manager. Ultimately decisions on these sorts of matters and their funding would rest with the SEDHS, the Director-General, the Minister or the Government depending on the level and importance of the investigation.

15.8 The issue of patient confidentiality was one which QH considered in deciding the extent to which a report should be disseminated. Another issue arose in relation to the report prepared by Drs Giblin and North - QH had concerns regarding the possibly defamatory nature of parts of that report and the implications of publishing the report, particularly before persons referred to in the report were given a right to respond to the allegations contained therein.

15.9 I cannot say categorically that there are no other reports relevant to the Commission's terms of reference which have not been made public or sighted by the Commission. In my time with QH my approach was to provide genuine assistance with getting out documents for the Commission.

16. **What is Dr Scott's knowledge of the process by which Queensland Health competes with other governmental departments for budget funds? What was the avenue, if any, for clinicians or bureaucrats to explain any circumstances**

where deaths or adverse outcomes were being caused by underfunding? Does Dr Scott consider that the budget process should be altered?

16.1 It is my understanding that the budget funds allocated to government departments are generally apportioned between the departments by the government on an historical basis. Bids were able to be made by QH to Cabinet for additional funding. This was regularly done with varying degrees of success.

16.2 The Minister is briefed by QH on various issues on a regular basis. As with other matters, issues related to under funding were able to be raised with the Minister by way of a briefing. Clinicians were able to raise issues with district management to be referred to central administration. Clinicians were also able to raise issues with their professional organisations who could take those issues up with the Minister, the Ombudsman, the Medical Board or the Health Rights Commission.

16.3 I do not feel that I am in a position to comment on whether the government's budget process should be altered.

17. What is the process by which funds are allocated by Queensland Health to individual hospitals in Queensland?

17.1 Responsibility for the department budget is with the Minister through the Budget Review Committee of Cabinet. This budget does not have particular funds earmarked for particular hospitals. After the Budget Review Committee process the Minister will produce a Ministerial Portfolio statement. This document is produced by Ministerial Staff in consultation with department staff. This document explains the allocation of the budget in more detail but still addresses services on a Statewide level – e.g., X number of outpatient appointments across the State. But new initiatives may name individual hospitals – e.g., a new programme, say at PA, costing $X.

17.2 Individual hospitals will receive about the same funding they received the year before, this is generally not CPI adjusted. They will also receive supplementation provided through Commonwealth and State government-determined budget initiatives (examples include Commonwealth allocations for new vaccines or the allocation of $20 million by the State in 2004 to boost elective surgery performance), through election commitments when in that part of the election cycle, and through supplementation from the growth component of the State budget.

17.3 Each year QH is given an allocation for growth funding. For example in 2004-05 the allocation was, to the best of my knowledge, approximately $215 million. From that amount an Enterprise Bargaining wage component, wage indexation for Non-Government Organisations, matching of Commonwealth funds for provision of blood and blood products – all totalling about $115 million had to be expended. There were also allocations approved by the government or Minister such as election commitments, budget announcements and Cabinet Budget Review Committee - directed initiatives totalling about $65 million. This left, in 2004-05, an amount of about $35

million to compensate for the increase in costs (other than wage costs) since the previous year and the needs created by an increase in population.

17.4 The $35 million was prioritised across all directorates, and within the Health Services Directorate had to be prioritised across requests from zones and Statewide services. HS Directorate received approximately $32 million. The prioritisation was a determination by the Board of Management (which is comprised of the positions shown as directorates on **"JGS2"** and the Director-General).

17.5 The Director-General had issued a memorandum dated 14 October 2004 to QH generally seeking funding proposal initiatives (or bids) from all areas. Bids were gathered from Districts through Zones and those received totalled about $200 million. This included requests for extra medical staff and preventative health care programs. The Board of Management has to make the decisions necessary to allocate $32 million across the $200 million bids received.

17.6 Clinicians' only input is in the initial bids. Personally I support clinicians having more input, but is very difficult to see how this could be achieved without radically altering the whole process. Realistically, clinicians don't have time to devote to complex administration under the current systems and if they are motivated to become involved therefore, end up as full time administrators.

18. **A number of people have given evidence about the care provided at Bundaberg Base Hospital to a 15 year old male identified as P26 (see especially the evidence of Dr Jenkins, Dr Ray, Dr Rashford, Dr Gaffield, Dr Boyd, and the mother of P26). Dr Rashford, who oversaw the patient's transfer to Brisbane, raised concerns about the patient's care by an email of 4 January 2005 to Dr Scott. That email and the subsequent follow-up are contained in the attachments to exhibit 210. It might be contended that the care provided to the patient was not fully investigated because no report was received from the operating surgeon in Bundaberg (namely Dr Patel) or the treating surgeons in Brisbane (namely Drs Jenkins and Ray), because the briefing note on the topic was completed within 24 hours, and because it appears that no clear protocols were put in place to avoid a recurrence. What does Dr Scott say to such contentions? Does he consider that the follow up by Queensland Health to the incident was adequate?**

18.1 See paragraphs 8.5 and 8.6 above.

18.2 It appears from the report which is **"JGS7"** above that the accident was on 23 December and Dr Patel's surgery (all 3 operations) was complete within 12 hours of admission. It does not appear from the report that the surgery was inappropriate or carried out badly – Dr Rashford thought it saved the boy's life.

18.3 Dr Patel was on leave from 26 December and still on leave when the briefing was written on 5 January. The briefing report identified the major problem as being the time the boy was allowed to remain at BBH after surgery. So it did not seem imperative to me at the time to have Dr Patel's comments. The

review, which I supported, recommended that in future patients are transferred as soon as they are stable. The clinical call as to whether this patient was stable after the first or second operation would be difficult, as the patient was very shocked, so I was not alert to issues about Dr Patel's initial post-surgical judgment needing further examination; the problems with the boy's health emerged after Dr Patel went on leave. As to subsequent care, I agreed with the recommendations that major vascular injuries should be transferred as soon as possible, so again I did not see a need to get Dr Patel's views on that.

18.4 I agree that the severity of the patient's condition as described in the 5 January briefing report is difficult to reconcile with the descriptions received by the Commission from e.g. Dr Rashford. At the time the issue I saw was that the initial surgery was appropriate, but the post-surgical care was not. Reports from the RBH may have given me a different, more damning picture of the post-surgical care at Bundaberg. This would not have led me to enquire about Dr Patel because, as explained he was on leave before the boy's condition worsened. Even had I received reports from RBH I doubt I would have investigated further as to their (too lengthy) retention of the patient with Bundaberg because that hospital had accepted that they should transfer such patients at the earliest stage possible – i.e., the hospital had put in place a policy to prevent repetition of like occurrences and the Zone Manager was working with RBH to ensure the policy worked, as that hospital would be the receiving hospital.

19. Dr Aroney in his evidence (see the statement and the transcripts for 10 August and 24 August 2005) makes a number of comments about Dr Scott. Does Dr Scott dispute the accuracy of those comments?

19.1 I dispute the accuracy of Dr Aroney's comments. Prior to my commencing the role of SEDHS, work had been started to develop separate cardiac services at TPCH, RBWH, and PAH, to establish services at Gold Coast and to enhance services at Townsville/Cairns. I believe this approach is appropriate given that Queensland is a decentralised state and treating patients close to where they live is the ideal both in terms of patient convenience (thereby ensuring that patients are likely to attend for treatment), and also to provide equity of access.

19.2 Dr Aroney makes reference to Queensland's coronary mortality rate. QH's approach was to address all facets of cardiac disease not just coronary artery disease. As well as coronary artery disease this requires an approach to heart failure management; rheumatic heart disease; and congenital conditions. To comprehensively address these matters it is also necessary to consider environmental, lifestyle and risk factors; access to primary treatment services; prevention approaches like diabetes and blood pressure management; access to secondary level diagnostic services to identify and treat conditions before serious outcomes develop, and access to tertiary level treatment. The responsibility of any health department is to ensure all of these factors are addressed. QH is required to allocate funding within its budget. The funds available to QH are not unlimited and must be used to address all aspects of public health management. To give a disproportionately high level of funding to tertiary treatment services using

percutaneous coronary interventions in one location is to condemn more people to developing what are often preventible conditions and probably to allow more preventable deaths than those to which Dr Aroney refers. Dr Aroney's view that QH's approach was simply to take services away from TPCH is deeply flawed.

19.3 I believe that the development of a properly organised cardiac service across the state was the appropriate direction to take in providing the best possible cardiac care in Queensland.

19.4 The first round of cuts to which Dr Aroney refers (Statement page 3), was not a cut in funding but a reallocation of funds from TPCH to the PAH after construction of cardiac catheter laboratory and other facilities at the PAH. After the construction of the cardiac catheter laboratory, the level of activity funded at TPCH and the PAH was determined based on population figures. Any perception that there was a cut in funding to TPCH was not real as patient treatment activity had moved, with funds, to PAH from TPCH i.e., patients who were historically treated at TPCH were now treated at PAH. QH was not reducing services across the state and TPCH was still receiving the same amount per patient treated. In fact QH put significant extra amounts of funding into cardiac services in the 2003/4 financial year - an extra $1.86 million into the RBWH; $4.5 million into TPCH; $1.44 million into PAH to build the extra catheter laboratory and other facilities and $1 million for ongoing work, $290,000 into Townsville, and $5.1 million into the Gold Coast. In addition approximately $1 million extra beyond the population-based estimate was put into TPCH budget based on work done by an independent external consultant Mr Jim Lowth (currently assisting Mr Peter Forster).

19.5 I was not involved in the issues Dr Aroney describes prior to November 2003 as I was not in the SEDHS position at that time. I was in fact State Manager of Public Health Services, working at the state and national levels to reduce smoking rates (a major cause of coronary artery disease); respond to some of the highest rates of childhood obesity in the world (a risk factor for heart disease); improve nutrition and physical activity (risk factors for heart disease) across the population, and to improve remote aboriginal community living conditions (risk factors for rheumatic heart disease). My budget to address these issues was about 1% of the total health budget, giving little chance of adequately responding to these major health determinants and making me very aware of the need for a balance in terms of how funds were allocated to respond to heart disease.

19.6 Dr Aroney refers to a cut in activity at TPCH in 2003 of "300 cardiac surgical cases, 500 angiograms, and 96 angioplasties/stents" (Statement page 3). This reduction in activity was part of the transfer of funds and activity to PAH referred to above which took effect on 1 July 2003. While the budgeted activity at TPCH reduced by these levels, the budgeted activity at PAH increased by 300 cardiac surgical cases, 560 angiograms, and 140 angioplasties/stents. As such there was no reduction across the two facilities, in fact there was an increase of 60 angiograms and 44 angioplasties/stents with cardiac surgical cases remaining static. Activity across the state in 2002/03 was 2720 cardiac surgical cases, 6238 angiograms, and 1427 angioplasties/stents whereas for 2003/04 it was 2706

cardiac surgical cases, 6394 angiograms, and 1724 angioplasties/stents. Again, there was no reduction. Rather there was an increase of 303 cases (and an increase from 2001/02 of 766 cases).

19.7 Dr Aroney suggests that there was a second cut in activity announced for 1 January 2004 (Statement page 4). There was in fact no cut in activity in January 2004. In November 2003 the district of which TPCH was a part, had provided figures indicating that they would be over budget for the financial year by approximately $2.2m. This was caused in a large part by the fact that cardiac interventions were being performed at a greater rate than was allowed for by the funding that had been provided to TPCH. Dr Aroney would have been aware of the level of activity that was funded and that he was exceeding this level of activity. TPCH was reminded by QH that they were obliged to limit themselves to the new level of activity which had been funded. It was not concerned that the procedures at TPCH were unnecessary, but to ensure equity across districts. These are obviously difficult matters. This is what Dr Aroney refers to as the second round of cuts. There was in fact no cut in activity at this time. In fact funding to TPCH in the 2003/04 financial year, for coronary related inventions, increased above the baseline budget by at least $1.45 million.

19.8 Dr Aroney talks of a third cutback in September 2004 (Statement page 6). I was not involved personally in this issue as I was on long service leave from July to October 2004. Again there was no cutback but a return to baseline activity after the one-off extra funding ($20 million to reduce elective surgery waiting lists) provided after the election of early 2004.

19.9 In fact, the available budget was sufficient to allow 57 procedures per week to be performed and that is the level to which activity was limited. When further funds were made available in January 2004 as part of the 2004/05 $20 million funding increases, further work was able to be undertaken. When this funding had been expended, activity level was reduced to the budget level of 57 procedures per week. There was no decrease in funding activity below the budgeted level.

19.10 Dr Aroney suggests that subsequently in January 2005 the hospital realised that they weren't doing enough to get funding, because funding is based on activity and these activity cuts were then withdrawn in January 2005 and the numbers were pushed up in order to obtain the appropriate funding for activity – t 3948. In fact in January 2005 extra funding became available. Some of this money went to TPCH, allowing activity to be increased from 57 to 65 procedures per week. Dr Aroney's suppositions about the reasons for the increase in activity in January 2005 are totally untrue.

19.11 The matter of what activity budget allows compared to what is needed due to clinical demand is a major problem across the world and creates hugely difficult decisions for politicians, administrators and clinicians. Available funds must be spread across services from the primary to the tertiary level, from prevention to treatment, from neurology to podiatry, from the north to the south of the state, from hospitals to the community. The administrator is uniquely placed to be aware of all of the impacts of non-availability of optimal resources, the deaths that occur, and the frustrations of not having enough

resources to respond comprehensively. The administrator is required to allocate the available budget appropriately, always knowing that not all people will get the services they need. This can often be a thankless task which results in criticism from people such as Dr Aroney, who only consider their particular area of interest.

19.12 Dr Aroney met with me, accompanied by Dr Andrew Galbraith and Mr Dan Bergin on 8 January 2004. He has made allegations of bullying against me at that meeting. I reject the allegations that I bullied Dr Aroney at that meeting or on any other occasion. Before the meeting Dr Aroney chose to go to the media, and to proclaim that Queensland Health administrators did not care if people died but was driven by budgets. He had not taken the time to meet with me to discuss his issues and concerns. I found the claim personally deeply offensive having worked in direct patient care and being at least as ethical and morally motivated as Dr Aroney. After fifteen years in direct patient care I had come to Public Health and to public sector management not to rest, but rather to do my best for patients and the people of Queensland at the statewide level. His claims were made without speaking to me and without making any attempt to ascertain my personal views and values. At that meeting I did say words to the effect that if Dr Aroney came after us we would come after him. This was never intended to convey that QH would take steps to go after Dr Aroney personally. What I intended to convey was that if Dr Aroney continued to criticise QH in the media, that we would respond directly to any allegations he made.

19.13 His recollection of the events of the meeting (as contained in his statement) is clearly intended to paint me as uncaring and insensitive. I am amazed that he chooses to suggest that I seriously tried to tell him how to treat acute coronary syndrome. For fifteen years as a GP I referred my patients to specialists in recognition of their expert knowledge in their particular field. I stated to Dr Aroney that I had difficulty getting a consensus view on management of cardiac issues from a range of expert clinicians in the area. I did not disagree with the views put to me by Drs Aroney and Galbraith regarding the management of acute coronary syndromes. What I said was that I had been provided with differing views regarding management. I do not accept that it follows that I do not have any idea about the central principles of modern management of such patients.

19.14 At the meeting I tried to talk through a range of issues with Dr Aroney. In particular I advised Dr Aroney of the variety of issues which were required to be managed by QH and in particular the breadth of the approach being taken. His responses appeared to indicate that he was only interested in TPCH and tertiary services. It became apparent to me in that meeting that Dr Aroney did not have the capacity to be objective in terms of what I said to him. My kindest interpretation is that he was passionate about the issues and this clouded his observations of my actions and views. I have spoken to Mr Bergin about this meeting, Dr Aroney's comment regarding Mr Bergin's memory of the conversation does not fit with Mr Bergin's recollection of the meeting. Mr Bergin's recollection, and my recollection, is that Mr Bergin did not speak to the media. Mr Bergin's recollection is that he did not state that he was in the bathroom during part of the meeting.

19.15 I later wrote twice to Dr Aroney saying I would appreciate the Cardiac Society's view on how they believed we should allocate funding in the south-east corner. He did not help us with this. He replied asking for staffing numbers, budgets, numbers of patients etc. At my initiative, Dr Buckland and I met with members of the Cardiac Society to address this and other issues.

19.16 Dr Buckland and I went to the meeting with the Cardiac Society on 15 February 2004 to hear what the Society had to say and to share information. From the first presentation we, and the QH position, were attacked. Steve Buckland said that we were happy to hear people's points of view but we weren't there to be personally attacked. I reject the allegation that we had an intention to intimidate speakers or to discourage open discussion of the problems being presented. Nor do I believe that there was such behaviour on our part. To the contrary, Dr Buckland and I remained after the formal meeting speaking with participants. I subsequently spoke further with one or two of the participants to follow-up themes presented.

19.17 The first speaker at that meeting, who is mentioned by Dr Aroney in his statement, Dr Darren Walters, has since been promoted to the position of Director of Cardiology at TPCH. Obviously this does not demonstrate malice, bullying or victimisation and I am happy to have on record my appreciation for Dr Walters' actions as Director.

19.18 Dr Aroney raises the issue of publication of waiting lists for coronary angiograms and cardiac defibrillators. These lists were not published because they did not form part of the national reporting requirements for elective surgery. This is however a decision for government and not QH. If the government decides that they wish to have additional waiting lists published, this will be done by QH. Data was collected and used within the department. Had the government wished to use it publicly it was available.

19.19 Dr Aroney refers to an inquiry into three deaths, completed in January/February 2004. He disparagingly refers to the two authors as QH bureaucrats although they were in fact the Deputy Medical Superintendent of the RBWH and the Deputy Director of the PAH Emergency Department. He says he feared that the internal enquiry would be a whitewash. In fact the report made three recommendations regarding inter-hospital referrals, bookings of procedures, and a review of the implantable defibrillator waiting lists at different facilities to ensure that there was consistency of categorisation and potential for referrals of patients between TPCH, RBWH and PAH depending on clinical urgency. It was not released publicly as it contained information on the deceased patients that was identifiable and the recommendations in the report were implemented.

19.20 Classification of patients as categories 1, 2 or 3 between PAH, RBWH and TPCH was problematic given that different criteria seemed to be used at each hospital. Dr Aroney in his evidence to the Commission labels this discrepancy as a devious excuse to transfer patients and cut services at TPCH yet the categorisation of patients at the PAH was done by clinicians and these same clinicians were prepared to accept patients transferred from TPCH. On 22 January 2004 the DG requested that further steps be taken to

ensure that patients referred for cardiac services could be efficiently managed across the three Brisbane facilities to ensure that patients were seen in whichever facility could ensure their treatment first. In particular the DG noted "Executive Management at PAH advise they have immediate capacity to address patients on the Prince Charles Hospital angiography waiting list".

19.21 At the same time work was being done to establish the Clinical Coordination Centre and to establish a contract (subsequently signed with Care Flight) to enhance our capacity to refer people, by air if required, to facilities for appropriate care and to ensure that the first available bed was used. Our response was to increase the numbers of interventions provided and the ability of people in peripheral areas to be transferred when they need it. This work around transfers was not just about cardiac care but also involved intensive care, general surgical and medical processes and other key emergencies.

19.22 As I have stated, an extra $11,250,000 was put into cardiac services across the state in 2004/05 and an extra $17,330,000 will be allocated in each year from 2005/06 onwards. Dr Aroney's statement that QH was either deliberately trying to precipitate a crisis by enforcing cutbacks or was guilty of culpable negligence as managers, is totally baseless and untrue. I absolutely reject Dr Aroney's comment that suggests cutbacks occurred as a punishment against the hospital for his stance on speaking out about deaths of people on waiting lists.

19.23 Dr Aroney accuses me of labelling him as dishonest on radio and television. I do not recall saying such things and do not expect that I would have done so. I did however disagree with the view he was putting forward in the media. Dr Aroney says that other clinicians were unwilling to go public. In fact I believe the clinical staff at TPCH were becoming tired of Dr Aroney's constant sniping. They told me in a meeting with them that they just wanted the issue to settle down. I believe that members of the clinical staff may have had a quiet word with Dr Aroney around this time to suggest that it was time for things to be allowed to settle.

19.24 Dr Aroney refers to my comments on the ABC Stateline programme and implies that I lied when asked if cardiac catheter laboratory work was planned to be reduced to 57 procedures per week. The baseline of activity in the laboratory was always 57 and I stand by my comments.

19.25 The Maher Report was released in late February 2005, though Dr Aroney says that the Report was not released until April 2005. In discussing the Mahar Report, Dr Aroney accuses QH management of media bullying and making a thinly veiled attack on the two dedicated cardiologists at TPCH (Denman and Walters) who perform these life-saving procedures, as well as a vindictive attack on the hospital itself. I have nothing but respect from these two doctors and have spoken to both of them and indicated my support for their work.

19.26 In discussing his resignation, Dr Aroney talks of QH's cavalier attitude to unnecessary deaths and says that QH's stated intention of establishing more

cardiac committees without increasing activity was totally inadequate. He also says that he felt QH's continued failure to consult the CSANZ on important issues and QH's dismissal of the advice provided in CSANZ's submission meant that progress appeared unlikely. Dr Aroney was however invited in April 2005 to participate in a meeting on 5 May 2005 to develop a strategic approach to cardiac services in Queensland. He also spoke in early 2004 of the need to have an expert cardiac committee for Queensland.

19.27 Dr Aroney says that I threatened to punish TPCH and made him fear for his job. These allegations are untrue. So is his allegation that TPCH "cuts" were as a punishment for his speaking out.

20 The Commission website contains a number of discussion papers. What comments, if any, does Dr Scott wish to make about those papers?

20.1 I have not had time to prepare a response to this question and I rely on the Morris Commission's letter of 30 August 2005 in this regard. I am happy to deal with any specific questions in my evidence.

John Scott

Dr John Grant Scott

9/9/05.

Date