

facing public hospitals in Queensland, particularly those outside of the south-east corner such as:

- Either an inadequacy in funding or a reluctance by administration; or both
- Difficulty in attracting and retaining sufficient specialist staff to provide an adequate and safe service;
- A lack of sufficient specialist staff to create a 'critical mass' of practitioners within a hospital.
- A tendency to use Senior Medical Officers instead of recognised specialist staff;
- Inadequate supervision of junior staff, both Australian and overseas trained;
- An excessive number of inadequately qualified overseas trained doctors
- Consequently, a lesser standard of medical treatment in rural and regional public hospitals

Part D – The Prince Charles Hospital

Cardiac care at Prince Charles Hospital

- 5.254 The Prince Charles Hospital, located at Rode Road, Chermside, Brisbane is within the Prince Charles Hospital Health Service District (Central Zone). The District includes the City of Brisbane north of the Brisbane River and the Shire of Pine Rivers but excludes the Royal Brisbane Hospital complex, the Royal Womens Hospital complex, the Royal Childrens Hospital complex, the Queensland Radium Institute, and integrated adult mental health services associated with the Royal Brisbane Hospital.³⁸²
- 5.255 The hospital provides quaternary and supra-regional cardiac services, including Cardiac Surgery and Cardiology (including paediatric cardiac), quaternary and supra-regional thoracic services, orthopaedic surgery, rehabilitation and geriatric respiratory medicine, adult mental health and palliative care. The District provides health services to residents living in the northern suburbs of Brisbane and specialist services to the broader Queensland and Northern New South Wales population.

³⁸² www.health.qld.gov.au

An increasing demand for cardiac services

- 5.256 Cardiovascular disease is the major cause of morbidity and mortality in Australia. The most common forms of heart disease in Australia are coronary heart disease, acquired valve disease, conduction defects, congenital heart failure and congenital heart defects.³⁸³
- 5.257 Dr Con Aroney commenced at the Prince Charles Hospital as a Staff Cardiologist on 11 February 1991. He was appointed a Senior Staff Cardiologist on 1 July 1994, and on 4 August 1994 he was appointed Clinical Director of the Coronary Care Unit.³⁸⁴ Dr Aroney was the President of the Cardiac Society of Australia and New Zealand. He was on leave for 1 year prior to his resignation from the position as Senior Staff Cardiologist at the Prince Charles Hospital³⁸⁵ effective from 22 May 2005.
- 5.258 Dr Michael Cleary held the position of Executive Director of Medical Services at the Prince Charles Hospital for approximately five years before taking up the position of Acting District Manager at the Prince Charles Hospital on 2 August 2005.³⁸⁶ Dr John Scott was State Manager, Public Health Services from October 1996 until November 2003 when he was appointed to act as Senior Executive Director, Health Services and was appointed to the role in December 2004. Dr Scott was on long service leave from July to October 2004. His services were terminated by the Queensland Government on 27 July 2005.³⁸⁷
- 5.259 Until 1996 public cardiac surgical services were provided solely by the Prince Charles Hospital.³⁸⁸ In 1996, as a result of an increased and changing demand for cardiology services, particularly in relation to management of the acute coronary syndrome, and acute myocardial infarction,³⁸⁹ Queensland Health supported the development of two additional cardiac surgical units at Townsville and the Princess Alexandra Hospital Health Service District to establish and develop zonal services.³⁹⁰
- 5.260 In order to improve access to cardiac services in Queensland, Princess Alexandra Hospital established its service in 1998-1999.³⁹¹ The Prince Charles Hospital was also funded to address the extensive waiting list which existed for cardiac surgery.³⁹² The Prince Charles Hospital was allocated

³⁸³ Exhibit 301C para 3

³⁸⁴ Exhibit 301C para 15

³⁸⁵ Exhibit 403; Aroney T4801 line 55

³⁸⁶ Exhibit 301C para 17

³⁸⁷ Exhibit 317 para 1.6; T5230 line 15 (Dr Scott)

³⁸⁸ Exhibit 301C para 6

³⁸⁹ Exhibit 301C para 5

³⁹⁰ Exhibit 301C para 6

³⁹¹ Exhibit 301C para 19

³⁹² Exhibit 301C para 19

elective surgery funding during the late 1990s.³⁹³ The Prince Charles Hospital had been faced with significant cost pressures resulting from:

- (a) Increased demand for interventional cardiology;
- (b) Marginal cost funding of elective surgery;
- (c) Growth in transplant services;
- (d) Clinical supply cost increases which eventuated from the devaluation of the Australian dollar; and
- (e) Increased clinical consumable costs related to single use items.³⁹⁴

Those demands resulted in the Prince Charles Hospital incurring a budget deficit in the 1999-2000, 2000-2001, and 2001-2002 financial years.³⁹⁵

5.261 Some of this increase in demand related to changes in clinical practice following the release of the 'Australian Management of Unstable Angina Guidelines – 2000' by the National Heart Foundation and Cardiac Society of Australia and New Zealand.³⁹⁶ The guidelines represent a much more aggressive strategy of doing angiograms on patients and revascularising them before they die or have further heart attacks.³⁹⁷ Following the release of the guidelines the number of inter-hospital transfers to the Prince Charles Hospital has increased significantly.³⁹⁸ Dr Aroney gave evidence that additional causes of the increase were population growth, an increasingly ageing population and a severe unmet need for coronary angiography due to under servicing of the community for the past 20 years.³⁹⁹ The waiting list for coronary care was large and growing.

5.262 Dr Aroney gave evidence that between 2001 and 2003 cardiologists made repeated warnings to management in most cardiac tertiary hospitals about the lack of response by management to increasing demand particularly in respect of heart attack and unstable angina.⁴⁰⁰ Over several years cardiologists met with administration at the Prince Charles Hospital to discuss problems with bed access block; restrictions in beds which were 'physically available' in the Coronary Care Unit, but closed for financial reasons and restrictions upon performing procedures.⁴⁰¹ These problems were not alleviated, apparently due to financial constraint.

³⁹³ Exhibit 301C para 19

³⁹⁴ Exhibit 301C para 20

³⁹⁵ Exhibit 301C para 20

³⁹⁶ Exhibit 301C para 7 attachment-MIC1; Aroney T4807 line 50

³⁹⁷ Aroney T4807 line 55

³⁹⁸ Exhibit 301C para 9

³⁹⁹ Aroney T 4807 line 55

⁴⁰⁰ Exhibit 263 para 5

⁴⁰¹ Aroney T3926 line 12-22

A change in management of cardiac budgets; some apparent consequences

- 5.263 Dr Aroney said that, until 2003, a practising cardiologist or cardiac surgeon was the chair of a cardiac committee which made budgetary decisions in relation to the Prince Charles Hospital cardiac program.⁴⁰² In 2003 Ms Podbury, the Hospital Manager, altered the management structure of the program to a triumvirate of the cardiac surgeon, a senior administrative nurse and a business manager. Dr Aroney states that under the auspices of this triumvirate there were significant delays, major cutbacks to the rehabilitation clinic and the dissolution of the anti-smoking clinic.⁴⁰³
- 5.264 In May 2003 Dr Aroney met with the Minister for Health, Ms Edmond, the Director-General, Dr Stable, Central Regional Director, Mr Bergin and the Prince Charles Hospital District Manager, Ms Podbury and informed them of the increased demand for cardiac care and that an increase in funding was required and not cutbacks and transfer of funds.⁴⁰⁴ Dr Aroney states that, as there was no positive outcome from that meeting, he along with other cardiologists attended a further meeting in June 2003 with the Director-General of Queensland Health, Dr Stable and the regional directors. At this meeting the cardiologists detailed Queensland's high coronary morbidity and mortality rate, Queensland Health's inadequate response to increased demand of acute coronary syndromes and the urgent need for funding more beds and activity.⁴⁰⁵
- 5.265 In his evidence Dr Aroney gave examples of two requests by Dr Pohlner, the most experienced paediatric cardiac surgeon in the State, for the availability of a ventricular assist device which were refused by hospital administration.⁴⁰⁶ These refusals, he said, caused dislocation of the operating staff⁴⁰⁷ and, in the second case, delayed surgery.⁴⁰⁸ Dr Aroney gave evidence that he believed that the issue was the cost of the use of the device and the cost of the consumables.⁴⁰⁹ The decisions were ultimately reversed. Dr Aroney gave evidence that Dr Pohlner was threatened with a code of conduct violation by Ms Podbury.⁴¹⁰
- 5.266 Dr Cleary, the Director of Medical Services stated that he recalled the cases referred to by Dr Aroney. He said that, in the first case, after extensive consultation with the Director of Cardiac Surgery at the Prince Charles Hospital and the Director of the National Unit in Melbourne, it was suggested

⁴⁰² Aroney T3933 line 30

⁴⁰³ Exhibit 263 para 10; Aroney T3933 line 45

⁴⁰⁴ Exhibit 263 para 13

⁴⁰⁵ Exhibit 263 para 14; Aroney T3937 line 40

⁴⁰⁶ Exhibit 263 para 9; Aroney T3931 - T3932

⁴⁰⁷ Aroney T3932 line 10

⁴⁰⁸ Aroney T3932 line 30

⁴⁰⁹ Aroney T3933 line 1

⁴¹⁰ Aroney T3931 line 40

that, if the child required support, the child could be maintained on cardiac bypass overnight and reassessed the following morning.⁴¹¹ He said that this approach was in line with previously accepted clinical practice.⁴¹² But the fact is that the decision whether the device was necessary for safe practice was made, not by the experienced paediatric cardiac surgeon, but at an administrative level. The same criticism may be made of the second case.

- 5.267 Dr Cleary referred to a bundle of documents,⁴¹³ which included a memorandum dated 8 July 2003 from Ms Podbury to Dr Pohlner advising that, while she believed there had been a breach of the Code of Conduct, she did not propose to take any further action, but required acknowledgement that it was unacceptable for Dr Pohlner to willfully disregard a lawful instruction given by a staff member in authority.⁴¹⁴ This tends to support, rather than deny, Dr Aroney's evidence that Dr Pohlner was threatened with a code of conduct violation or, at least, reprimanded for requesting equipment which he thought was necessary for safe medical treatment. Ms Podbury did not give evidence.
- 5.268 Ms Podbury had earlier given a directive on 28 August 2002 that 'under no circumstances has approval been granted for the use of Sirolimus – Eluting Stent Devices'.⁴¹⁵ Dr Aroney said that, in late 2003, Ms Podbury had threatened to dismiss the Director of the Prince Charles Hospital Catheter Laboratory who considered it was clinically indicated to implant a stent in a private patient.⁴¹⁶ Dr Aroney said that the doctor's position was only saved by a large petition of staff members because they realised that his loss would have been catastrophic to the provision of cardiac services.⁴¹⁷ As mentioned earlier, Ms Podbury did not give evidence.

A proposal to transfer cardiac procedures to Princess Alexandra Hospital

- 5.269 In February 2002, Princess Alexandra Hospital prepared a submission to the Director-General of Queensland Health seeking funding to expand cardiac surgical services. This submission was presented again in February 2003.⁴¹⁸ Following discussions between the Director-General, General Manager Health Services, and Zonal Managers, Queensland Health made a decision in early 2003 to transfer services from the Prince Charles Hospital to Princess Alexandra Hospital.⁴¹⁹ This decision was made without reference to clinicians at the Prince Charles Hospital. For reasons mentioned below, this may have

⁴¹¹ Exhibit 301C para 88

⁴¹² Exhibit 301C para 88

⁴¹³ Exhibit 301C para 97 attachment – MIC 18

⁴¹⁴ Memorandum dated 8 July 2003 attachment - MIC18

⁴¹⁵ Exhibit 301C attachment -MIC 17B

⁴¹⁶ Exhibit 263 para 8

⁴¹⁷ Exhibit 263 para 8

⁴¹⁸ Exhibit 301C par 21; Cleary T4839

⁴¹⁹ Exhibit 301C paras 22-23

effectively reduced the level of cardiac services overall. It certainly reduced the level of cardiac services provided by Prince Charles Hospital.

- 5.270 A Cardiac Surgery Services working party was commissioned to 'facilitate the allocation of resources to Princess Alexandra Hospital to enable a targeted increase of 300 cardiac surgery cases in the Southern Zone'.⁴²⁰ One of its roles was to determine an appropriate volume and mix of resources to be transferred to Princess Alexandra Hospital from the Prince Charles Hospital, it was said, to support a sustainable efficient and equitable service delivery at both sites.⁴²¹ Of the 17 members of the working party only four were clinicians.⁴²²
- 5.271 In April and May 2003 both the Prince Charles Hospital and Princess Alexandra Hospital prepared Impact Analysis Reports based upon the transfer of 300 cardiac surgical procedures, 700 coronary angiograms and 233 coronary angioplasty procedures.⁴²³ The Prince Charles report, produced by a committee consisting primarily of administrators,⁴²⁴ expressed concern that the continuing growth of cardiac services at Princess Alexandra Hospital might be at the cost of existing services at the Prince Charles Hospital. That is, of course, what occurred. By reducing the amount paid to the Prince Charles Hospital for cardiac services, the transfer effectively reduced the existing service which could be provided at the Prince Charles Hospital. The report also noted that the terms of reference restricted it to the analysis of the impact following the transfer; and that no consideration was to be taken of population trends, existing service profiles, or planned future service delivery.⁴²⁵ It made clear that assessment had to be made 'in light of the existing resource environment'.⁴²⁶
- 5.272 Dr Aroney said that the reduction of funding for cardiac services at the Prince Charles Hospital, which happened because of the transfer of procedures to Princess Alexandra Hospital, was done at a time when hospital administrators were aware of a huge increase in demand in inter hospital transfers to the Prince Charles Hospital.⁴²⁷ This increase from 46 patients in the September 2002 quarter to 93 patients in the September 2003 quarter, had led to a major imbalance between demand and capacity for cardiac services.⁴²⁸ Dr Aroney said that, in 2003, he attended a large Prince Charles Hospital staff meeting at which 12 presentations were handed to Mr Bergin, Zonal Manager on the

⁴²⁰ Exhibit 301C paras 24, 25 attachment MIC 3

⁴²¹ Exhibit 301C- MIC3

⁴²² See membership list in attachment MIC 3

⁴²³ Exhibit 301C attachment MIC4; Cleary T4839

⁴²⁴ Exhibit 301C attachment MIC 4/p2

⁴²⁵ Exhibit 301C attachment MIC 4 /p77

⁴²⁶ Exhibit 301C attachment MIC 4 /p77

⁴²⁷ Aroney T3934 line 50

⁴²⁸ Exhibit 263 par 12; Aroney T 3934 line 50

deleterious effect on the hospital and the community of the cutback in funding at the Prince Charles Hospital caused by the reduction in its allocation of clinical procedures.⁴²⁹ Dr Aroney said that Mr Bergin stated that the cuts would proceed and that the funds were required for the Princess Alexandra Hospital.⁴³⁰

The transfer of procedures, and consequently of funds, to Princess Alexandra Hospital

- 5.273 On 30 July 2003, at a meeting between Dr Cleary, an independent consultant, Mr Jim Louth, Mr Graeme Herridge, Manager Central Zone Management Unit, and Dr Paul Garrahy, Director of Cardiology Princess Alexandra Hospital, it was agreed that the final transfer numbers from the Prince Charles Hospital to Princess Alexandra Hospital would be 300 cardiac surgical procedures, 500 coronary angiograms and 96 coronary angioplasty stent procedures.⁴³¹ This was to occur between April and July 2004.⁴³² Dr Cleary gave evidence that he personally found it difficult to support the transfer.⁴³³ He said that the decision to make the transfer was made by Dr Buckland.⁴³⁴
- 5.274 The simple and fair solution to the perceived problem would have been to have transferred the above patient procedures to Princess Alexandra, but, given the large backlog at Prince Charles, to have provided extra funding for this to Princess Alexandra, leaving the total funding at Prince Charles intact. But that would have required an increase in total funding of cardiac care and that was never the intention of Queensland Health. To be fair to its officers, it may have been beyond its capacity to provide it.

A further attempt to obtain more funding

- 5.275 On 24 November 2003, an urgent submission was made by the Prince Charles Hospital Cardiology Department to Dr John Scott seeking additional funding within Central Zone to address the increasing ratio of emergency unplanned activity that was compromising capacity to undertake elective revascularisation procedures at the Prince Charles Hospital.⁴³⁵ Dr Scott was not sure but imagined he would have responded to the submission.⁴³⁶
- 5.276 On 16 December 2003, Dr Aroney wrote to the Honourable the Premier advising him of the very serious and deteriorating state of public cardiac services in Queensland and the death of three cardiac patients on the waiting

⁴²⁹ Exhibit 263 para 12; Aroney T3936 line 10

⁴³⁰ Exhibit 263 para 12; Aroney T3936 lines 10 - 30

⁴³¹ Exhibit 301C para 28 and 29

⁴³² Exhibit 301C para 30; Exhibit 263 para 4

⁴³³ Cleary T4843 line 5

⁴³⁴ Cleary T4845 line 10

⁴³⁵ Exhibit 263 attachment CA 4

⁴³⁶ Scott T5279 line 40

- list.⁴³⁷ A copy of the letter to the Premier was provided to Dr Cleary. On 5 January 2004 he cleared a briefing note for the Minister for Health providing a response to Dr Aroney. The response did not propose any action other than the Minister note the contents.⁴³⁸
- 5.277 Dr Aroney said that, during December 2003, as a cost control measure, there was enforced closure of catheter laboratory activity at the Prince Charles Hospital for all except emergency cases, and of the cardiac outpatients. Staff were advised to take holidays at this time.⁴³⁹
- 5.278 Dr Scott denied that there was a cut in activity at that time.⁴⁴⁰ However, in November 2003, the District of which the Prince Charles Hospital was a part, had provided figures indicating that they would be over budget for the financial year by approximately \$2.2m.⁴⁴¹ 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 the Prince Charles Hospital.⁴⁴² Dr Scott said that Dr Aroney would have been aware of the level of activity that was funded and that he was exceeding this level of activity. Queensland Health reminded the Prince Charles Hospital that they were obliged to limit themselves to the new level of activity which had been funded.⁴⁴³
- 5.279 Dr Aroney gave evidence that the outpatients department at the Prince Charles Hospital was closed for a month over the Christmas period for several years for budgetary reasons.⁴⁴⁴ He said that, during December 2003, there was also an enforced closure of catheter laboratory activity for all except emergency cases.
- 5.280 Dr Cleary responded that it was usual practice at the Prince Charles Hospital and other major hospitals to have a period over Christmas during which minimal activity was undertaken. Emergency and acute services were maintained but elective services were generally not scheduled during the period. This provided an opportunity for staff to take leave and was not a cost cutting exercise.⁴⁴⁵ But this, to me, does not make sense. I would have thought leave should have been staggered so that services important as these are maintained continuously.

⁴³⁷ Exhibit 301C para 43

⁴³⁸ Exhibit 301C attachment MIC 8

⁴³⁹ Exhibit 263 para 16; Aroney T3929 line 30

⁴⁴⁰ Exhibit 317 para 19.7

⁴⁴¹ Exhibit 317 para 19.7

⁴⁴² Exhibit 317 para 19.7

⁴⁴³ Exhibit 317 para 19.7

⁴⁴⁴ Aroney T3929 line 28

⁴⁴⁵ Exhibit 301C paras 123 - 126

- 5.281 On 5 January 2004, Dr Aroney attended a meeting of all the cardiologists at the Prince Charles Hospital at which the affect of the cutbacks were discussed. The cardiologists were concerned that the cutbacks imposed restrictions on placing stents into patients unless it was an emergency.⁴⁴⁶ Dr Aroney said that it was felt that this was totally untenable.⁴⁴⁷ The cardiologists decided at the meeting in desperation to present this publicly.⁴⁴⁸ On the following day Dr Aroney released details of these cutbacks and what he believed were unnecessary recent deaths to the media.
- 5.282 On 7 January 2004, in view of Dr Aroney's allegations regarding the recent deaths, Dr Cleary appointed Dr Stephen Ayre, Deputy Executive-Director of Medical Services of the Royal Brisbane and Womens Hospital and Health Service District, and Dr Peter Thomas, Principal Clinical Co-ordinator of the Princess Alexandra Hospital Health Service District to ascertain whether there was evidence to support or reject the allegations.⁴⁴⁹ Neither Dr Ayre nor Dr Thomas was a cardiologist. Dr Cleary said that the report made 3 recommendations relating to the inter-hospital referral process, procedure bookings and waiting lists for implantable cardioverter defibrillators which were implemented.⁴⁵⁰ Dr Aroney states that as far as he is aware the results of this internal inquiry were never released despite repeated requests.⁴⁵¹

Dr Aroney's public disclosure causes a threat of retribution

- 5.283 On 8 January 2004, following a telephone request by Dr Scott, Dr Aroney, accompanied by Dr Andrew Galbraith, met Dr Scott and Mr Bergin to discuss the issues raised in his media release. Dr Aroney had assumed that the meeting would be about remedying the problem but it related to his going to the media about it. He said that Dr Scott stated to him 'you come after us with more shots and we'll come after you'. He said that he felt intimidated by that statement and thought it was a threat of retribution.⁴⁵²
- 5.284 At that meeting, Dr Aroney said that he also raised the question of the high risk of acute coronary syndrome and the topic of whether patients should be treated with stents and not surgery. He said Dr Scott informed him that he had advice from another cardiac specialist that they should be treated with surgery rather than stents. Dr Aroney said that he informed Dr Scott that his view was to the contrary and that Dr Scott had obviously not read the national guidelines for treating acute coronary syndromes of which he, Dr Aroney, was a national

⁴⁴⁶ Aroney T3937 line 5

⁴⁴⁷ Aroney T3937 line 15

⁴⁴⁸ Exhibit 263 para 20; Aroney T3937 line 15

⁴⁴⁹ Exhibit 301C para 48

⁴⁵⁰ Exhibit 301C para 50 – attachment MIC10

⁴⁵¹ Exhibit 263 para 32

⁴⁵² Exhibit 263 para 23; Aroney T3938 line 55

author.⁴⁵³ Dr Aroney and Dr Galbraith made minutes of the meeting.⁴⁵⁴ Although Dr Scott has a different recollection of what occurred, I accept what seems to be the better recollection of Dr Aroney in this respect which is corroborated by the minutes of the meeting.

5.285 Dr Scott denied any intention to intimidate. He admitted that he did state words to the effect attributed to him⁴⁵⁵ but said that he did not intend to convey that Queensland Health would take steps to go after Dr Aroney personally, but that, if he continued to criticise Queensland Health in the media, Queensland Health would respond directly to any allegations he made.⁴⁵⁶ Whatever Dr Scott's intention was, I am satisfied that Dr Aroney was justified in thinking, in the circumstances, that it was a threat of retribution if he continued to make public statements about what he perceived to be a very serious issue of patients' lives and safety.

Further cuts

5.286 On 8 January 2004 Dr Cleary wrote to Dr Andrew Braithwaite, Director of Cardiology, Jenny Walsh, Nursing Director, Cardiology, and Hayley Middleton, Business Manager, Cardiology which included an instruction effective immediately that 'patients referred from within Central Zone but from outside the Brisbane North area, are only to be accepted if they can be managed within our existing capacity.'⁴⁵⁷ Dr Aroney asked why Central Zone patients were made a lower priority than Brisbane North patients when Central Zone patients were an accepted responsibility of the Prince Charles Hospital.⁴⁵⁸

5.287 Dr Cleary said that his memorandum of 8 January 2004 was sent in response to advice from Queensland Health and the Executive and Director of Cardiology at Princess Alexandra Hospital that:

- Princess Alexandra Hospital had the capacity to undertake additional activity (in the order of 10-20 cases a week) effective immediately.
- The waiting list at Princess Alexandra Hospital (category 1 patients = -0); (category 2 patients = 2) was dramatically lower than that at the Prince Charles Hospital; (category 1 patients = 229; category 2 patients = 79).⁴⁵⁹

5.288 It was these figures, it seems, which were said to justify the transfer of procedures from Prince Charles Hospital to Princess Alexandra Hospital in 2004. Dr Aroney had consistently maintained that these figures were

⁴⁵³ Aroney T3940 line 15

⁴⁵⁴ Exhibit 263 attachment CA6

⁴⁵⁵ Exhibit 317 para 19.12

⁴⁵⁶ Scott T5281 lines 1-20

⁴⁵⁷ Exhibit 263 attachment CA3

⁴⁵⁸ Exhibit 263 para 6

⁴⁵⁹ Exhibit 301C para 35

erroneous and that, in real terms, the waiting list at Princess Alexandra Hospital were much greater than this.⁴⁶⁰ This was belatedly recognised. Dr Cleary said that, in or about January 2005, he became aware for the first time, that Princess Alexandra Hospital had been using a different categorisation process in cardiology from that used by the Prince Charles Hospital and acknowledged that this would have contributed to the significant difference in waiting list numbers between the two hospitals.⁴⁶¹ It seems that Princess Alexandra Hospital had a much narrower view of who should be included in categories 1 and 2 (urgent and semi-urgent cases) than other public hospitals.⁴⁶²

- 5.289 Dr Cleary said that the implementation of the arrangements in the memorandum of 8 January 2004 meant that approximately 10 patients a week were receiving care earlier, and that this, in particular, related to patients in the Central Zone who appeared to have delayed access to services at the Prince Charles Hospital.⁴⁶³ It is difficult to see how Dr Cleary could have any confidence in saying that in the light of the information in the preceding paragraph.

Further complaints and criticisms by clinicians

- 5.290 On 25 January 2004, Dr Aroney again wrote to the Premier informing him of his continuing concern and that three further patients had died on cardiac waiting lists at the Prince Charles Hospital.⁴⁶⁴
- 5.291 On 15 February 2004, Queensland Health called an urgent meeting of the Cardiac Society of Australia and New Zealand which was attended by almost all the senior cardiologists who worked in the public hospitals in South East Queensland together with the acting Director-General, Dr Buckland and Dr Scott.⁴⁶⁵ Dr Aroney said that during the presentation of the first speaker, who was giving details of the inadequacy of public services for managing acute coronary syndrome, Dr Buckland stood up, interjected very aggressively, mentioned a profanity and stated that what had been said by the speaker was Prince Charles-centric and that the information was irrelevant.⁴⁶⁶ Dr Aroney said that, in his view, Dr Buckland's outburst intimidated subsequent speakers and discouraged an open discussion of the problems being presented.⁴⁶⁷

⁴⁶⁰ Aroney T6241 - 6242

⁴⁶¹ Exhibit 301C para 41; Cleary T4833, 4865

⁴⁶² Aroney T6241 - 6242

⁴⁶³ Exhibit 301C para 38

⁴⁶⁴ Exhibit 263 para 27 attachment CA7

⁴⁶⁵ Exhibit 263 para 28

⁴⁶⁶ Exhibit 263 para 30; Aroney T 3941 line 15

⁴⁶⁷ Exhibit 263 para 30; Aroney T3941 line 20

- 5.292 Dr Aroney said that, nevertheless, later there was considerable discussion about the lack of publication of waiting lists for coronary angiograms and cardiac defibrillators which the doctors considered should be transparent as by far more cardiac deaths occurred on those lists than on the open cardiac surgical lists.⁴⁶⁸ Dr Aroney said that Dr Buckland and Dr Scott would not accept that the lists should be public.⁴⁶⁹ Whilst not denying that he said that, Dr Scott said that the decision to publish waiting lists was a decision for government and not Queensland Health. The data was available to the government if it wished to publicly use it.⁴⁷⁰
- 5.293 Dr Scott said that, from the first presentation at the meeting, he, Dr Buckland and Queensland Health were attacked. He said that Dr Buckland had said that they were happy to hear peoples' points of view, but that they were not there to be personally attacked.⁴⁷¹ Dr Scott rejected the allegation of any intention to intimidate speakers or to discourage open discussion of the problems being presented.⁴⁷² He pointed to the fact that the first speaker at the meeting was Dr Darren Walters who has since been promoted to the position of Director of Cardiology at the Prince Charles Hospital.⁴⁷³
- 5.294 It was unanimously agreed by all cardiac society members at the meeting that:
- Queensland had the worst coronary heart disease outcomes of all the major States;
 - There was severe tertiary public cardiac under servicing in Queensland;
 - All tertiary cardiac units in Queensland required major upgrades;
 - There was a major deficiency in the public cardiology workforce;
 - There was a lack of transparency in cardiology waiting lists and bed access block.⁴⁷⁴
- Drs Buckland and Scott asked the Cardiac Society of Australia and New Zealand provide a submission on cardiac services in Queensland.⁴⁷⁵
- 5.295 On 24 May 2004, Prince Charles Hospital made a submission to Dr Scott for additional funding to allow the Prince Charles Hospital to increase elective cardiac surgery throughput.⁴⁷⁶ Additional funding in the sum of \$2.4 m was provided for the 2004-2005 financial year.⁴⁷⁷

⁴⁶⁸ Exhibit 263 para 31

⁴⁶⁹ Exhibit 263 para 31; Aroney T3941 line 35

⁴⁷⁰ Exhibit 317 para 19.18

⁴⁷¹ Exhibit 317 para 19.16

⁴⁷² Exhibit 317 para 19.16

⁴⁷³ Exhibit 317 para 19.17

⁴⁷⁴ Exhibit 263 para 31 attachment CA 8

⁴⁷⁵ Exhibit 263 para 31

⁴⁷⁶ Exhibit 301C para 32 – attachment MIC7

⁴⁷⁷ Exhibit 301C para 33

5.296 On 29 July 2004, in response to the request by Drs Buckland and Scott on 15 February 2004, the Queensland Branch of the Cardiac Society of Australia and New Zealand provided a submission to Queensland Health.⁴⁷⁸ The submission emphasised the crisis in adult and paediatric care in all areas, particularly in acute coronary syndrome management and cardiac defibrillators where most deaths had occurred, and asked for an increase in activity.⁴⁷⁹

5.297 By memorandum dated 4 August 2004 Janelle Taylor, Acting Nursing Director – Cardiology Program informed Cherly Burns, Executive Sponsor, Cardiology Program as follows:

As an acting member of the Cardiology program management team I believe that it is my role to apprise you of the situation resulting from the high numbers of patients waiting in regional hospitals as priority cases for cardiac investigation/intervention. Over the past month I have observed a particular situation many times but none more so than today and I believe it is worthy of your notice.

Dr Darren Walters was due to be on leave from today and henceforth had no bookings for cardiac procedures for the next ten days due to his heavy involvement in the organizing of the August meeting of the Cardiac Society of Australia and New Zealand. It became clear to us as today progressed that the increasing number of patients waiting in regional hospitals as priority cases for cardiac investigation/intervention was getting to levels that needed addressing. CCL activity is being reduced over the next 10 days and there was potential for some 9 patients to be held in regional health facilities for 10 days or more until full CCL activity recommenced.

The NUM of CCL, the D/NUM, the Medical Director of Cardiology and myself tried to sort out some way of dealing with this situation. The RBH was contacted and unable to assist us in any significant way. When Dr Walters was apprised of the situation he voluntarily gave up his leave to do 7 of the cases tomorrow afternoon.

I have seen Dr Walters repeatedly pick up a disproportionate workload many times over the past month in an effort to ensure patient safety and service is continued. As such I believe he is to be commended for his commitment to the Cardiology program and as such deserves our collective thanks.⁴⁸⁰

5.298 As a result of emails by Dr Russell Denman, and Dr Darren Walters dated 29 August, and 30 August 2004 regarding the death of a patient awaiting an automatic implantable cardiac defibrillator implantation and a patient awaiting cardiac surgery, it was decided by management that a further investigation was needed.⁴⁸¹ On 20 September 2004 Dr Andrew Johnson, Executive Director, Medical Services, Townsville General Hospital, and Dr Leo Mahar, Director, Cardiology, Royal Adelaide Hospital were appointed as investigating officers.⁴⁸² Also following the issue being raised by the Opposition Health Spokesman, Dr Cleary undertook a review of the procedural management of

⁴⁷⁸ Exhibit 263 para 35 attachment CA2

⁴⁷⁹ Exhibit 263 para 35

⁴⁸⁰ Exhibit 263 para 36 attachment CA10

⁴⁸¹ Exhibit 301C paras 57 - 59

⁴⁸² Exhibit 301 C para 61

the patients and prepared a memorandum to Dr Scott dated 22 October 2004.⁴⁸³

A further cutback in activity

- 5.299 Dr Aroney gave evidence that at a staff meeting on 24 September 2004 the Prince Charles Hospital Manager, Ms Gloria Wallace (Ms Podbury had moved to Princess Alexandra Hospital) announced that cardiac catheter laboratory activity would be reduced from the 70-90 (average 80) cases per week to 57 cases per week, including a 50 per cent reduction in paediatric cases (from 8 to 4).⁴⁸⁴ Dr Aroney said that the cardiologists at the Prince Charles Hospital were shocked as in December 2003 they had asked for an increase of 19 cases per week because of the increase in demand and in waiting lists.⁴⁸⁵ Dr Aroney stated at this meeting that the reduction was totally unacceptable, and unconscionable, and that more patients were condemned to death while waiting for coronary angiography.⁴⁸⁶
- 5.300 Dr Aroney, in his evidence, expressed the view that the cutback was imposed as a deliberate target against the Prince Charles Hospital because of persistence in raising the alarm about deaths of patients on waiting lists.⁴⁸⁷ Dr Aroney also said that Ms Wallace stated that she had a list of foreign doctors who were prepared to take our positions.⁴⁸⁸ He also said that, as a response to a statement that the Prince Charles Hospital was being bullied, Ms Wallace stated that Queensland Health bureaucracy had a poor perception of the cardiology program at the Prince Charles Hospital and it had to become more politically savvy.⁴⁸⁹ Minutes to the meeting taken by Dr Radford make reference to possible locums from an agency in South Africa.⁴⁹⁰
- 5.301 Dr Aroney said that he construed the statement by Ms Wallace about foreign doctors as a threat to replace the existing troublesome cardiologists with overseas trained doctors. I think that this was a reasonable construction of what was said.
- 5.302 By memorandum dated 28 September 2004, Dr Darren Walters, Director Cardiac Catherterisation Laboratory, provided responses to the District Manager in relation to the reduction requirements and identified risks which may result from the requirements.⁴⁹¹ Results of a statistical evaluation of the effect of cutbacks on cardiac catheter laboratory waiting lists which had been

⁴⁸³ Exhibit 301C para 69 attachment MIC 17A

⁴⁸⁴ Exhibit 263 para 39; Aroney T3944 line 40

⁴⁸⁵ Exhibit 263 para 39; T3944 line 45

⁴⁸⁶ Exhibit 263 para 39; Aroney T3944 line 50

⁴⁸⁷ Aroney T3947 line 40

⁴⁸⁸ Exhibit 263 para 39; Aroney T3945 line 1

⁴⁸⁹ Exhibit 263 para 39; Aroney T3947 line 50

⁴⁹⁰ Exhibit 301C para 106, 107 attachment MIC19

⁴⁹¹ Exhibit 263 para 41 attachment CA11

commissioned by the Catheter Laboratory Director from Dr H Bartlett of the School of Mathematics at Queensland University of Technology, were also provided.⁴⁹² These results indicated that the required reduction would have the effect of increasing the waiting list.

- 5.303 Dr Scott said that this was not a cutback in activity, but a return to baseline activity after the one-off extra funding of \$20 million to reduce elective surgery waiting lists, provided after the election of early 2004.⁴⁹³ But even if that was correct, the base line level was far too low to permit Prince Charles Hospital to provide an adequate, safe system of cardiology.
- 5.304 In any event, it seems that the reduction of cardiac catheter laboratory activity to 57 cases per week lasted only about three months.⁴⁹⁴ But Dr Aroney said that, during that time, there was a huge escalation in problems attending to patients and that he had identified 11 patients who he believed had died as a result of the cutbacks.⁴⁹⁵ It is by no means clear that the latter was the case but that does not detract from the seriousness of the cutbacks, whether or not they reflected a return to an earlier lower baseline. Dr Aroney also said that, during this time, the Catheter Laboratory lost a substantial number of highly trained scrub nurses because they were not required, and it would take many months to train up nurses to become experienced and safe.⁴⁹⁶
- 5.305 Ironically, it appears from Dr Aroney's evidence that these restrictions were removed in January 2005 purely for funding reasons. The Prince Charles Hospital realised that funding was contingent on maintaining elective surgery activity and if activity of the elective cardiac program remained low, then funding would be greatly reduced for the following year.⁴⁹⁷ Dr Scott said that this extra funding was provided.⁴⁹⁸

Further complaints and responses

- 5.306 In September/October 2004 Dr Aroney publicly disclosed in radio interviews that many more deaths had occurred on cardiac waiting lists in the period since the first enquiry into deaths in February.⁴⁹⁹ Dr Aroney raised the issue of the deaths of patients on waiting lists at the Prince Charles Hospital due to regional hospital access block to a tertiary hospital and identified Patient nine from Kilcoy as an example.⁵⁰⁰

⁴⁹² Exhibit 263 para 42 attachment CA12

⁴⁹³ Exhibit 317 para 19.8; Scott T5274 line 20 – 5275 line 10, T5392 line 50

⁴⁹⁴ Aroney T3948 line 10

⁴⁹⁵ Aroney T3948 lines 10, 25

⁴⁹⁶ Exhibit 263 para 44; Aroney T 3950 line 10

⁴⁹⁷ Aroney T3948 lines 15 - 25

⁴⁹⁸ Exhibit 317 para 19.10

⁴⁹⁹ Exhibit 263 para 45

⁵⁰⁰ Exhibit 263 para 37

5.307 Dr Aroney said that following his press release he was labeled as dishonest on television by Dr Scott.⁵⁰¹ He said that on 15 October 2004 he stated on ABC Stateline that cardiac catheter laboratory activity was planned to be reduced to 57 per week but when Dr Scott was asked on the same program he stated that this was not true.⁵⁰² He further states that he was repeatedly attacked in the media and elsewhere by the Health Minister, Gordon Nuttall.⁵⁰³ Dr Scott said that while he disagreed with the view put forward by Dr Aroney to the media, he did not recall labeling Dr Aroney as dishonest.⁵⁰⁴ I accept that Dr Scott did not intend that, but his statements could have been construed that way.

5.308 On 24 February 2005, Ms Wallace and Dr Cleary proposed a briefing to Dr Terry Mehan, Acting Senior Director Health Services informing him of issues in the development of the Mahar-Johnson Report.⁵⁰⁵ On 4 March 2005 the Mahar-Johnson Report which contained 10 recommendations was circulated.⁵⁰⁶ Its general conclusions were expressed in vague terms rather than directly. It said in relation to inadequate funding:

Queensland Health was unable to routinely achieve best practice in this regard as tertiary hospitals were unable to accept their patients for care in a timely fashion due to either bed unavailability or capped activity in cardiac catheter laboratories.

Nowhere does the report say, as was clearly the case, and as this statement appears to imply, that cardiac services were grossly underfunded

5.309 In response to the Mahar-Johnson Investigation Report recommendations, Dr Cleary prepared a document entitled 'Queensland Health Response to Recommendation Contained in the Mahar-Johnson Report'.⁵⁰⁷

Dr Aroney resigns and the hospital rejects his offer

5.310 By letter dated 9 March 2005 Dr Aroney tendered his resignation from Senior Staff Cardiologist at the Prince Charles Hospital effective from 22 May 2005.⁵⁰⁸ Dr Aroney said that he felt overwhelmed by the intransigence of Queensland Health in relation to the crisis and its cavalier attitude to unnecessary deaths and patient care requirements.⁵⁰⁹ Dr Aroney also said that he could not work with the bullying, intimidation and threat of reprisals, and that he felt personally unsafe in his employment with Queensland Health after being previously threatened by Dr Scott.⁵¹⁰ Dr Aroney offered to continue

⁵⁰¹ Exhibit 263 para 46

⁵⁰² Exhibit 263 para 46 Aroney T3945 line 45

⁵⁰³ Exhibit 263 para 47; Aroney T 3947 lines 10 - 30

⁵⁰⁴ Exhibit 317 paras 19, 23

⁵⁰⁵ Exhibit 301C para 64 – MIC15

⁵⁰⁶ Exhibit 301C para 65 – MIC 16

⁵⁰⁷ Exhibit 301C para 66 attachment MIC 17

⁵⁰⁸ Exhibit 403

⁵⁰⁹ Exhibit 263 para 55

⁵¹⁰ Exhibit 263 para 56

as an honorary visiting cardiologist with catheter laboratory credentialing to assist where required in difficult cardiac interventional cases.⁵¹¹ His offer was in effect refused.⁵¹² By letter dated 21 March 2005 Dr Cleary advised Dr Aroney that, if the need arose, the process for considering and awarding privileges would be through Medical Administration.⁵¹³ There was no sensible reason for refusing Dr Aroney's offer. I infer that it was because he had been publicly critical of Queensland Health.

Conclusion with respect to cardiac services at Prince Charles

5.311 The following conclusions, in my opinion, follow from the above brief summary of the evidence:

- (a) Throughout the relevant period the demand for cardiac services at Prince Charles Hospital greatly exceeded its capacity to supply these services; and that incapacity was caused by a gross under-funding of those services.
- (b) There was too much administrative involvement and too little clinical involvement in decision making about the need for these services and the way in which they should be supplied.
- (c) Those who complained about the gross under-funding of those services, especially those like Dr Aroney who did so publicly, reasonably perceived that they were threatened for doing so. In particular what Dr Scott said to Dr Aroney, what Ms Podbury said to Dr Polhner and what Ms Wallace said at a staff meeting were all reasonably perceived as such threats.

⁵¹¹ Exhibit 403, 263 para 58

⁵¹² Exhibit 263 para 58; T3925 line 40

⁵¹³ Exhibit 301C para 113 attachment MIC 22