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Department of Justice and Attorney-General

Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 27/07/2005

..DAY 28

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THE COMMISSION RESUMED AT 9.01 A.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Thank you. If I might recall Dr Nankivell.

COMMISSIONER: Yes.

EDWIN CHARLES NANKIVELL, CONTINUING EXAMINATION-IN-CHIEF:

MR ATKINSON: Good morning, doctor?-- Morning.

Do you have your submissions with you and your statement?-- I do.

We haven't strictly followed the format, but if I can take you to page 3 - sorry, page 2, you talk there in paragraph 5 on page 2 about anger and frustration expressed by patients. I notice that ties in with one of the annexures, a letter from you to Mr Leck dated 14 October 1999. In the paragraph in your statement, and in the letter, you talk about what you found quite a soul destroying experience of working very hard in a country hospital to make sure that patients' needs were accommodated, but on the other hand, because of the lag with the waiting lists, receiving abuse for you and for your staff from patients because of the perceived delays on your part?-- The surgical outpatient waiting clinic was a shambles, and I use that word very deliberately because that's what I used at every single meeting. I told the manager, Peter Leck, it was a shambles. I told the zonal manager it was a shambles. I told Mrs Cunningham it was a shambles. It was an absolute shambles. We had a tiny area that people crowded in like a cattle market. There was not enough seats to sit on. There were - if you've been waiting an hour and there's no seat to sit on, naturally you're cranky by the time you get there. Patients have often waited a year to see you anyway.

In the last two sentences of your letter to Mr Leck you go to the extent of saying that it might be in order to have a closed-circuit television in the area, and also that certainly a security officer needs to be on close standby?-- Correct.

That's the last sentence?-- Correct. This was because of the abuse that the girls at the reception desk were suffering. I just got sick of seeing them in tears at the end of a clinic, because there was too many people for them to actually get through, and the patients would be crowding around like a shop market trying to give their personal - you know, you go to a reception and you say who you are, your name, your date of birth, all the usual things, with people standing around and - they get people ringing them up and they'd get abused, and I just got fed up with the abuse. I must say, I'm not blaming

the patients. I'm not saying these are bad people. These are frustrated people who are at the end of their tether, and the staff are frustrated and at the end of their tether. The clerical resourcing was inadequate, and it really was a shambles. It also had legal consequences. I mention in one of the letters that I had to see 28 patients in two hours, which is pretty obviously impossible. My patients know that I spend a long time - I try and average two patients per hour - two new patients per hour. I sometimes get through a third. So we've got the registrar - I didn't have a training registrar - a non-accredited registrar seeing patients. I'm not quite sure - I hope he was doing the right thing. You've got an intern who is in fact, from a legal point of view, an unregistered doctor seeing patients. I don't know what they were doing. I hope they were doing the right thing. Of course if there was a problem they'd knock on my door. It was a complete shambles. I keep using that word. It was.

You mention, doctor, that you used that word when you spoke to the hospital manager, the zonal manager and the local member of parliament?-- Correct.

I notice in your exhibits there's also a memo to Dr Stable?-- Yes.

And there also you described the Accident & Emergency as a shambles?-- Yes, it was.

When did that memo go across to Dr Stable?-- That was when he visited Bundaberg. I didn't date it, but it would have been approximately November 2001.

You raised some very serious issues in that memorandum?-- Extremely serious issues were raised.

No effective communication with Queensland Health, Accident & Emergency a shambles, numerous examples of unnecessarily delayed diagnosis of cancer?-- Yes.

What response did you receive?-- Nothing. As in zero. N-O-T-H-I-N-G. Nothing.

Not a letter of acknowledgement-----?-- The only response I got was from Peter Leck. I met Peter Leck - it was either the same afternoon or the next day. Peter Leck was a little bit downcast, and he was disappointed at me for feeling that I'd not been thanked and supported during the shattering experience that I describe in August 2000. I feel sad for Peter Leck, because I actually wasn't referring to him. I was referring to Corporate Office. So I know Dr Stable read my letter, because Peter Leck got the feedback. I don't know what Dr Stable told Peter Leck, but when I talk about the fact that I wasn't thanked, I was not referring to the local staff at the Bundaberg Base Hospital. So I know it was got, but I mean, as I said yesterday, you can say all you like, "Complaints are welcome." I complained and I wasn't welcome.

Now, return to your statement. If I can take you to page 3, many of these issues set out here are already covered. I'm really just asking you whether there's anything you want to add to your evidence yesterday or to the statement, but you say in the second paragraph there on page 3 that, "There is an inadequate understanding by city based bureaucrats of the peculiar nature and needs of provincial services."?-- Yes.

Now, there's obviously issues such as the importance of grabbing VMOs as and when they come along, and issues of proximity and the lack of proximity to specialist hospitals, like you mentioned the PA for head injuries. Are there other things that are peculiar about the rural areas that you think Queensland Health doesn't have a grasp upon?-- When you look at funding models, everything now is sort of aiming at 100 per cent efficiency, or whatever they want to call it. I won't say 100 per cent. But rural services, by definition, have to have a bit of laxity in them more than they would in the city. For example, where I am in Logan, if I go away on holidays, my operating list is idle? Of course no, it's not. There's the opportunity for other people to take that operating list. "Oh, Dr Nankivell is away. I'll get some cases done on his list." So the efficiency has the potential to remain high, as long as you've got the anaesthetists and surgeons. When there are six of us, if someone is away, someone else can hopefully grab that operating time. When in Bundaberg, as I pointed out to Queensland Health, for three months of the year you're down to one surgeon only for 78,000 people. We occasionally got locums. There are very few around, and most of them are old, do minor surgery. You wouldn't give a locum coming just for one week a major cancer to do. You can't have them fly in, fly out and leave someone. So by definition they're inefficient, and we have to understand they will always be - it's the economy of size sort of stuff. A rural hospital will always be less efficient.

I understand with surgeons it's important to have some match fitness. You need to have - you prefer surgeons who have been doing a lot of surgery to somebody who is semi-retired and-----?-- Yes, but you won't get them because there are no locums. There are very few locums. They don't exist hardly. We did get a few American locums when I was there and, as I say, I think the hospital did try. I'm not blaming management. I think they tried. And locums get paid double what I get and do half the work, and there's not many of them anyway.

So the solution to that is, is this right: you talked about laxity. You mean there should be a more generous-----?-- We should have had more surgeons. We may not have been as tight with the numbers as a city hospital, but you have to, in a rural hospital, have more laxity, because there is no locum cover. It's not going to happen.

COMMISSIONER: Doctor, I have to confess I have some difficulty with the notion of even applying the term of "efficiency" to medical services. If one makes a contrast with a purely business model, a hotel or a holiday resort is

efficient if they have 100 per cent occupancy of the beds?-- Sure.

But that's not a test of efficiency for a hospital?-- It's not, but it's what's being used. It's what's being used. One of our hugest stresses at Logan Hospital, particularly for last year, was the emergency surgery utilisation data. Someone in head office has got this idea that for emergency theatre to be effectively utilised, it has to be used 70 per cent of the time. Now, compare that to a fire engine. A fire engine sitting in the garage, is that wasted or not? You see what I'm trying to get at?

Yes?-- Now, to say that an operating theatre that's not always being used is somehow wrong is a false argument, and yet we've been pressurised to achieve a 70 per cent utilisation target, which is medically dangerous, to put it bluntly, but this comes out of Corporate Office, these figures of efficiency that have no true scientific or medical worth.

MR ATKINSON: Doctor, in terms of what's special about rural areas, I notice you make another point further down which is that in Bundaberg there's really not much bulk billing that goes on, and I guess that's part of the issue of competition in a small town. The result is that Outpatients at the Base sees a lot more patients than might happen in a more affluent area?-- Yes, that's true.

D COMMISSIONER VIDER: Doctor, am I correct in interpreting your thoughts from yesterday as saying that you don't believe that the local rural areas have much autonomy, that it's all coming from Corporate Office?-- Correct. That is my opinion. I believe that's accurate.

And therefore, did you have much opportunity in, say, Bundaberg - you and other medical practitioners who were experiencing the problem - have the opportunity to come together with your suggestions as to how to solve the problem, and obviously that wasn't taken into account?-- No, it wasn't. I think part of the problem is that we were talking to the wrong people. Let me explain. You may have read the Giblin and North report into Hervey Bay.

Yes?-- That's a brilliant report, and the problem is all the issues that I had with patients, I was talking to managers, bureaucrats. I don't mean that in any rude sense, but some people would fly up from Brisbane who were in head office who were not medically qualified, and who may be brilliant managers, and I'm not running them down, but I'm sure what I said was not going in. Had Giblin and North or their equivalent come up, they would have seen the problem in five minutes, written a report and solved it, or at least understood it. So I'm not sure if our message - even though from my point of view the message was clearly being stated - our opportunities - my opportunities - I only ever spoke to non-medical, non-nursing people working for the bureaucracy who, as I said, at one stage didn't even know that surgeons did endoscopies. One of my solutions to the problem is

probably every two years a Giblin and North type team of people such as myself who have been in the practice a long time, could just visit a place like Rockhampton or Mackay, talk to the doctors, because I can get all the stuff I need to know in five minutes because I know what to look for, as you would if you dealt with the nursing issues. You would see things that I would not see, or just wouldn't understand.

MR ATKINSON: We're hearing-----?-- We're talking to the wrong people.

D COMMISSIONER VIDER: We've had evidence in other places that the doctors did get together and they had suggestions. They even were able to recruit for themselves further staff that could have come in at their equivalent level and that would have increased the pool of medical expertise considerably, but that was never actioned at local level. It was rejected. I'm saying that your experience would have been much along the same lines at that local level-----?-- We had ideas, and I was always writing discussion papers and thoughts, but never went anywhere. It never went anywhere.

MR ATKINSON: Doctor, there were reports done into the Rockhampton Base Emergency Department and the one you speak about in Hervey Bay. They weren't published nearly as widely as they might have been, and an argument that has been put in support of that is that if you publish broadly a report like that, and if it makes criticisms of the hospitals, it will undermine patient confidence in the services being provided. Do you see some force in that argument?-- No, not really. If we're going to have an open, honest policy, it has to come out. I guess people will write a report differently if they know it's going to come out, but I'm frightened of the reports getting buried.

Yes, of course?-- So I think at some point it's got to come out.

COMMISSIONER: Doctor, I wonder if I can use you as a guinea pig to try out a thought that's been going through my mind. I've spoken to a number of witnesses about a view I have that there should be a central complaints registry outside Queensland Health as a stand-alone body such as a health sector ombudsman. Parallel to that, though, it seems to me that there is a real conflict in having the Chief Medical Officer, whose primary role is to maintain healthcare standards throughout the state, based within a department which is governed by policy and budgetary and other considerations, and I'm starting to wonder whether - along the lines of what you were talking about with Giblin and North - that there might be some merit in having an inspectorate of hospitals or something like that so that the Chief Health Officer - and none of this is meant as criticism of Dr Fitzgerald who currently holds - until yesterday held that role - but having that based outside Queensland Health as an inspectorate that really is quite independent of the political, bureaucratic, budgetary and other considerations that operate, and have to operate within the department?-- I

think that's a good idea. I know in the UK they have these things called Rapid Response Teams. We're used to the word "rapid response" in the Emergency Department, but say there was a complaint from - let's say Mount Isa. The Rapid Response Team would consist of the Giblin/North type people who would be told, "Up you go. Sort it out now. Give us a report now." After the Bristol Royal Infirmary disaster they introduced this Rapid Response Team. Obviously the doctors would need to be indemnified for this sort of work, but I don't think the standard complaints and incident report type things deals effectively enough with what you're talking about. And it's got to be outside the system, but you will have to use staff within the system to do it.

One of the complaints we keep hearing is that reports do get generated, but then they get buried, and in a sense that's understandable, because the top echelon within Queensland Health have responsibilities to their political masters, to the budgetary constraints, to all sorts of other things. But my idea really is that the response to those sort of issues and investigation and the reporting should be outside the paradigm that involves those political, budgetary, bureaucratic controls, and that the response to them may be influenced by politics and by budgetary considerations and by bureaucratic considerations, but the report should be quite independent?-- Yes, I think that is correct.

MR ATKINSON: A good report sets out clinically what's required, and it's a matter for the politicians, independently of the report-----?-- Yes.

-----the extent to which they respond?-- Yes.

That's what you're looking for in a report?-- Correct.

Doctor, in terms of-----

COMMISSIONER: Sorry, Sir Llew-----

D COMMISSIONER EDWARDS: I was just going to say, in our discussions with some of the doctors at Bundaberg when we were in Bundaberg, they mentioned that the Medibank agreement between the state and the federal government had operative procedures written into it which prevented - which they were told prevented some of the activities that have come up by reference to the North reports and so forth, and the Medibank agreement was very restrictive on the operations of hospitals by the bureaucrats and by the health officials. Are you aware of those restrictions, and is there any truth in such allegations?-- Are you referring to bulk billing in public hospitals?

Yes?-- One of the factors.

This was raised by a couple of the doctors, that there were very major bureaucratic restrictions by the Medibank agreement that prevented some of the opportunities to which you have referred, and many other witnesses have referred to us as

being potential opportunities for better servicing of public hospitals. I'm just wondering whether you - and we have not been able to get any information relative to the Medibank agreement, but this has been thrown up to me personally on a number of occasions?-- The bulk billing in public hospitals issue has been a very vexed issue because no-one has ever been sure whether it's sort of legal or not, and this was a burning issue up in Bundaberg. One doctor in Bundaberg, for example, never ever wrote a letter, "Dear doctor". It was a referring letter, the usual, "Dear doctor, see this patient with a hernia", whatever. He'd always write, "Dear sister" so it would go to the Outpatients and could not be bulk billed, because he believed that was illegal. Now, I have no idea what the legalities are. All I do know is bulk billing occurs in public hospitals on the basis that if you see Dr Smith at Wickham Terrace, he has a Medicare click-click, you know, so if you go to a public hospital and see Dr Jones, why can't he go click-click with the voucher? So everyone bulk bills in public hospitals, and I don't quite understand - if that's the issue you're trying to say-----

No, I'm saying that is the case, but I'm also being informed that that agreement puts very marked restrictions on the kind of services that can be provided through Outpatients, and surgical procedures and so forth?-- The only one that I'm aware of-----

I'm just wondering whether you're aware of that, and has that been drawn to your attention?-- The only one I'm aware of that's been brought to my attention which makes our Outpatients inefficient is that under the Medicare agreement, the post-operative care is covered by the operative fee or whatever. So, for example, if I do an operation - public operation and the patient needs their stitches to be removed, they have to come back to the hospital to have their stitches removed. They can't go to their GP to have their stitches removed because it's not legal for the GP to then charge a fee to take the stitches out, because the hospital was paid to do the operation, and that includes post-op care. If the Medicare agreement was changed so the GPs could do post-op care, we could immediately - these huge thousands of people waiting to see a doctor in outpatients clinics - more than half the people coming back to the clinic are follow-up patients who have had an operation. Obviously legally I need to check them and - someone has got to check them and say, "Are you okay? Is everything fine? Is the wound infected" or whatever. Now, the GPs aren't allowed to do that under the Medicare agreement because they can't charge for that. Now, if you change that agreement we could dismiss half the patients from our clinic. You would give the GPs protocols saying, "This patient has a gallbladder. Please ask these 10 questions. Please look at these five things. If they're happy, you look after it. If you're unhappy, straight back to the clinic. No waiting list, just come back in and see us." You'd get rid of half the patients.

MR ATKINSON: Doctor, can I take you to page 4 of your statement? You speak about there four bullet points under the

heading of, "How many surgeons in Bundaberg", and effectively the dearth of surgeons. The first bullet point speaks about the inflexible attitude of Queensland Health to surgeons doing private versus public work. Do you want to speak to that at all?-- There was a feeling in Bundaberg, as I think has been addressed, that Queensland Health were anti-VMO. Dr Anderson had wanted to be a VMO and they wouldn't let him. That led to conflict. I'd asked how about - this was after Peter had left. I'd said, "Look, I wouldn't mind being a visiting medical officer." "No, no, we can't have that." It was just this very inflexible attitude to different working arrangements that could have been fair and reasonable and equitable.

The last bullet point-----

COMMISSIONER: Sorry, Mr Atkinson. That's one situation where an existing staff doctor becomes a VMO?-- Yes.

The other situation that Dr Anderson brought up was where a staff doctor wishes to do some private work in what is effectively his or her own time. It seems to me that that doesn't cost the public system anything. On the other hand, it makes the position much more attractive to a staff specialist if he or she can make some extra income on the side?-- The Dr Anderson issue is a very difficult one.

Yes?-- It was-----

Let's not focus on it with that specific case in mind, but just as the general principle?-- Yes, of course there should be more flexibility and more opportunities for part-time, three-quarter time, whatever time.

Yes?-- So that if someone wanted to work four days a week as a staff specialist and one day a week in private, that should be encouraged, you know?

I've been told, for example, that in particular, if a provincial hospital has trouble attracting a staff specialist, rather than offering that specialist a full-time salary package that may be, say, 200,000, they will instead say, "We want you to come and work three days a week for 120,000 salary and you'll have two days a week in private practice." That sort of flexibility seems to me something that's tremendously desirable in Queensland larger's provincial cities?-- Absolutely. If we'd had that in Bundaberg, I'd probably still be there and Dr Patel would never have come. It's as simple as that.

MR ATKINSON: In your fourth bullet point under that heading you talk about excessive hours that surgeons are required to work?-- Yes.

Obviously you spoke yesterday about the problems for a one-in-two system, and the problems in terms of you may only be asked to do an hour's worth of surgery, but there's delay and admin time, if you like, either side. Is there anything

else you'd like to add about excessive hours that surgeons are required to work?-- How much time have we got? We were going to go through my submissions, the 19 plus the extra attachments. Do you want me to leave that now or deal-----

No, just speak to the issues. If that requires you to refer to your attachments, certainly go ahead and do that.

COMMISSIONER: Or come back to it later if you prefer?-- I guess we can deal with that now. It's a long issue and it's going to take us around the world, but we can deal with it now if you like.

MR ATKINSON: Yes?-- The hours that surgeons work will always be irregular by nature of the job. You can't program who is going to get a bowel blockage at 9 o'clock tonight. Okay? So you will have your rostered hours and you will have your on-call hours, and the on-call can be nothing, or you can work non-stop. This is an issue that has never been addressed except perhaps in the falsehood. I have read many times in the newspaper - and I've cross-referenced this with my junior staff and other senior staff who can verify they've read it - that, "We don't make our doctors work these hours." I know and have personal evidence of one doctor in Queensland Health this year, 2005, who did 36 hours non-stop no sleep. Okay? Now, that should be a sentinel event for risk management. I mean, we can talk about if you operate on the wrong side of a patient's hip joint, that's a sentinel event. If someone goes 36 hours and doesn't sleep, that is a sentinel event.

It wouldn't be very different to working while you're drunk?-- No, and the medical research on this has been done, and you can certainly look that up or get experts on that. The research is all out there. It's dangerous. It's documented. And we don't have that flexibility in the system because, as I said, we've got a Monday to Friday thing that's booked. Your schedules are all booked up, and so if you do get very tired and you work, there's no - from overwork, there's no - the system has no way of coping with that.

Now, I got distressed by that and in my letter dated - I have just got to get the right letter now - it is the one to Mr Lindsay Pyne, dated 19 October 2000. I refer to the page 2, paragraph is headed "solutions".

Right?-- And I asked Queensland Health to do a study focussing on the safety of provincial surgeons' work practices. You will see halfway down that paragraph I talk about doctors working unsafe practices, such as myself. Now, I was a senior doctor - I was Director of the Department of Surgery. I have sent this letter to the zonal manager who got it and did reply and said, "I will pass this further on up the top." That's the letter from Mr Lindsay Pyne dated 31 October 2000. The letter was got-----

He refers, doctor, to your letter, being dated 24 October 2000, but that's an error, is it?-- Yes, that must be an error. There is only one letter I have got.

And then we see that you get a response of sorts from Queensland Health which is the next attachment?-- Yes, the next attachment was - for me this was the straw that broke the camel's back. When I received this letter I sort of said, "That's it, I'm finished. I'm out of here."

You are referring to the letter-----?-- Dr John Young.

-----dated 19 January 2001?-- That's correct. This is the letter that broke the camel's back because after hitting my head against the brick wall again and again and again - we'd gone on and on and on about these issues, we begged, we begged, we complained, we complained, we documented - we'd done all the right things - I get a letter back that makes no mention of the unsafe working practices and then comes out with this ridiculous comment that there are no easy solutions. Now, there was a very, very, very easy solution which had been documented, and I refer you back to the letter dated 22nd of May 2000 from Dr John Wakefield, the Director of Medical Services - so this is months earlier. Dr Young's letter was January 2001, this is back in May 2000. The hospital management had done the proper thing and they have put in a business case saying, "We need more surgeons." That's in - that's the third paragraph of Dr Wakefield's letter. So there was a very easy answer to the doctors' fatigue issue. We needed more staff. Whether that was more full-time staff, more VMO staff, I don't really - I don't really mind, we just needed more staff. Dr Wakefield has applied for two more doctors - one full-time, one part-time. He has put a business case in. He is - obviously if he has written a business case, he must have attached some sort of logical reasons. From what I can see, our reasons were very logical. As I said yesterday, we documented unsafe working hours, we documented delayed diagnosis, we documented death. We had an expanding population, we had a largely bulk-billing population, we had a renal unit established, which was a great thing, but a renal unit brings more surgery into town. As I said yesterday, what more did we need to prove? So when I got this letter from

Dr Young, that was it.

There is a sentence there that's a little delphic. It says, from Dr Young, "A decentralised State does have additional barriers, particularly to lifestyle as it is not possible to engage enough staff to facilitate a roster in some disciplines."?-- No, no, no that's actually not true. You can't engage a staff unless you have been given permission to employ it. So the step one is for central office to say, "Yes, you need a surgeon or two. Here is your funding allocation for it." So you can't say "we can't engage a doctor" if you haven't even advertised. I certainly agree advertising would have been difficult and, yes, we may have had to have recruited from overseas. I don't see overseas recruitment as necessarily being a problem. I mean, there are people, for example, in England who would like to come to Australia. If you go back to this time, there was Dr Thiele, Anderson, myself, there are other doctors in town. We could have been a supervisor for a foreign surgeon to do a probationary period. It could have been dealt with. So when you say it is not possible to engage enough staff, I can only say we didn't try. It is as simple as that. We hadn't tried.

So-----?-- But I went on - can I keep going on unsafe practices?

COMMISSIONER: Yes, please finish this?-- Because I then was desperate about this issue so I wrote to the Director-General. This is a personal issue for me. I had a friend die many years ago in a car accident as a consequence of working brutal shifts. I have also been hospitalised as a consequence of sleep deprivation. It is page 2. And I have got - if I can refer, it is the third paragraph from the bottom.

MR ATKINSON: Sorry, where are you reading from?-- Letter to Dr Stable.

Right?-- It is the second page.

The paragraph that starts, "When Dr Anderson"-----?-- "When Dr Anderson left." If I can focus - I have got to go backwards now. It is the third last sentence. This is when essentially I was just dropped in the middle of it by Queensland Health. No-one offered me any support. But I wrote to Dr Stable and said I suffered enormous physical and mental exhaustion and was operating on patients when I was totally unfit. No reply to that. Now, in my mind that's a sentinel event. Here was a senior doctor writing to the very top saying, "I have been forced to operate when I was unfit." I couldn't let people die. What am I supposed to do? Issue's not dealt with. Now, had this issue been dealt with - I am going to bring up a very touchy subject, if we're going to get to the bottom, sir, of people leaving it - you can't ignore the Caloundra tragedy. The Caloundra - the death of the 10-year-old girl in Caloundra, apart from devastating, obviously, her family, had a very devastating effect on the medical community. Particularly the junior doctors who work the unsafe hours that everyone says they don't work. That was

the child-----

Yes, we know of the case?-- Doctor had worked 19 hours, okay. I don't know the full medical things. I am not-----

We won't go into that, but your point, I understand, is a discrete one?-- The point is 19 hours - people say that people don't work that. People do work-----

Junior doctor shouldn't have been asked to work those hours, is your point?-- Of course not, or a senior doctor.

Anyone?-- No-one. No-one should be asked to work those hours. Now, had this issue been dealt with years ago, maybe that child would not have died. I don't know, I can't answer that, but I can only say the situation could have perhaps been different. Now, I became very distressed by all this so I wrote to the Medical Board about this issue. Could we go about that later or now?

Do that now. It is not in your attachments. There is no letter to the Medical Board, you have a separate letter?-- No, the one-----

You showed me this morning?-- Yes.

Can you produce that letter?-- Yes, I can.

D COMMISSIONER EDWARDS: What date was that letter, roughly?-- You don't have the letter but the reply from the Medical Board is the 7th of September 2004.

MR ATKINSON: I should say, Commissioner, that the doctor showed me this letter on the way into Court this morning and I haven't provided a copy - I don't have a copy myself but I haven't provided a copy to Mr Devlin.

COMMISSIONER: Perhaps we can put it up on the screen.

WITNESS: My barrister has a copy. I would like her to-----

MR ATKINSON: We can put this one on the overhead projector and we can let everyone see it.

COMMISSIONER: Just while that's going up, I want to make sure we're not getting into false issues here. You are not making any criticism of the doctor who was involved in that tragedy?-- No, not at all. I am purely talking about unsafe work practices.

Yes. And you are not - as I understand your evidence, you are identifying that tragedy, not because you're in a position to give any evidence about that particular incident-----?-- Yes.

-----but simply as an illustration of the sort of things that can go wrong if doctors are expected to work unsafe hours?-- Yes.

For all you know, that patient may tragically have died in any event?-- That's true. I know nothing about that particular case.

So your point is that here is a well-known case that's been widely reported in the media where a doctor was working 19 hours-----?-- Yes.

-----it was investigated by the Medical Board, and it is publicly established that the doctor was compelled to work for those hours?-- Correct. So-----

MR ATKINSON: So frustrated by the lack of responses you had received, you wrote independently, did you, to the Medical Board?-- Yes, I wrote independently to the Medical Board. As I said, who do you go to? I had gone through all the channels. I thought I will go to the Medical Board because I perhaps naively thought they must be in charge of these things.

What's the date of your letter to the Medical Board?

COMMISSIONER: Just a minute, Mr Atkinson, our technology is letting us down again. Do you have copies come up on the screens down there?

MR FITZPATRICK: Yes.

COMMISSIONER: Ours haven't. I am sorry, Dr Nankivell, we had this problem on Monday and someone assured our secretary it had been fixed and it is still not working.

MR ATKINSON: One option, Commissioner, is we adjourn for five minutes and I get 10 photocopies of the letter.

COMMISSIONER: I think you better do that, and meanwhile we might see if the technologists involved are able to get it working. I am sorry, Dr Nankivell, for that inconvenience. We will just rise for five minutes.

THE COMMISSION ADJOURNED AT 9.41 A.M.

THE COMMISSION RESUMED AT 9.53 A.M.

EDWIN CHARLES NANKIVELL, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: We now have both copies and on-line copies.

WITNESS: Thank you.

MR ATKINSON: Doctor, would you tell us the lead-up to this letter, if you don't mind?-- The essential lead-up was that I wanted the Medical Board to put in writing what was acceptable hours, and I actually spoke to somebody on the phone, and I said, "No, I want it in writing. What's the policy?", and this was the reply. I have obliterated two paragraphs which were personal information not relevant to the guidance that they have given, and I want to focus on the sentence that you can see I have actually underlined, so it is probably underlined in everyone's photocopies. It is this issue of personal responsibility because every doctor I have discussed this with has just been quite shocked. If I can just read that one out for everybody to know. This, "Medical practitioners have a personal responsibility to ensure their practice and practice environment would be conducive to the delivery of professional, safe and competent services to the public." The situation that existed in Bundaberg did not allow professional, safe and competent delivery of services to the public. And, I mean, how can it? I have already told everyone what a shambles it was, we have spoken about the unsafe working hours, et cetera, et cetera.

In terms of personal responsibility, it wasn't within-----?-- You carry the lot.

It wasn't within your power to change?-- No, no, you are rostered on. Call it on-call rather than rostered, but your name's on the timetable, and all the junior doctors say to me, "But my name is on the roster. How can it be my personal responsibility?", and they have said to me, "Well, what if I refuse to do that? I will be sacked." And we say, "Of course you can't refuse to do your duty." Now, if my interpretation of this reply is correct, then what we were doing at Bundaberg was in breach of the law because we were breaking - if that's what the Act says - am I going in the wrong direction?

COMMISSIONER: Doctor, it strikes me that the issue you raise here is undoubtedly a very important one, has some analogy to the situation that arose several years ago in the transport industry with bus drivers and truck drivers and people like that. Now, I am inclined to think that our society is entitled to expect higher standards from medical practitioners than the transport workers?-- Mmm.

At least equivalent standards?-- Yep.

The situation which arose there, as I am sure you know, is that drivers who were working excessive hours found themselves charged personally with dangerous driving, or dangerous driving causing death, or even manslaughter-----?-- Yes, yes.

-----when they fell asleep at the wheel, and that sort of thing. And Mr Hughie Williams, from the Transport Workers' Union, validly made the point, well, if drivers are forced to work those ridiculous hours, it is the fault of the employer rather than the employee, and there was subsequent legislative changes. Do I take it that the drift of your evidence is to this effect: (1) that on-call time should be regarded, for

all purposes, as part of a doctor's working time because there is at least the theoretical possibility, and in many cases the practical reality, that the doctor will be working for all of those hours?-- Depending on the discipline, yes. For things like obstetrics, very surgical disciplines, that is frequently true because we have to come in and do things. I can't say on the phone, "Give someone a blood pressure pill", like a physician needs. I have got to come in and physically do the operation. So it does - on call varies with the disciplines of medicine.

But, generally speaking, regardless of the disciplinary, a doctor who is on call can't engage in a social life, can't go to the movies, can't be out of touch?-- Yes, yes.

Can't take their children to a sporting event that's more than half an hour's drive from the hospital?-- Yes.

Can't have a drink?-- Yes.

All of those sort of social inhibitions, and, therefore, can't have normal recreation that any other worker has in their down time?-- Yes, yes.

I guess the second thing that flows from what you say is that no doubt the Medical Board is right when they tell you in this letter that it is not their responsibility to make the rules, they just apply them, but the rules should be that doctors, like bus and truck drivers and airline pilots and other people who are in a position where lives depend on their competence, should have limited working hours and those limitations should be enforced against the employer rather than merely being the personal responsibility of the employee?-- Correct, correct. It's the words "personal responsibility" that's shocked everybody that I have shown this to because they had no idea that it was actually my fault, if I can use that word. If I am working 24 hours without sleep, that somehow it is my fault.

Yes?-- You know.

I will mark - I think I overlooked yesterday giving an exhibit number, so I will mark as exhibit 214 the article that Dr Nankivell brought to our attention yesterday from the Medical Journal of Australia of the 5th of July 2004 entitled "Three Australian Whistleblowing Sagas: Lessons for internal and external regulation". That will be exhibit 214.

ADMITTED AND MARKED "EXHIBIT 214"

COMMISSIONER: And the letter of 7th of September 2004 from the Medical Board to Dr Nankivell will be exhibit 215.

ADMITTED AND MARKED "EXHIBIT 215"

MR ATKINSON: Thank you. Dr Nankivell, the letter from the Medical Board suggests that if it is a problem, it is an issue you might take up as a workplace condition or an industrial issue. Did you take the matter any further?-- I am not an industrially-minded person. I just - I am just a doctor and I am not - don't belong to any of the right committees. I have taken it up, and I can say in all honesty I have spoken directly to my District Manager at Logan about this, who is extremely sympathetic and is working on this, and I am told that in the next enterprise bargaining agreement there will be changes. But my point is safety has got nothing to do with an enterprise bargaining agreement. I mean, we shouldn't have to negotiate for what is safe and unsafe. Some external body based on the evidence should say, "You can't do that. It is not safe." It has nothing to do with union, non-union, or anything; it is just unsafe, full stop.

It is not about employment conditions, it is about patient safety?-- It is about safety.

And that should be an issue quite independent of bargaining?-- Absolutely. Nothing to do with bargaining awards, salaries, nothing. It is just a safety issue. You say, "Stop, you don't do that."

COMMISSIONER: For all that, the AMA is the doctors' union, they might benefit from borrowing Mr Hughie Williams from the Transport Workers' Union on negotiating that sort of outcome, because it seems inevitably correct, from what you are telling us?-- Yes.

MR ATKINSON: I understand you would see the College of Surgeons as your industrial body rather than the AMA?-- Not really, no, I don't. The College of Surgeons - and, again, I don't hold any official capacity - does not see itself as a doctors' union or a surgeons' union. I have a feeling they have actually said that they see themselves as a professional standards body charged with ensuring the professional standards of surgeons, the training, accreditation, ongoing assessment of who or what is a qualified surgeon. They don't see it as their role to be involved in union disputes and I think they actually deliberately don't, because once you get involved with union-type disputes, you actually change your relationship with the government.

Doctor, unless there is other things you would like to say about excessive hours, I was going to take you to your recommendations for improvement. The first one is you say there should be a separate model for funding for provincial and rural areas as opposed to the city?-- Yes.

And you explain some of that, somewhere like Bundaberg, ageing, expanding non-bulkbilling population?-- Yes, that's

right. I think, actually, that came out in Dr Thiele's submission as well. I think it is probably self-explanatory. You can't apply the same model in a rural town. Even the work that a general surgeon does is quite different. I work as a general surgeon now in the city. My type of operation I do is quite different, my patients' selection is quite different. It is a different ballgame.

The second point you make is that there should be an improved system for transferring patients. We heard yesterday from Dr Rashford - I think you might have heard some of his evidence - there does seem to be an improvement at least in terms of coordination between patients, hospitals, aircraft. Are you talking about something more than that, such as hospitals understanding more clearly their scope of practice?-- We need to be - this is actually quite a big issue throughout rural Australia and it is not properly represented, I don't think. When you ring up Royal Brisbane and say, "I want to transfer somebody", you have to justify it to somebody who may not necessarily believe it or want it. Now, in the - you know, there is gatekeepers because beds are restricted. Don't think for one minute I ring up Royal Brisbane and say, "I want to send down Mr Smith." "Yes, put him on the plane, we will send up somebody." It doesn't work that way. The problem that we had, one of the neglected areas that's an issue that drives everyone in rural Australia crazy is head injuries. I am not a neurosurgeon, I am unqualified to deal with head injuries. What I can do is stabilise the patients and transfer them on. But you can't do that. The policy in practice is unless the patient needs an operation they can't get transferred. And-----

You like to transfer them for monitoring after you've done a stabilising operation?-- I'm not a neurosurgeon. You see, the care of a neurosurgically injured patient is more than just a an operation. If they need an operation, you can get them out. If they don't need an operation, you can't. Patients need rehabilitation. We don't have that. We - you know, one thing that drove me mad was looking after patients with head injuries that I felt I was not qualified to do, who didn't need an operation but still had some sort of neurological impairment for example. And there was - that's a huge issue and I can spend an hour - I probably shouldn't go down that path.

There needs to be an increased readiness to allow the transfers?-- I think if a doctor in a country town says, "I'm not happy looking after this patient", that's a good enough reason to get them out.

Especially if it's a surgeon?-- Yes. Now, you know, I can give you a classic example. There was some chap in Bundaberg who had an eye injury. I'm not an ophthalmologist, I know nothing about eyes, but I do know that there is a guy who's got glass in his eye who says, "I can't see very well." Okay, now, everyone in this room now knows as much as I need to know. He's got glass in his eye. He can't see. "Can you see?" "Not much." Well, that guy should be in Brisbane, shouldn't he? No, you ring them up, "Oh, oh, oh." "Can you do a CAT scan?" "Yeah, I can do a CAT scan." So you've got to ring people - this is two hours later. I've got to get them from home. This is two hours later at night. You've got to do a report. "Yeah, there's glass in the eye." It's now about midnight, I'm still up, you know. "Oh, yeah, send him down." We had a guy with a head injury who went mad, totally insane, and I can't deal with insane people, I'm not trained. But because he had a head injury, he is not a psychiatric patient, so the psychiatrists are not allowed to touch him, there's laws and so on. Couldn't get him down to Brisbane. We tried and we tried and we tried, and he didn't need an operation but the injury had neurological impart, and he drove us mad. So we stuck with this fellow we're not capable of dealing with. I went to the medical superintendent, who is being hounded by complaints by nurses. I finally got a bed from the Royal Brisbane and it was - I got on to someone who was I think - someone was sick or something like that and I spoke to someone who wasn't normally there and they said, "Yes", so we get him - he was booked on the plane the next morning and it was cancelled and I have a feeling they rang up the superintendent and said, "Why are you sending this guy down?", you know.

Is the source of the reluctance that there's a lack of beds or is there something else?-- Well, there's a lot of - there's a lack of beds and patients like that fall into the too hard basket because they don't need an operation. They need rehabilitation of course and we're not good at that.

That's a good reason, isn't it, to go to Brisbane, where there's neuropsychologists?-- Exactly.

MRIs?-- Hit it on the head. There's neuropsychologists. Because a lot of these patients, they can walk, they can talk, they can eat but, as you know, they're going to go to work, they're doing bad things, they're going to bash their wife and they're going to end up in gaol because they had an injury that nobody did those neurological studies and - that I'm not qualified to talk about but, you know, I'm the one stuck dealing with it because you're the general surgeon in a country town. You get everything, including things that you don't want to handle.

I glean the problem is bigger than just making more resources available in Brisbane, that for reasons independent of bed space there's a reluctance you're finding in Brisbane practitioners to accept the referrals?-- Well, I think it's bed space at the end of the day. But, you know, we had one guy on our ward and I may be slightly wrong of the time, but he was on the ward for 11 months, it was something like that, waiting for a transfer to Brisbane. Now, you imagine sitting on a ward for 11 months. He was - had to go to the spinal - you may be aware there's problems getting patients who need surgery for a pressure sore. It was actually Dr Anderson's patient and after Dr Anderson left, I took him over. He may have gone home for short periods but it was basically - it was something in the order of 11 months of a person's life just sitting around. And I rang up the head of Princess Alexandra Spinal Unit and said, "Who's in charge of this?", you know, and the person said, "I am", and I said, "Well, what's going to happen with this guy?" and they did actually - I think flew up a nurse to assess this guy. But I'm not qualified to assess paraplegics with bed sores. I have - from memory, his hip joint was exposed, like the flesh had rotted down to his hip bone. Now, this is not my area of speciality, okay.

No?-- But he was about, you know - this is what I have to deal with and this is what country doctors have to deal with and all the models - you can have all the models in the world but when the rubber hits the road you're stuck dealing with patients that you don't want to handle, you're not qualified - my fellowship is in - is not in that part of surgery. So it's not easy being a general surgeon in a rural town I can tell you now. It's not easy.

COMMISSIONER: Doctor, I was both impressed and appalled at some of the evidence we heard from Dr Rashford yesterday about what he has to go through to get beds for patients where there are emergency transfers from other parts of the state where the system is, on the face of it, so inefficient that he has to sort of pick up the phone and ring around a number of different hospitals to see where he can find a bed. One might contrast that with the private sector, the hotel industry for example, where, you know, if there's a conference on in town, there's a central database?-- Yes.

You can find out where there's a spare room, because there's money to be made out of that customer that's coming-----?--

Yes.

-----to a town and wants a bed?-- Mmm.

One of the thoughts that came out of that and in fact I discussed it this morning with Mr Peter Forster, who is doing the parallel review, and questions were raised as to whether what we need is a sort of a central bed registry?-- Yes.

So that we know there are 200 psychiatric beds and 60 neurological beds and so on, and they're allocated not on the basis of geographical convenience but on the basis of what patient actually needs them the most?-- Yes.

And it doesn't matter whether that patient lives in Brisbane or Bargara or Bamaga, the patient who needs that bed the most is the patient who gets that bed?-- Yes, I quite agree. Quite agree. The doctor shouldn't have to be running around getting a bed. The doctor should just say, "This is the treatment we do. Do this until I get there", rather than making a dozen phone calls, you know.

Well, everything else aside, the inefficiency, the waste of doctors' times-----?-- Yes.

-----seems to be a major flaw in the kind of system?-- Yes.

And people like Dr Rashford shouldn't have to be picking up the phone and ringing around-----?-- No.

-----half a dozen hospitals to see where he can find a bed?-- No, correct.

MR ATKINSON: Doctor, can you say whether there's any truth in this proposition, that some of the major hospitals in Brisbane were renovated, if you like, in the late '90s, in about '99, and at that stage there was a policy called Reversal of Flow to make sure that people were treated in the outlying areas rather than in the centre so that big hospitals don't actually have the physical capacity to take a big influx of patients from the outlying areas?-- I'm not familiar with the Reversal of Flow policy but I am quite aware of the difficulty of getting patients into Brisbane. It wasn't as easy as the people make out. It was - having said that, I mean, they wanted to. I'm not saying that people went - were being obstructive, but if there's no bed, there's no bed.

COMMISSIONER: Well, I mean, it's just the fact, isn't it, that today there are fewer beds at the Royal Brisbane and PA and other major hospitals than there were 20 years ago. To some extent that's justified because modern medical practice allows patients to stay in hospital for shorter periods and as a surgeon yourself, I'm sure you'd accept that laparoscopic surgery for example allows-----?-- That's right.

-----an appendicitis patient to be out in one to two days rather than a week. There are those sort of improvements?-- Yes.

But we've also got an increasing population and an ageing population and we just need more beds?-- We do. One of the interesting things that has actually changed as a result of all this move to day surgery, which is great, if you wander around the wards and see, well, who's occupying the beds, it's the really sick people.

Yes?-- Now, when I was in the UK, this is actually a true story, the hospitals save money by not giving the patients breakfast. They used to wheel in a trolley and the patients used to feed themselves and the not so sick patients used to say, "Hey, Fred, what do you want, some Weet-Bix?", and they used to feed themselves, because that was the days when - if you had an operation, you'd just sit around for 10 days doing nothing until the stitches came out, and they used to actually - the patients used to do the feeding. Now, that's gone but from the nursing point of view, you had lots of patients who didn't need a lot of care. Now the patients who are occupying the beds need - they're either really sick or they wouldn't be there, or they're the in/out patients. Although the in/out patient is good for the patient, from the nurse's point of view you're compressing maximum care into 24 hours. So every 24 hours - you see, let's pretend this is a bed I'm sitting on. If I sit here for a week, it may be inefficient but there's not a lot of work to do. But if seven different people run through this all needing an operation, all needing nursing care, the workload actually goes up. It's - because it - you know, because you're jamming that work and all this - everything into a very short period of time. You do not have people who are sort of convalescing for a week sitting around.

MR ATKINSON: So you should have less beds but more staff?-- Not less beds but we need to understand that the beds are being occupied by a totally different group of patients that used to happen when I was an intern. And, again, you'd know, Sir Llew, when you were younger, patients would stay in hospital till their stitches came out and they weren't that sick. You don't get a bed now unless you're really sick and, so, the demands on staff is actually higher.

Doctor, can I take you to the second-last bullet point on page 5 of your statement. One of the recommendations you make is that there be funding for audit activities. Can you speak to that?-- Yeah, this is a really - this one, I guess, will shock everybody, as to what really happens, because at the end of the day auditing can only be done by the doctors, particularly in the modern era, because what's been proven with this - now that most of my patients go home the same day or the next day, if the patient develops an adverse outcome, most adverse outcomes now are per post-discharge.

So they'll be seen by the GP?-- Well, they're not going to be picked up by in-hospital data. So the in-hospital data by necessity is not picking up anything except major problems. Now, if you work on the presumption that the badder surgeons will have lots of little problems, they won't be picked up.

And audit is being done manually, mainly by the junior doctors on the basis of what they remember or are diligent. So if they see a patient who comes back to the clinic who has got a wound infection, they will write it down on a scrap of paper and hopefully go back and, if they remember it properly, type it on to something. To do audit properly you need clerical staff to do the typing, to do data entry and to present reports, particularly, if you know what I mean, longitudinal data. I'll give you a simple example. Supposing at our next month's meeting at my hospital someone presents a wound dehiscence, which we've been talking about in the inquiry. What does that mean? Absolutely nothing. You will only know the meaning if you analyse that doctor's data over a period of time, because over the years everybody will get every complication, if you know what I'm trying to say. I mean, we all get complications. That's part of being a surgeon. What you have to do is look for a percentage because. We know what the acceptable, if you like, benchmarks are for, say, a wound dehiscence. There would be a benchmark that everybody will get. Now, unless we keep those benchmarks month by month by month so we have a denominator not just a numerator, we really are not catching the data.

I guess you also need to make sure that you're following through not just the patient's time in hospital but their visits to outpatient subsequently and their visits to their GP after that?-- That's right.

D COMMISSIONER VIDER: Dr Nankivell, we have had evidence given to us previously in the inquiry that that sort of clerical support in clinical services is not available?-- Correct.

And it needs to be available?-- It needs to be available.

We've had evidence that it's not available at ward level where many of the data collection agencies are and it's in the business side of the operation, but it's not in the clinical side of the operation. We certainly have heard that?-- Yes. Because at the end of the day, true audit does depend to some extent on the integrity of the individuals.

Yes?-- But if all-----

And it depends on the quality of the data that you're entering?-- Absolutely. And audit is also done improperly, because to have a proper audit meeting, it's got to be serious. I mean, this is serious stuff and there are guidelines for audit, and it should be educational, not threatening. We're trying to help each other. If I had an adverse outcome, I want my colleagues to give me advice, you know, "How would you have handled that?" It should be done in a positive manner, but we need the data. What happens is that audit is not included in a doctor's roster, okay, so it's squeezed into the lunchtime. So, for example, when I was at Bundaberg - and I'm very strict on audit. I attend every meeting. Do I get there on time, no. In Bundaberg I was always late because I had to do it after my morning clinic,

which was always running over. Now, in my own hospital, for example, one doctor always had to leave half an hour early, this is in the lunchtime meeting, to get to his - to go to another hospital for the afternoon. So he's not there for the whole time. I'm never there for the whole time in my current job because even though I'm on site, I have to leave early to start my operating list, because one of the things that they do, you know, the quality assurance people measure, is starting on time. So I don't want people pressing a button that I was late. So I leave the meeting early. So whatever is said at the end of the meeting, this peer review, I'm absent for. And as long as auditing is a lunchtime activity, done - and, you know, of all the - you would know, of course, Commissioner, what I'm referring to, the pager goes off, someone says, "Excuse me", and they're going outside and then another pager goes off, somebody else goes outside. As long as - it's not funded for the doctors and particularly for the VMOs, it's not part of salary, and it's much harder for a VMO to attend, particularly in the city. And, again, in Bundaberg it was easy; the private hospital is two, three minutes away. It's actually harder for a VMO to attend if he or she has just finished a list at Greenslopes for example or is about to go to a list, maybe it's at the Wesley, or whatever, to be there the full time to give proper peer review, to get the proper data collection. You know, I've got to say it, it's not being done properly.

MR ATKINSON: Your concern is there is not enough dedicated time and money to doing auditing and particularly to doing auditing in a non-blaming way?-- Yes, because if you look at the Dr Patel incident, and because I - I wasn't at Bundaberg, I can't comment on that.

No?-- But auditing has to be done properly or it's not worth anything. And we have to get the right data. Now, I - one of my recommendations that I have written there is that perhaps the Commissioner ought to speak or video conference to Dr Stephen Bolsin at the Geelong hospital because he's actually introduced into his hospital the correct system which is actually the hospital gives palms, you know, PDAs, to the doctor so they can just do it on the run. So that, it's somehow bringing the modern, you know, IT revolution into data collection. And he's got published studies on the use of hand-held PDAs by doctors in monitoring their progress so that when they, say, join the firm for six months, they can get given their PDAs, this is the benchmarks, and they've got to put it, how did they go, have the performance monitored, assessed and done properly. And, again, I'm not an expert on his data or research but I think we have to completely re-look at how auditing, particularly the data collection, is done and present it - particularly what we call the longitudinal data because it - you know, if you do enough operations you will get a complication. But unless we have that denominator of, say, 100 patients to know what the percentage is, we actually don't know if you've got an unacceptable rate or not. If there was no longitudinal data, if you can't see, for example at Bundaberg, what the percentage of dehiscences or whatever it was that Dr Patel was having. If there's no percentage

data, I as a surgeon can't say whether it's good or bad.

Doctor, you have spoken to Commissioner Vider about quality assurance and the quality of the data going in. I don't understand you to cavil with the idea that the surgeon should input his own information about his own surgery?-- Well, no-one else knows.

I guess except if there's well qualified junior doctors, they could assist, but that often isn't the case in provincial hospitals?-- No, they can assist and they can put it in and if it's done in a proper, non-threatening manner - see, the junior doctors all know. The junior doctors all know, particularly in the Queensland system as opposed to the New South Wales system. See, the New South Wales system being a VMO system, after your operation you go to the doctor's rooms. A lot of people in Queensland don't realise that outpatient clinic in Queensland, it's not throughout Australia, it's unique to us. So we actually have - we get them all back. We have the potential to have better data collection than any state in Australia.

COMMISSIONER: Doctor, your comments about auditing and data collection raise to my mind a number of the problems that we seem to keep facing and that is that each hospital or each region seems to be re-inventing the wheel for their own locality?-- Absolutely.

We've heard recently about a system introduced I think by Dr Thiele called the Otago system?-- Well, that was a New Zealand company.

I guessed that. And I'm not going to ask you to say whether that's the best system or whether there are better but my point was simply: there must be a good system that can be adopted state-wide so that you don't have each regional hospital investing in software-----?-- Yes.

-----training staff, spending a lot of time and money using one system and then when the patient gets transferred from Charleville to Toowoomba or from Bundaberg to Brisbane, all that data is defunct because another hospital is using a different system. I'm not a great advocate of centralisation by any means but it seems to me this is one of the areas where there should be standardisation throughout the entire state?-- I absolutely agree and software is the way to go. The Otago system fell out. The reason it fell out was it involved a huge amount of secretarial input and the hospital managers quite rightly said, "We're already collecting 90 per cent of this data." So a secretary will have to type in patient's name, date of birth, address, hospital procedure they're having done, date they were admitted, date they were discharged. Now, the hospital software that everyone's already got collects all that data, so all you need is to attach to what they're already collecting some confidential program that - just for the audit for that patient. And Otago fell out of favour because the secretarial input, when you've got thousands of patients going through the hospital each

year, typing in data was enormous. But 90 per cent of the data is already there. If we can somehow get a software just for the complications and if it is standardised, because every hospital, you're quite right, does a different system, but to call it system is - it's - I don't think it's as good as it should be.

Yes. Doctor, the other thing that your comments really twigged in my mind is again something that's been nagging throughout all of the evidence we've heard over a couple of months now and that is the situation with clerical support. As I see it, you have staff surgeons and I'm not going to embarrass anyone by referring to specific figures but we'll assume a staff surgeon is being paid a package of, say, $200,000. An efficient system allows that surgeon to spend as much time as possible doing surgery rather than writing up reports or answering e-mails or doing clerical services?-- Mmm.

At the other end you may have a manager within the hospital on half that salary but the system seems to regard the manager's time as so valuable that he or she doesn't have to type their own correspondence, he or she doesn't have to answer their own telephone; they've got a clerical assistant to do that for them. It seems to me that an efficient system would ensure that the most expensive and the most valuable people in the hospital have the support services where they need them?-- We do have a secretary or support service where I am. In fact, most hospitals will have a secretary to type letters.

Yes?-- That's obviously who typed up all the various letters that I've submitted. But there's the secretarial support that you need for audit. You really need an audit co-ordinator or somebody like that because if you combined all the subdivisions of the hospital, there's quite a lot of work. But there is - we've got to to be careful, there's lots of confidentiality problems with audit and the way that it's got to be conducted in a way that's safe and sound for everybody concerned.

MR ATKINSON: Your reference, doctor, I understand, is to have a hand-held personal computer and a pencil, and you can use it - with templates, no doubt - and you could enter in audit information very readily?-- I'm basing that on the published work from the Geelong Hospital where they've actually published it and in some way validated it as being the most efficient way, because if it's there in your pocket - there were legal issues of who owns the data, but they - they've demonstrated that that actually lowers the incidents of adverse events, sentinel events, because there's constant monitoring of the staff.

We understand - we've heard evidence-----

COMMISSIONER: Sorry, Mr Atkinson. Doctor, I don't think there's any risk that the three of us are going to be recommending what the system should be, even to the point of saying, "Well, it should be a hand-held palm pilot system" or something like that?-- Sure.

But really the fundamental point is there has to be a system, and it has to be a statewide system-----?-- Correct, correct.

-----and it has to be one which is user friendly for the medical practitioners, and which the medical practitioners are given paid time to utilise rather than having to do it in their lunch break or their time off?-- Correct. Correct.

MR ATKINSON: Doctor, that's the evidence that I propose to lead from you. I was going to make you available now for the other parties to cross-examine. Is there anything you'd like to speak to before I do that?-- Have I dealt with the issue - the very last one - very, very last point in my recommendations?

No, this issue about a model to say how many surgeons, physicians, anaesthetists there should be per head of uninsured population?-- That's right, because I, on two occasions, put this orally to Queensland Health staff, and I've actually written it - I believe it's in my letter to Lindsay Pyne.

COMMISSIONER: It is, yes.

D COMMISSIONER EDWARDS: It is.

WITNESS: If you go to the Department of Education, they can say, "Bundaberg has X number of people - children, therefore we need so many classrooms, so many English teachers, so many maths teachers, so many chairs." They will have a model. What I asked for - I said - very simple question - "Bundaberg has 78,000 people in the draining area. What is the model? How many paediatricians, obstetricians, general surgeons, orthopaedic surgeons, anaesthetists" - you name it. "What is the model that says this is what we need?" I accept that at the moment it's going to be pie in the sky. That doesn't matter. But if we can say, "This is our goal" - it may be a 10 year goal, but for this population this is what we should

have, because I couldn't understand - I mentioned yesterday, when we were turned down the position of an orthopaedic surgeon when it was such, to me, a blatantly, obvious need. We were turned down more general surgeons when it was such an obvious need. I said, "What is the model that says okay, Mt Isa needs this. This is the staffing model for Mt Isa. This is it for Mackay", and this is what we should be doing.

MR ATKINSON: You've never been told that a model exists?-- I've been told it doesn't exist. Of course I'm a few years out of date now. Perhaps it exists now, but I recommended that they get it. I was told on two occasions it did not exist, and it should exist, because then at least we all know what the standard is. I acknowledge, and I'm sympathetic, it's going to take a long time to get that standard, but let's say, "This is what we should have. Let's try and do it."

D COMMISSIONER VIDER: It's a fundamental building block to some workforce planning, isn't it?-- Absolutely. It is absolutely fundamental.

COMMISSIONER: Doctor, I wanted to pick up on your fourth last point and your third last point. I take the force of what you say about substantially reducing the number of hospital meetings. I guess the question is how you know which ones to get rid of?-- I heard some of Jeannette Young's testimony yesterday, and she did mention that some meetings had to happen because of ACHS requirements.

Yes?-- I think that's a really dumb thing. Why can't they just write to the ACHS and say, "This is not relevant." Now, when the ACHS came to Bundaberg, Dr Sam Baker and I had a brief time talking to them. What we spoke to them about is what a terrible place it was. I mean, there was - you know, we were honest. I don't think anything went in, because I don't think we were on the tick box. You know what I mean? I think they were obviously looking for things. What we were saying wasn't on the tick boxes. We said how awful it was, how unsafe the works hours were. We did all this. The only feedback I ever got from Peter Leck was if I - we did pass - was that we needed more meetings, and so - I just couldn't believe this, but we now had to have a monthly meeting of myself and the nurse in charge of the surgical ward, who I saw every day anyway, the nurse in charge of the day surgery ward, who I saw every day, every week - every day anyway. We now had to have a useless meeting so that a box could be ticked, and so there's an hour out of my clinical time, an hour out of a clinical nurse's clinical time to go to a meeting so that a box could be ticked. That's nonsense.

I have to tell you that from what I've learned - in fact Deputy Commissioner Vider knows a lot more about this than I'd pretend to, but ACHS seems to be being misrepresented in this context, in the sense that they put forward a minimum requirement, but if you have something at the hospital that you call a Surgical Clinical Forum where you review cases, and ACHS says you have to have a Morbidity and Mortality Forum, that doesn't mean you have to have a separate meeting so that

you can tick the box. ACHS would be quite happy that you've got your Morbidity and Mortality Meeting even if you give it a different name, or even if it's achieved in a different way. It really is supposed to be simply a minimum rather than a template?-- Yes.

But I take the force of what you say, that there seems to have been the impact at various hospitals that people said, "We've got all these meetings in place, then we do the ACHS accreditation and we're going to have another set of meetings with the names and the list of participants according to the ACHS schedule."?-- Yes.

Even so, undoubtedly meetings are necessary at various points and at various levels. I don't think it's going to be our function to say what should be retained and what should be thrown out. But how do we manage it? Is it a matter of saying, "Well, every regular meeting should have a sunset clause, and after 12 months a decision should be made are we achieving anything? Is there a purpose in going on? If not, we shut down this meeting and refer any outstanding issues to a different meeting."?-- I totally agree. My experience with meetings is they mainly cause aggravation, bitterness and pain, because people raise issues, get hot under the collar, and nothing gets done. That's the feeling of meetings. I don't think it's just in hospitals. It's probably across the board. I think we need to look at who chairs meetings. Are they trained to be a chairperson? Because as you know, it's a huge difference who the chairperson is, whether they stick to the agenda, whether they close off things that are just outside our Terms of Reference or whatever. I actually think if you're going to be a chairperson you need to be trained. There just seems to be a rule meetings have to occur monthly, just monthly, because it's a round number. I agree that perhaps some meetings only need to be every second month, every third month, but everything's held every month. A lot of people who chair meetings just are not good chairs, and I'm not being rude to people, but I think one course that's actually worth doing would be how to chair a meeting and do it properly, because most meetings just go around in circles. The same agenda occurs month after month, month after month, year in, year out. If you accidentally took an agenda from five years ago and said, "Here's the current agenda", no-one would know the difference. It's the same problems keep coming up, and that's what makes the aggravation.

Doctor, I might be a little bit more brutal than you are. My experience - admittedly in an entirely different professional context - is meetings are actually a very inefficient way of achieving something. If you want something achieved, you sit down one-on-one with the person that is going to be making the decision or going to be implementing the decision and decide what to do. The difficulty with meetings is that people feel they have to make speeches-----?-- Yes.

-----minutes are taken-----?-- Yes.

-----people want to be recorded as having said something on

the record-----?-- Yes.

-----even though no-one ever bothers to read the minutes. It's at a fixed time so that it can't be done to meet the convenience of those involved?-- Yes.

Meetings, as such, are quite inefficient. I'm not saying that there shouldn't be any meetings at all, but a lot of the things that you talk about seem to me to be the sort of things that could be achieved much more efficiently in an informal way, even to the point that maybe audit discussions should take place over coffee in the doctors' common room rather than sitting around a meeting table?-- Doctors' common room? You're out of touch, sir.

Yes?-- That's politically incorrect, and that's one of the - seriously. I shouldn't make jokes. In the old system doctors had a common room, and it sounds elitist, but it's not. It's actually where the business gets done, because you see everybody and you talk within that confidential circle about the difficulties that you've had, and you will say, "I've got this patient. What do you think I should do", and it's these consultations that are taking place off the cuff all the time that are now lost. Once you got rid of a common room - it's not just that we lost the camaraderie, it was those little conversations that actually helped patients because you were constantly getting advice. "Oh, I'd do this. I would do that. Oh, don't do that." If you felt stressed, you may even talk about a bad day you've had and you'd get that stress - you could get it off your chest, and someone would tell you their story and everyone was happy. In fact there has been work done by psychologists that people in the demanding professions like counselling and things like that, those who can come within that little sanctum to talk about it all actually are much more physically and psychologically healthy. Once you got rid of doctors' common rooms where - you haven't got that little meeting place where you actually just constantly are talking about patients in a way to get help. I don't mean help in a desperate sense, but that constant feedback that keeps you at the cutting edge. "What do you think I should do? I did this. I almost got caught on that. I had this funny anatomy", and you're talking to your colleagues in a professional sense, as I'm sure the lawyers here do. You're talking in a professional sense. It sharpens the blades.

And it's also an educational experience. Someone says, "Did you see the article in the latest Lancet?"?-- Exactly. Exactly.

MR ATKINSON: They do have - I've been to the room at the PA. They have a room near the theatres. Doctors and nurses share the room?-- That's a problem if you're talking about confidentiality. When I worked at a hospital in Sydney, the political correctness only had one room, but it was doctors at this end, nurses at that end. You may as well have had a brick wall in the middle of it, but for political correctness you had to have the one room. It's not politically incorrect

to have a common room if that's what helps people. It actually helps you. It helps you to be a better doctor because you're constantly sharpening the blades, talking about articles et cetera.

COMMISSIONER: Yes. The other point I wanted to pick up on is the third last one where you talk about clear guidance on safe working hours and so on?-- Yes.

Just to preempt a question that Mr Devlin might have, you say here the Medical Board must give that guidance. I take it that the Medical Board being the source of the guidance isn't critical to your recommendation. The important point is that there must be a rule, whoever is the appropriate authority, to promulgate that rule?-- That's right. I put "Medical Board" because I just assumed they were in charge. I gather they're not totally in charge, but-----

Well, that's a matter for them.

MR ATKINSON: That's the evidence-in-chief, Commissioner.

COMMISSIONER: Thank you. I'm sorry-----

D COMMISSIONER VIDER: Nothing further.

COMMISSIONER: Sir Llew? Ms Gallagher?

MS GALLAGHER: Thank you, Commissioner. I seek leave to appear for Dr Nankivell, instructed by United Medical Protection.

COMMISSIONER: Yes.

EXAMINATION-IN-CHIEF:

MS GALLAGHER: Two things, one of which is a housekeeping matter. Doctor, yesterday afternoon you spoke to a newsletter from the Bundaberg Base Hospital in respect of waiting lists at Bundaberg as compared to Hervey Bay and the fact that there was, if you like, room on the list at Hervey Bay?-- Yes.

Could I please ask you to have a look at this document. Is that the document to which you were referring?-- Yes, it is.

And the paragraph to which you spoke was the last paragraph on the second page?-- It's the last paragraph that's marked "044" on the copy I've been given.

Thank you. Commissioner, that was not part of the submission of the doctor, and I think it might have been thought that it was there, so I tender that document.

COMMISSIONER: Thank you.

WITNESS: I wanted this as proof that I wasn't just making it up about the maldistribution of resources. I discovered that document on Google.

COMMISSIONER: It's amazing the things you find on Google. Copy of the Bundaberg Base Hospital newsletter for specialists and general practitioners of December 2000 will be Exhibit 216.

ADMITTED AND MARKED "EXHIBIT 216"

MS GALLAGHER: One other issue, doctor. In response to an inquiry made of you by the Commissioner, you spoke of the emergency theatre at your hospital having to be occupied - or utilised 70 per cent of the time. Could you just take it back one step and tell us briefly, what's the function of an emergency theatre as opposed to any other theatre in a hospital?-- The other theatres have patients who are booked, so we know anything from the day before to two months before - whatever - that Mr Smith is going to have a hernia operation on Thursday, the 8th of October - whatever. That's booked, that's planned, staff are allocated et cetera. Emergency theatre is like a fire engine sitting in the garage.

Thank you. If the emergency theatre is not used 70 per cent of the time, as you presently understand it, what happens with that theatre?-- If it's not used 70 per cent - this is - you see, the hospitals are chasing goals and benchmarks that are unrealistic. It's never used nought per cent of the time because there will always be emergencies coming in either from - say from the obstetric ward, a caesarean section that needs to be performed, people coming from in emergency that have to have an operation. So it will always be used at some point, but our figures were below the 70 per cent, which to me is simply not a problem. Once - what happened to try and reach the benchmarks - as far as I'm concerned it was basically fudged. You see, there's different types of emergencies. If I fall down and break my ankle getting out of this witness box, I have a broken ankle. It needs a pin put in it. It doesn't have to be done today. I could go to a hospital, they could put me in a plaster cast overnight, I can be scheduled for tomorrow, which, in realistic terms is more efficient. Yes, I'd love to have the operation now, but that's not - that's quite difficult to get the orthopaedic surgeon's time, theatre time. So the orthopaedic surgeons have what is called a trauma list, which is a planned list. The names are not planned, but the time is planned, because you know there's going to be broken bones coming through. I mean, you just know it. And so if you break your hip today, we'll do you on the trauma list tomorrow. That's a very efficient way of doing it. To get the figures right they moved patients from the trauma list to the emergency list. The problem with that was it blocked up the emergency board.

So that if-----?-- So that the emergency - the genuine emergencies then got bumped because they couldn't be done - except the caesarean sections, of course. Emergency babies would always take priority. Now, the problem with that is you then get fantastic data, and so the data collection is good. "We're getting our 70 per cent target." The doctors and nurses are being demoralised because they know what's really going on. I do a night on call. I could be in at 10 o'clock, 11 o'clock doing a bowel obstruction. You're tired. The next day you've got new stuff. That's what I'm saying. The night on call is a misnomer. So I walk in at 8 o'clock the next morning, there's somebody who needs their appendix out. Okay? I then go to the operating room and say, "I've got an appendix to do", and the nurse in charge laughs at me. "You're joking. Come back tonight." Now, I'll give you an example - this is the sort of crazy things where it's not efficient. They'll say, "We're being efficient. The emergency theatre is being utilised 70 per cent of the time." It's not efficient because in reality you're just bumping patients on to night where the data is not being collected, because it's only 70 per cent in working hours, and so - I give you a case where a doctor who'd worked a Thursday night, was back until after 11 o'clock because the appendixes had come in - there were three of them. Two of them couldn't be done until late that night, so she was back until - it must have been after 11. On the Friday night, finishing off the appendixes - appendix operations from Thursday, meanwhile I've seen a patient at 4 p.m. with appendicitis who needs an operation. I have to come in now at 11.30 at night to do it - okay - which is not efficient, not good, because during the day the emergency theatre was being blocked by shifting patients from the trauma list to the emergency list to make the theatre look good. Now, the bureaucrats will think we're being efficient and the data will be presented as an increased efficiency, but it's not. What it was was shifting patients from the in-hours data is being measured, to out-of-hours where data was not being measured to make things look good. Now, this was talked about - again every month the staff would groan, and again at the meeting there'd be anger, resentment at what was going on with the emergency list. Now, I should say at the moment we actually have lost the emergency list, so what I'm saying now is not applying because we've had anaesthetic resignations, we don't have the luxury of being able to support a trauma list and an emergency list. But when we did have the staff to do it properly - I don't have a personal problem if the emergency list and the emergency nurses are sitting around empty. The nurses can still be doing something. They can still be checking stock or doing some education or doing tea relief. I don't see that as being inefficient. I think it is part of emergency theatre. Every hospital must have some degree of inefficiency. It's like an emergency hospital. Some days there may be no car accidents or stabbings at all. We don't say that's inefficient. You may have too many staff for that day. The next day when there's a bus crash or something you've got less staff. That's the way - and nobody believes the data that's being produced, but it's the mindset that will say, "This is efficient" when it's not, and patients are

waiting two or three days with broken bones, being on a list this day to have their broken bone done, there's not enough time so they will get put on to the next day, not enough time, put on the next day. We have to - the figures that will be produced no-one believes, and one of the problems that Queensland Health has got is the lack of credibility, and Mr Peter Forster, he will be the master on this, and if he disagrees with me then I will withdraw this, but there is a lack of - the staff of Queensland Health, which are its greatest resource, don't have the faith in the organisation. I have faith in individuals, because there are good managers, there are good doctors, there are good people, but something's gone wrong with that faith and trust between the top and the bottom, which you have to have to move forward.

Thank you, doctor.

D COMMISSIONER VIDER: We've been told many times what's gone wrong is we've lost sight of the patient.

MS GALLAGHER: Thank you, Commissioner. I have nothing further for Dr Nankivell, but he has reminded me this morning he has an operating list today and he needs to be gone by quarter to 12 or make alternate arrangements. So if I may bring that to your attention once again.

COMMISSIONER: We're not going to allow his operating list to be interfered with. Mr Harper, any questions?

MR HARPER: No questions.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: We have no questions of the doctor.

COMMISSIONER: Mr Allen?

MR ALLEN: Just briefly, thank you, Commissioner.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR ALLEN: Doctor, you mentioned in your evidence yesterday - and it was after what might have been a Freudian slip where you mentioned the Code of Misconduct - that persons in Queensland Health, especially nurses, are terrified of the Code of Conduct?-- Absolutely terrified. Terrified.

Is that something which you experienced in Bundaberg?-- Well, they all - the feeling amongst all nurses is that if you complain you'll be sacked or discriminated against. Again I will defer to Commissioner Vider, but that is the feeling. Now - and everybody has their story, and as somebody - a nurse

said to me about Bundaberg, "What were you supposed to do?" They knew there were bad things happening. The Code of Conduct - it's like the Code of Silence, isn't it, and the nurses are scared. They are scared of it.

When you referred to a fear held by staff, including nurses, about the Code of Conduct, it was a fear that that would be used as some type of means of retaliation?-- Yes.

If they broke the Code of Silence?-- Yes.

All right. Now, you have referred us to the document which is now Exhibit 215, which was the letter from the Medical Board of Queensland, which seems to have sent a shudder of fear not only through yourself, but through your colleagues, where the Medical Board points out that medical practitioners have the personal responsibility to ensure their practice and practice environment, and I suppose one of the fears in relation to that is that that brings to mind the fact that if you're working an excessive workload, and as a result of that there is an adverse outcome, that the medical practitioner his or herself may be subject to professional sanctions?-- Yes. Everybody who has read that is - their jaw drops. They suddenly think, "I'm the one who's going to get the blame. I've just worked 24 hours, an adverse event occurs, have I lost my indemnity if I'm now outside the rules?"

Okay. Well, I suppose there's that aspect of the fear of some type of civil liability?-- Yes.

There's the concern about some type of sanction by way of, for example, disciplinary proceedings before a tribunal?-- Yes.

With possible restriction of practise, or even loss of practising rights, and I suppose in the extreme case there could be a fear of criminal sanction?-- Yes.

You certainly wouldn't be surprised to know that a similar situation exists in relation to the professional responsibility of nurses?-- Yes.

Who have certain responsibilities under the Nursing Act and can be subject to the same sort of sanctions in those circumstances?-- Mmm hmm.

And really it's outside the control of the clinicians - be they doctors or nurses - in the public health system for what reasons? Why are they required to place themselves at such jeopardy in the situation as it now exists?-- Can I first say if it is my personal responsibility or the nurses' personal responsibility, they should be the one in control.

COMMISSIONER: Yes?-- If I'm the one bearing the blame, I have to say, "No." The problem is if you say, "No", who is going to work it? It involves a massive rerostering, but I think we've got to - through our unions or whatever - just have a policy that says if it's your personal responsibility, you have the right to say, "No." But as the doctors say to me

- and I can't speak for the nurses - "Well, I'll be kicked out if I say, 'No'", you know?

MR ALLEN: Well, there's not only the fear of the loss of a job, but on the particular day where you're confronting that situation there's that sense of professional obligation-----?-- Correct.

-----to actually treat the patient-----?-- Yes.

-----isn't there?-- There is. We all feel guilty. Everyone feels guilty if we have to cancel a list. Patients have taken time off, have got their children in childcare, their parents from New South Wales have come up to look after them. There's a lot of issues that make us feel really, really bad to cancel a list, and so what happens is fatigued doctors don't cancel the lists.

COMMISSIONER: And there are also the practical complications that, you know, you have been working eight hours, you are getting towards the end of your list and something goes wrong with the operation. You can't just sew up the patient and - well, if you are Dr Patel perhaps you do - but generally speaking you can't sew up a patient and say, "Well, I will see you next week and when the weekend is over."?-- Yep. No, that's right. It is difficult. It always will be difficult. There has been a real crisis in the United Kingdom where they've introduced the European Work Time Directive, and I have been following some of the British literature on that that's been coming out in the Gazettes. Once you introduce a safe work practice, you totally devastate your roster system because if you can't work a doctor for 24 hours then you need two doctors to work 12 hours. And so the system issues are devastating for Queensland Health. And I have my sympathy. If you introduce the European Working Time Directive, it just totally changes everything, from your elective lists, your emergency lists, your rostered hours, your targets, your throughput. Everything changes dramatically.

Doctor, do you happen to know whether this issue has been addressed anywhere else in Australia?-- I don't, but I have not researched it. It probably depends very much on staffing levels.

Yes?-- Because I know that the managers want to do it but the problem is - if you have got a hospital with lots of staff you do it.

Yes?-- If your hospital has got no staff, you don't do it, and the rules should be if you have got no staff, bad luck, you close shop-----

Yes?-- -----you know.

And I imagine the situation would be different in New South Wales and other States where there aren't outpatient clinics in the sense in which we know them in Queensland?-- Yes.

And where, as I understand it, a majority, if not all specialist services are provided by visiting specialists?-- Yes. Completely different ballgame there. The visiting specialists then can control their life, which - it is a completely different system. Queensland actually has the hardest system to work.

Yes.

D COMMISSIONER VIDER: I think system is the operative word. It has to come back and be a system situation-----?-- Yes.

-----that resolves the issue because, as you have indicated, patient acuity is so much higher, the patients are sicker, and certainly in the hospital system it is a constant?-- Yes.

We know the patients are sicker, we know the hours of service are 365 days/24 hours. So we have got to be able to provide

the staff that do that, and that might mean a change to the way it is being looked at?-- It does need a change and one point that you mentioned yesterday was the out-of-hours clinics. The point I am taking from that is the flexibility, which we don't have.

Yes?-- I mean, I haven't really seen, for example for female nurses, a really workable child-friendly solution for women who want to take their kids to school, work, pick them up. Individually that can occur but I think the whole game needs to be thought out. See, why does every doctor in the hospital have to turn up at 8 o'clock in the morning? Why couldn't someone not turn up till 10 o'clock but work a bit later? So there is a broader range of coverage, more hours. For example, if we increase the number of obstetricians at my hospital, say full-time people, what's the point of having everybody there at 8 o'clock in the morning when babies are being born 24 hours a day? Now, no-one wants to do night duty, but can we get more flexibility in the system and think outside this 9 to 5 routine, that everyone has to do 9 to 5. See, in Bundaberg we did Monday to Friday, then did the weekend. Why couldn't I have done what the nurses did and work, say, Thursday to Tuesday and have Wednesday, Thursday off? Now, that's a complete revolution for the system.

But it is not rocket science?-- It is not rocket science but it is very dramatic for a system as it is at the moment. But it is a rocket science change, it is a blast off to the system.

Yes?-- Sorry, have I answered your question?

MR ALLEN: Yes, you have, thank you, doctor. In relation to an industrial matter such as that, the Medical Board basically suggested that you should address the matter of excessive work loads as an industrial matter?-- Yes.

Now, isn't one of the problems with that that because of their sense of professional obligation, both doctors and nurses within the public health system have been most reluctant to withdraw their labour as a means of negotiation? There is this reluctance to leave the patients without care?-- And there should be.

Exactly?-- There should be.

But that means that one of the traditional tools of industrial negotiation really isn't used in the public health system, and has that not, in your experience, been taken advantage of by the employer?-- Let me answer that perhaps indirectly. I certainly have never, nor will ever withdraw my labour, and a lot of nurses would say the same.

A majority, I am sure?-- Sure would. The point that I would make is that this should never be - safety and personal responsibility should never be an industrial relations issue. I have talked to my District Manager about this as part of the enterprise bargaining agreement and he is extremely

sympathetic and helpful, okay. So - but why should safety be an enterprise bargaining agreement? I think what the nursing union and the AMA should do, and certainly what my recommendation to the Commissioner is it just has to be law. You can't do it.

COMMISSIONER: Well, the issue here is not simply, in effect, a contractual one between employer and employee; the central party in all of this is the patient, what's best for the patient?-- Yes.

And that shouldn't be a matter of negotiating in a master-servant relationship; it should be a matter of examining what's best in a regulatory sense for the patient?-- Correct. I mentioned about not cancelling the patient who has arranged childcare, but if it is safety we should.

Yes?-- So we - as a profession we have to change our mindset, but we actually need help to do that - perhaps direction is the correct word. We just have to be told, "You have to do this", full stop.

MR ALLEN: And following on from something the Commissioner asked, if not the Medical Board or the Queensland Nurses' Council, what sort of body could determine safe working hours for doctors and nurses?-- I just think it should be the Medical Board - and perhaps I am naive, but my understanding is the - you know, the Nursing Council, the Medical Practitioners Registration Board, or whatever in each State, is independent of the hospital system, is independent of Queensland Health or New South Wales Health, or whoever. I think they should take the lead because they're not - I don't think it should be a union issue at all. I think the Queensland Nursing Council, who represents not just the nurses but the patients as part - I think it is part of their Terms of Reference, they represent the ethics of patient care. They should be giving strict written guidance. The problem is that Medical Board - I get a roster that says hours on it, a nurse gets a thing with written hours on it. Broad guidance like if you are not feeling well, or things like that, or, you know, if you have worked too much, what is too much. Whether you like it or not, in a system that has rosters with hours written on it you have to nominate a numerical figure. This is what they have done in Europe. I know that's hard but a numerical figure gives the nurses protection, gives the patients protection, and if you exceed that numerical figure, you have to close shop, unless, of course, it is like a good samaritan type clause. I mean, if the patient is bleeding, you can't go home. We accept you may go past the numerical figure, but that would be in an emergency where it is felt justified in clear - patient's imminent interest, you can't go home, you know, but I think Queensland Nursing Council. I did read years ago its brief - perhaps Commissioner Vider would know that. I think those bodies that are not - they are not just a doctors' body, I understand those bodies have solicitors, computer advocates on them, senior public servants who are not doctors. That's the Board that should say, "This is what you do."

COMMISSIONER: And in further answer to Mr Allen's question, it may also be a Workplace Health & Safety issue?-- It is.

We've heard references, without any detail, to the incidents of doctors who, for example, become themselves addicted to narcotics and other substances and so on, and I have no doubt the long working hours you are talking about are a factor in bringing about that sort of situation?-- I am sure it could be. Certainly brings out psychological distress. There is no question. That's well documented, and the effects of psychological distress can be numerous, and drug dependency is one of them.

Yes.

MR ALLEN: One aspect you touched upon in relation to the increase over the years in nurses' workload was due to the factors that there is this decreased average length of stay of patients?-- Yes.

And also at the same time an increased patient acuity?-- Yes.

And, for the reasons you have mentioned, that has obviously produced a significant increase in the workload of nurses?-- Mmm.

I suppose, given those factors, an actual drop in nursing numbers in the public health system over the same period of time means a disaster looms?-- It does. There is a disaster. I refer you to the current edition of the Medical Journal of Australia entitled something like The Babyboomer Generation. You can get it on the web, under mja.com.au. It talks about the fact of nurses retiring earlier, doctors retiring earlier. If I can give my own tuppence worth on that issue, I think the nurses have made a giant mistake in the way they've gone about their negotiations, because if a nurse wants to get promoted, they have got to stop treating patients. I am being a little bit rude here but I don't see why a nurse who treats patients should get less money - you know, the classification of - I am not great on that, but level 1, 2, 3, 4, 5, et cetera. I personally feel there has got to be completely new classifications, and clinical nurses who treat patients get good income. My impression, I may be wrong, but male nurses, for example, tend to drift more to admin. Perhaps, Commissioner Vider, I am wrong, but to get a better salary you go towards the administrative end of nursing. And I am passionate about clinical nurses and I just don't see why a good competent clinical nurse shouldn't have a new pay scale. I think the whole pay scale thing needs to be worked out because, you know, by the time you are 55, female nurse, you are working on a ward, you are doing, you know, the three shifts nurses work, you do the day shift this week, then it is the nightshift, and then it is the midnight horror shift. When you are doing that when you are in your 50s and you are getting a sore back because of osteoporosis - all the nurses say I am crazy but nurses I think - I see them as being a very vulnerable group. They are not a rich group, with marital

breakdown being obviously a big issue. They don't get much choice. I personally would like to see this whole thing opened up, but there is a huge problem looming in the nursing profession, absolutely huge because of the shortage, and I think - as we have said, the patients are getting harder and harder to deal with. I think that is a well recognised problem and people are more competent than me to speak on that. Did I answer the question?

Yes, thank you, doctor. I suppose if, as a matter of fact, the public health system has been employing less nurses over the period of time when the workloads have been increasing, because of patient acuity and decreased length of stay, the inescapable fact is those nurses who are employed have been working much and much harder?-- That is my belief.

Yes?-- I can say that as an observer. I am not qualified to give data but my observation is very clear. There has been a lot of change over my lifespan, which is 25 years as a doctor.

And one matter which is perhaps analogous to the one you have spoken of is the increasing time having to be spent on documentation by both nurses and doctors?-- Yes, that's not going to go away.

No, of course not?-- So we have to deal with it.

Yes. One of the ways it has to be dealt with is it has to be recognised that, just as doctors need paid time to deal with auditing matters, the time spent by nurses in completing documentation has to be recognised?-- That's true work. It is absolutely true and it is mandatory. So if it is mandatory, the documentation is correct, it should be remunerated and rostered within your working day, time for documentation. That's common sense.

I just get the impression from your evidence that as a thumbnail sketch we have a situation where doctors and nurses are working much harder to try and care for their patients, to the extent that they're reaching burnout or coming close to it?-- That is definitely true.

They feel unsupported by the system, they bear the brunt of patient dissatisfaction because of their inability to carry out their clinical duties the way they would like to?-- That is correct and I think it is well documented.

Isn't the inescapable conclusion, from all that, that the government has to spend more money on the public health system?-- That's obvious.

Thank you, doctor.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, Ralph Devlin is my name. I represent the Medical Board. I take it the point you seek to make through the letter that you have put into evidence is that whether it be the Medical Board or some other regulator, you see a need for some regulator to impose a standard of working hours?-- Yes.

And conditions upon your employer?-- Correct. I mean no criticism of the Medical Board. I wrote to them because I have no idea who else to write to and I may have asked from them things that were not within their power to do. But what you say - I don't care who fixes it, please someone fix it.

Yes. The point you are making is there is a greater need than ever, in light of what you have just said to Mr - to counsel for the nurses here, that there is a greater need than ever in the current circumstances for some form of imposition of a standard?-- Correct. Absolutely.

And I take it you accept the general propositions advanced in the letter that the legislative make-up of the Medical Board as it currently exists is such that the Medical Board is concerned with the registration and regulation of the medical practitioners?-- That's right. After I received this letter, I realised the Medical Board did not have the power to do what I was asking, but I was still shocked that it was my - they were telling me it was my personal responsibility when I have no control over what is my personal responsibility.

To take up the final parts of the letter then where your attention was directed towards your association, for example, are you aware of agitation about excessive work hours that has been advanced by your association from time to time?-- I am actually not a member of the AMA, but through information I have seen, yes, I am aware they have been agitating for that.

It has been a live issue-----?-- For a long time.

Long time?-- It is often brought up in the context of junior doctors' hours and people have been leaving out senior doctors' hours.

Yes. So can we take your strong evidence on this point to be a plea for the senior doctors as well?-- For everybody. Everybody who touches a patient, whether it be a doctor, or nurse, physiotherapist, or whoever, if you touch a patient there have to be these rules, full stop.

Yes. The other point you are making is - and very forcibly - is that up to that point the individual doctor has to look to his own performance in a very pressurised circumstance?-- Correct.

Thank you.

COMMISSIONER: Thank you, Mr Devlin. Mr Diehm?

MR DIEHM: No questions, thank you.

COMMISSIONER: Mr Chowdhury?

CROSS-EXAMINATION:

MR CHOWDHURY: Dr Nankivell, Craig Chowdhury. I appear for. Mr Leck?-- Yes.

I just want to make a few points. I think you made it quite clear yesterday that there was what you considered a gradual downhill slide at Bundaberg?-- Yes.

And it would be wrong to blame it on any one individual?-- Correct.

And you particularly made the point that you had no problems with Mr Leck or, in particular, Dr Wakefield when he was Medical Superintendent?-- That is true.

And you found in particular Mr Leck to be polite, kind and helpful?-- Yes, I did sort of ask him about these sort of issues. He did say - you know, he was emphatic, "I'm trying", so.

He appeared to be just as frustrated as you were?-- Yes, that is true. That is my belief.

And you made the point quite fairly yesterday what more could you have done; you went to the zonal manager, went to the Director-General, went to your local Member of Parliament in an extraordinary meeting?-- Yes.

And nothing happened?-- Correct. And so we went above Mr Leck, not out of disrespect to him, but we realised he did not have the power to fix things. And so having gone above him it then becomes the responsibility of the people above him.

COMMISSIONER: And having done that, you found yourself beating your head against the same brick wall that obviously Mr Leck had been beating his head against for some time?-- Yes.

MR CHOWDHURY: It was also quite evident to you, was it, that there was pressure on Mr Leck as the District Manager to stay within budget?-- Absolutely. He was set up to fail. And I will tell this story because I want to be fair to Mr Leck.

Yes?-- We had a visiting superintendent by the name of Jean Collie come up from Brisbane, a senior person. She was a new

person in town. I grabbed her by the neck and said, "Sit down. I am going to tell you how bad it is here." And I was talking about Mr Leck and she said, "Poor man. He is set up to fail.", and I kept going on about how bad the hospital was, and I presumably said something that made me a bit negative. She said, "Poor man, he is set up to fail." I said, "What do you mean Mr Leck is set up to fail?" She said, "He is set up to fail" - and I am paraphrasing. I don't remember her words. I am paraphrasing my understanding - the message - I am paraphrasing the message I got. "Brisbane have told him to do this, he is resourced to do that. Thereby Brisbane have set him up to fail." That's what I'm told. Ever since then my understanding of Mr Leck changed. That's all I can say.

Thank you. When you actually came to resign, do you recall having a meeting with Mr Leck, I think in his office, where he expressed regret about you leaving, said he was sorry that you were going?-- I can't remember the specific meeting, but I do clearly remember him expressing regret, he was shocked, he was sad.

And he was very appreciative of the efforts you had put in at the hospital, wasn't he?-- Yes, he was.

And I also understand that before you resigned I think you sent a little note, might have been a handwritten note, to. Mr Leck thanking him and basically saying it was nice working with him?-- I do remember that. I can't remember the contents of that but.

It was to that effect?-- It was to that effect. Peter Leck came to my farewell dinner. I have a card from him. I appreciate that he did his best and I thank him for trying to do the right thing with the issues that I have raised.

Thank you. Quite obviously your area of concern was surgery because that was your area?-- Yes.

But, of course, there were other areas that caused a demand of resources in the hospital as well, presumably; psychiatry, obstetrics and gynaecology?-- Of course everyone is begging for money.

Yes?-- And I perhaps need to clarify, when I said it was a terrible place to work, it was a shambles, I am specifically referring to the surgical workload.

COMMISSIONER: Yes.

MR CHOWDHURY: Yes?-- I am not making any comment - I want to clarify that I am not making any comments on other wards or other units because I am not qualified to make those judgments. My judgment is purely upon what was happening in surgery in Bundaberg.

COMMISSIONER: But, doctor, you would accept what Mr Chowdhury is suggesting to you that other departments within the hospital may have had equal - equally difficult resourcing

problems and that Mr Leck wasn't only concerned with your resourcing problems but with resourcing problems throughout the entire hospital?-- Yes, that is a correct point, yes. So if it is under-resourced in one department, it is across the Board.

MR CHOWDHURY: And leaving to one side then the medical side of the hospital, you raised in your correspondence that is attached to your statement a question, for example, of security?-- Yes.

And that was a problem that you raised?-- Yes.

And in particular you suggested at least there needed to be closed circuit TV. So the running of a hospital isn't just the medical side, it includes the cleaners, catering?-- Yes, yes, absolutely.

The admin staff, security staff?-- Yes, it does.

All of that. And from what you said yesterday, there was this corporate attitude from head office, as it were, that the hospital had to be run like a business?-- Correct. And you can't because it is a service industry.

Just one final point, you did make this yesterday, but it is quite clear from the first three letters that are annexed to your statement that the waiting list problems go back before Mr Leck's time, to far back as '97?-- Correct.

And the problem continues?-- Yes, he didn't create the problems. We have got to be careful we don't put a causal association between Peter Leck's arrival and the going downhill.

Yes?-- I am talking about my experience. There was a change, I believe, in corporate policy. Peter Leck's duty in Bundaberg was to represent corporate policy. That's his job. He does not answer to me, he answers to what people in Brisbane tell him to do.

And had you heard of District Managers being disciplined or even being dismissed-----?-- Toowoomba.

-----if they didn't come in under budget?-- Everyone knows the Toowoomba story, Royal Brisbane story. These stories go around. We probably hear them fifth hand, with changes, but I have no doubt that he was terrified of being dismissed, because I understand key performance indicator for District Manager is coming in on budget and the District Manager does not set the budget, his job is to implement it. If the budget is inadequate - and I have to say - and I have made it very clear - I believe the budget was vastly under-resourced - that is also Dr Thiele's testimony. He has said it to me a million times. You have got Dr John Wakefield's testimony attached to my statements-----

Yes?-- -----that we needed external moneys. It is crystal

clear we were under-resourced, so he is trying to keep an under-resourced budget on track. Which you can't do.

Thank you. And, look, this might be an obvious point but in a large workplace such as a hospital, doctors, nurses administrative staff and so forth, you are dealing with people day-in, day-out, not everyone is going to get on with everyone else, are they?-- Yes.

Some people just don't get on. Nothing to do with their competence or anything like that, they just don't get on. That's reality, isn't it?-- Yes, that's absolute reality.

Nothing further.

COMMISSIONER: Any re-examination, Ms Gallagher?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: No Commissioner. May the witness be excused?

COMMISSIONER: Yes, doctor, just-----

D COMMISSIONER EDWARDS: I just have one philosophical question, if I am allowed to put it: having been looked over the years in another life as one in control of the budgets in the Health Department, one in control of a total budget as a treasurer, one understanding the demands of a community for the best service on roads, so forth, have you got any feelings as to how governments in general, doctors in general, can tailor the needs to assist the level be a good system and meet the requirements of all the community? I guess one of the great things that I am finding out of this inquiry, 20, 30 years after leaving public life, is that there is an expectation for the very best. Have you a view, from a practising clinician, whether that view can be satisfied in any way or are we going to have not only Morris Inquiries in Brisbane but throughout Australia because of the deficiencies of the system that's inadequately funded, because of pressures of all other demands by a community and by governments? And please don't answer if you don't feel you would like to make a comment, but it is just something that I am getting a very strong feeling about through this Commission and past experiences, that it really is a funding issue, how we deal with the problems, and if we are prepared, as governments and communities, to fund extensively to the detriment of Main Roads or whoever it might be, perhaps we may have another system that will benefit the patients in the long-term, which to me is the ultimate responsibility that all people have. Please don't feel obliged to answer. This one is a philosophical, but I think, personally, a very important issue that I'm reigniting in my mind relative to this Commission?-- I have sympathy for Departments of Health who are fighting with Departments of Transport and Primary Industries and Education. I mean, it is difficult. I think what I have seen, though, what can be made better is there is a gulf

between those people who understand budgets and things and people like myself who don't understand budgets. So, for example, I go to a meeting and I don't understand the English that's coming out of the bureaucratic structure. And there is two big a gap between the people who understand the money and those who understand the medicine. Probably all of us should do, you know, a little management course, so I can understand management better and understand where they're coming from and vice versa. But I think, you know, the public probably have to pay more in taxes, if you want to get a better system, but I think if it came out - I mean, I would beg governments to be totally open on this, lay every card on the table, and if our tax went up half a per cent and you knew every single dollar went into the public system, I think a lot of people would say yes, you know what I mean? I think the community, if it is sold as an honest deal, we want to fix the hospital system, these are our problems, we have got to lay everything on the table and hide nothing to fix this, we are going to have to raise taxes, you as the public have to make a decision. I will pay more tax if it is going to fix the system. But I think probably as a doctor I need to do a little management course so that I can better assist my managers, because when you are talking about doctors having control of budgets, I know nothing about a budget, you know what I mean? And that is a problem perhaps we have to fix.

COMMISSIONER: Doctor, I have to say, though, what has actually surprised me so much about your evidence, everyone knows that the medical profession can mount a case that an amount in excess of GDP should be spent on health care?-- Yes.

That's the sort of standard proposition. But so much of what you've said would actually save money, at least in the long term. You know, having more endoscopies and colonoscopies is going to save money in terms of acute care for cancer patients-----?-- Yes.

-----in the relatively short horizon, in two or three or four or five years down the track?-- Yes.

The issue you raised yesterday about utilising a VMO in Bundaberg to provide those services-----?-- Yes.

-----rather than flying up a specialist one day a week-----?-- Yes.

-----is going to save money?-- Yes.

I think, you know, fortunately for the three of us, we don't have those budgetary decisions. Whatever else we do, we don't go back to the government and say, "The solution to this problem is to spend more money." But what we can say is that at least part of the solution is to spend the money you've got more wisely?-- Yes. And to listen to the local people.

Yes?-- Who know what the issues are. For example, in my statement I've mentioned that I - when we were in Bundaberg, we decided not to hammer Queensland Health with too much demands.

Yes?-- That we would prioritise what we wanted and we said that the department of surgery would be the number one priority. That was in my statement. So on at least two occasions I gave my speech with an overhead projector, as it was in those days, clearly stating that the department of surgery was the number one priority for the Bundaberg Base Hospital and that was agreed by the doctors in the hospital. So I always gave my presentation, telling the people what a shambles it was, I went through my usual spiel. So we'd identified surgery as the number one problem and when Queensland Health came back with their new Santa Claus goodies for the next year, surgery was left off and we'd identified it as the number one problem.

In fact, this inquiry is an illustration of how we're not just talking about bigger budgets. I mean, if there was no Dr Jayant Patel, for a start, the five million or whatever it's costing to run this inquiry would be saved?-- Mmm, correct.

From what I've seen so far, it's going to cost the State of Queensland literally tens of millions of dollars in damages claims for the patients who have been treated by Dr Patel?-- Yes.

All of that could have been prevented by keeping on a team of surgeons like Dr Thiele, Dr Anderson, yourself, Dr Baker, providing very marginally better services to retain that group at Bundaberg at a cost which would have been a fraction of the cost that Dr Patel has cost the State of Queensland?-- Correct. Absolutely correct. And it wouldn't have been that much money really. In the overall picture, it would have been quite a small amount.

Any questions arising out of that? Doctor, we are extraordinarily grateful for your time?-- Thank you.

We know that you have a very busy list at Logan and we are really thankful that you've been able to come not only yesterday afternoon but to finish up this morning. We also appreciate the candour and forcefulness with which you've expressed your point of view?-- Thank you, sir. It's been a pleasure.

Thank you.

WITNESS EXCUSED

COMMISSIONER: We might now take a 15-minute morning break if that suits everyone.

MR ATKINSON: And Dr Cook will be the next witness.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 11.33 A.M.

THE COMMISSION RESUMED AT 12.07 P.M.

COMMISSIONER: Mr Andrews.

MR ANDREWS: Commissioner, I call Dr Peter Cook.

COMMISSIONER: Would Dr Cook kindly come forward. Mr Lyons.

MR LYONS: Mr Commissioner, might I seek leave to appear on behalf of Mater Misericordiae Health Services Limited. I seek leave simply in relation to the evidence of Dr Cook. The connection is that Dr Cook is employed by the Mater.

COMMISSIONER: Certainly, Mr Lyons. You have that leave. Please be seated, Doctor.

MR LYONS: Thank you, Commissioner.

PETER DALTON COOK, SWORN AND EXAMINED:

COMMISSIONER: Doctor, make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- Not at all, Commissioner. On that front, if I could just say one thing?

Yes?-- Within the courtroom, I'm more than happy for photographs or reporting of my evidence or any of the cross-examination. I'm more than happy to discuss any of my submission or any other matters that are relevant. However, I'd emphasise that I don't view myself as a public figure and so outside of the courtroom, if people did want to follow up on any of the evidence that I submit, I would refer them to the Australian Medical Association.

Thank you for that, Doctor, and I think that's a very appropriate way of handling the situation. Can I also mention, you're probably aware we have a system in place of giving code numbers to patients' names to protect the patient confidentiality. I don't know whether that issue is going to arise with your evidence because I think some of the patients you deal with have already had their names in the public arena but if at any stage you have a concern about patient confidentiality, please feel free to raise that?-- Commissioner, could I just make one point in relation to that. Personally, I believe there are two patients that may be discussed in the courtroom in some detail and I, within the last seven days, have contacted their next of kin to inform them that I was coming to the Commission and there was a possibility that their cases would be discussed and could possibly be reported in the media. However, it is - I reassured them that it was likely to be in de-identified form.

Yes. Mr Andrews, you'll ensure that that's attended to.

MR ANDREWS: Certainly, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: Dr Cook, would you tell us your full name, please?-- Peter Dalton Cook.

And you have prepared yourself, and without the assistance of lawyers, a submission to the Inquiry dated the 25th of May 2005. Is that correct?-- I prepared the submission myself, however it was reviewed by lawyers prior to submission to the Commission.

COMMISSIONER: Dr Cook, I'm sorry, one other thing before we go on. I'm very conscious of not keeping doctors away from their clinical duties. Are you under any time constraints today?-- Commissioner, this week is one of the rare weeks that I have no clinical commitments, and so that's - in conjunction with AMA counsel, I was eager to give my evidence. I find, to be frank, that the issues raised here are complex, and difficult to accommodate within a clinical working week, and so - and I would like to thank you and your staff for allowing me to give this evidence this week.

Not at all. Thank you.

MR ANDREWS: Dr Cook, the opinions expressed in your submission, they are honestly held by you?-- Correct.

Where your submission refers to facts, they're true to the best of your knowledge?-- Correct.

Within your submission - indeed the very last annexure contains your curriculum vitae. I note from page 2 of that CV that you are a Fellow of the Faculty of Anaesthetists, Royal Australian College of Surgeons, a Fellow of the Australian and New Zealand College of Anaesthetists, a Fellow of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, and a Fellow of the Joint Faculty of Intensive Care Medicine?-- That's correct. If I could just clarify one point there. Some of the societies I'm a member of have changed their names over the years, and broadly speaking there are three qualifications I hold. One is in general medicine from the University of Queensland in 1982, the second one is in anaesthesia, which is covered by two of those titles, and the third one is in intensive care.

Thank you. Your experience on the fourth page shows us that you were experienced in rural, small Queensland hospitals from your time at Baralaba and Woorabinda?-- That's correct. I was a Queensland Government scholarship holder, as others have been at this Commission. I was - I had a three year commitment to serve back. The first year was spent as an intern at Royal Brisbane and the following two were spent in a single doctor practice roughly two hours south-west of Rockhampton.

And you seem to have spent eight to 10 years working in the health system in New South Wales at Albury and Lismore?-- Correct. Predominantly during that time I worked in Lismore, and prior to moving back to Brisbane I was Director of Intensive Care at Lismore.

Since 2001 you have been the complex-wide Director of Adult Critical Care Services, Mater Health Services, Brisbane?-- That's correct. It's a large title, but it serves to reflect the fact that I look after adult intensive care patients in both the public and the private hospital with a team of intensive care specialists. Could I just clarify one more point, and that is that I'm currently a staff specialist, whereas previously at Lismore, and prior to that in Albury, I was a visiting medical officer.

And as I proceed through your submission, there will be occasions where you speak about the difference between systems where there is heavy reliance upon visiting medical officers and systems where there's heavy reliance upon staff specialists?-- Correct.

Your time in New South Wales was a time in a state where there's a primary emphasis on providing specialist care by visiting medical officers rather than by staff specialists. Is that the case?-- It would be more correct to say that hospitals in New South Wales come in two different styles, broadly speaking, major procedural hospitals - the larger teaching hospitals would have a large number of staff specialists. However, the smaller hospitals or more regional hospitals would understand that it is difficult to recruit staff specialists and so they would elect to employ visiting medical officers, and I've provided some data lifted from the Northern Rivers Area Health Service website giving staffing levels of hospitals in the Northern Rivers, pointing out that Lismore, with a population of 40,000, draining an area of 180,000 people, has 73 specialist VMOs.

And that compares with Bundaberg with a greater population?-- My guess would be that Bundaberg town would be about the same, however the drainage population would be smaller, possibly half the size. However, I'm not privy to the number of VMOs at Bundaberg, but quite clearly many of the services that Lismore would provide are not available in Bundaberg.

Now, within your submission - I will proceed through it in the order in which you raise matters. You begin with your recollections of patient P18

COMMISSIONER: I'll just remind the press and media that that name is not to be published or disclosed outside these proceedings.

MR ANDREWS: You observe that when patient P18 was transferred to the Mater on the 20th of June 2003, you were immediately concerned that the operation which had occurred had occurred at such a small hospital. Was it the fact that this particular surgery had occurred which triggered your alarm?-- Broadly speaking, there are three separate issues here. One is - in these types of settings there is the competence of the surgeon, the currency of practice of the surgeon, i.e. how many of these procedures are done per year, and the third thing is the level of robustness of hospital support. Now,

I'm not a surgeon and, as the letter states, I consulted with a surgical colleague at Mater to discuss these issues, but the thing I know is the robustness of medical support at Bundaberg in terms of intensive care is limited, and so my concern was that if there was someone who was performing these procedures in a hospital without robust intensive care support, then that called into question those other two factors. I had no knowledge of the surgeon's training or the numbers that they were doing per year, but if you were properly trained, it would surprise me if you would embark on major surgery in Bundaberg.

Let me clarify. Do you mean that if there was, within Queensland, a surgeon who regularly performed oesophagogastrectomies who happened to have been passing through Bundaberg in June 2003 to perform this surgery on this patient, you still would have been concerned that it had been performed in the Bundaberg Base Hospital?-- I would phrase it the other way. I would suggest that if you had someone who was experienced in this type of surgery, then they would be aware of the complications that can arise, and even if they were a world expert in this type of surgery, they would elect not to do it in a hospital that would struggle to support complications, should they occur, and there's some outcome data in relation to the frequency of practice of the procedure as it relates to outcome.

Yes, and I'm grateful that you have it included within your submission. The knowledge that you have that it was inappropriate to perform an oesophagogastrectomy in the Bundaberg Base Hospital, is that knowledge that ought to have been understood routinely by medical practitioners in rural areas?-- In my view, yes.

You were caused such concern by this that you discussed your concerns with the Executive Officer at the time of the Mater Public Hospital - that's a Ms Jenny Skinner - and she urged you to put your concerns in the form of a letter which I see is Appendix A2 to your submission?-- Correct. It is important to emphasise that the letter is a two-page document, but it was forwarded with copies of the transfer letters, operation notes, pathology report and a CT scan result.

Within that annexure - I think I'll put it up on the monitor if - Commissioner, this morning I know that the monitors weren't working successfully.

COMMISSIONER: I think they're now working effectively.

MR ANDREWS: Commissioner, they seem to be working effectively everywhere but in front of me - no - intermittently.

COMMISSIONER: Are you able to continue in any event while that's being looked at?

MR ANDREWS: No, I didn't have the foresight to create two versions of the document.

WITNESS: I have a spare copy of the letter.

MR ANDREWS: I don't have the longsight to see what's on the monitor. Thank you. You discussed this matter, it seems, with, among other people, Dr Keating, if the third paragraph of your letter is correct?-- That is correct. I rang Dr Keating to discuss the case. Can I just give a little insight into the practice of intensive care. Intensive care in some respects - we get an undifferentiated group of patients. We may have a medical patient in one bed, a surgical patient in the next, an obstetric patient - particularly at the Mater - in the next bed, and if you work in regional centres you may have a child in the next bed. It's difficult to be an expert at everything, and so it is an area that I'm in charge - or the intensive care specialist is in charge of the management of the patient, but consultation is very important. So before embarking down this course I had a long discussion with one of the experienced general surgeons, a Dr Chris Elmes at the Mater, to ensure that the concerns I had about the case were shared by him, and they were.

Having done that you made contact with Dr Darren Keating, presumably because he's the Director of Medical Services at the Bundaberg Base Hospital?-- Correct.

Do you recall the substance of any conversation you had with Dr Keating?-- I need to prefix my answer by saying that this is over two years ago, and to be honest, I had no concept that this letter would be discussed in this forum. I recall that I had discussed it with Dr Keating. I had voiced my concerns, particularly about the robust hospital support required for this type of surgery, and I voiced my concern as to whether this was an appropriate operation to be done at Bundaberg.

Doctor - I see. You voiced your concern as to whether this was an appropriate operation to be done. Did you make a recommendation to Dr Keating, or did you leave the question as one for him to consider and to determine the answer?-- No, I didn't imply that this was a decision that Bundaberg should make on their own. If I did, then the letter would have been addressed to Darren Keating. Clearly I - I did not think that this type of practice was appropriate-----

I'm wondering what it was that you communicated to Dr Keating?-- The sense was, in a polite way, that on the information that I had, my view was that this was not appropriate to be done at Bundaberg, and could I just add that I did not have all the facts, and the analogy I would use is someone who is sitting in the back of the plane as a passenger and who looks out the window and sees that some of the cowling on the wing is a bit loose. The first response to that is not to ring CASA, but to call a member of the flight crew, perhaps a flight attendant, over to say, "That doesn't look right to me. Could you look into it and see if that is appropriate?" But the letter wasn't addressed to Bundaberg because it was clear to me that if this type of surgery was currently going on in Bundaberg, it was going to be difficult to address this

as a Bundaberg issue alone.

COMMISSIONER: I think what Mr Andrews is driving at, though, is this: your letter sets out your concerns in a very frank and succinct way. Did you convey those concerns to Dr Keating when you spoke to him directly?-- Correct.

MR ANDREWS: You do, within your letter, set out more than one concern for - within the last few minutes you've concentrated primarily upon the capacity of the hospital to deal with the complications that ensue after such complicated surgery. I notice within your letter you speak also about another issue not related to the hospital itself, but to the surgeon, and then yet another issue related to the number of similar procedures performed. Am I right in summarising it as those three primary issues?-- I think those are the three issues that need to be considered in this type of surgery-----

Is it likely that all three of those were put to Dr Keating?-- Correct, yes. Correct. Highly likely.

COMMISSIONER: Doctor, we've heard a lot of evidence - you realise, of course, I've got no medical background or qualifications at all. We've heard a lot of reference to operations described as oesophagectomies. Is there a difference between an oesophagectomy so called and the oesophagogastrectomy that's referred to here?-- The first thing to say is - and I have to be very careful about this - I am not a surgeon, and if you wanted a precise answer, a surgeon would be a more appropriate person to get an answer from, but cancer of the oesophagus can occur at a variety of levels within the oesophagus.

Yes?-- And if it occurs at the bottom end of the oesophagus where the oesophagus meets the stomach, then an extensive resection of the stomach has to occur as well, and then there needs to be a reconnection from that area - the remaining area of stomach up to the oesophagus in the neck, and that can be done in a variety of ways. And so if it is at the oesophagogastric junction, then an extensive resection of the stomach would occur and that would be described as an oesophagogastrectomy, whereas if it's higher in the oesophagus then the operation may be described as an oesophagectomy.

My reason for asking that question, viewing the matter as a lawyer rather than a doctor, is that the particular warning set out in this letter relates to the operation described as an oesophagogastrectomy, but would it be fair to infer that the same concerns would apply to an oesophagectomy?-- Absolutely.

And that it would be apparent to anyone with medical knowledge who was informed of these concerns that exactly the same issues would arise with an oesophagectomy?-- That's correct. I would have to look back through the correspondence, Commissioner, but my understanding is on the second page the operation is in fact referred to as an oesophagectomy.

Yes?-- It's a change in emphasis, and maybe some slight change in actual physical technique, but the broad principles of the operation are the same.

Yes. And at least someone with medical background should understand that they are equally difficult, equally complex, and therefore equally relevant to the points you're making in this letter?-- Correct.

D COMMISSIONER EDWARDS: Also, would it be fair to say that this wasn't an operation that needed to be done immediately. It would be a planned procedure that could be delayed for the time of transfer. It wasn't the kind of operation, as I understand from the notes that you've given - the notes that we've seen - that needed to be done in one hour?-- Absolutely correct.

This was a selective period for a diagnosed malignancy that could be done in the best facilities at the most appropriate time, provided that was only a short time away?-- Correct. In fact most patients with this disease who lived in Bundaberg could catch the Tilt Train to Brisbane as opposed to aeromedical transfer.

Thank you?-- And certainly there's no evidence of the patient bleeding, which would be the other indication why intervention could be precipitated more quickly, and there are good reasons for a slower - meaning a week or two - work-up in this type of patient, because we know this is a cancer which spreads early, and even with complete resection, the five year survival is not great, and a lot of time and effort should be put in in these patients to ensure that there is no spread to lymph nodes outside of the oesophagus and stomach, because if there is evidence of that, then the operation shouldn't be performed because the outlook is so poor with or without the operation, that going through the entire operation is not appropriate. There are techniques which can be used, PET scanning - positron emission tomography - which can be done in Brisbane, or simple things which I think I mentioned in the letter, from memory, in relation to looking into the belly under general anaesthetic with a telescope, a laparoscopy, to see if there is any spread to the surrounding nodes, and it's interesting that the histology report indicated that there was spread to the nodes and the operation report referred to a large tumour, which it appears from the operation notes - and they are a little hard to read - had spread outside the bowel.

Some of those pre-operative procedures would certainly not be available to Bundaberg Hospital or even Townsville or Cairns hospital. They would be uniquely available probably in Brisbane?-- The laparoscopy would be available in all centres. The positron emission tomography scanning, which would be done routinely for these patients - and these are parents we see a lot of at the Mater - would be a common investigation, but would not be available in Bundaberg. I can't comment on the other institutions.

COMMISSIONER: Mr Andrews, can you just remind me, amongst the patients who died from oesophagectomies we have Mr Kemps who was P21, and I think Mr Phillips who is P34. Are you able to recall whether both of those post-dated this letter on 7 July 2003? Certainly Mr Kemps did.

WITNESS: Commissioner, I may be able to provide that information. I've got the print-out from the website of the patient details which has the date of surgery, if you could stand by for a second.

That would be very helpful.

MS McMILLAN: I can assist. Page 124 of Dr Woodruff's report, Phillips, patient died 21/5/03.

COMMISSIONER: 21 May '03, so he may have preceded this, whereas Kemps was afterwards.

MS McMILLAN: Yes.

COMMISSIONER: We have at least one example then of a patient who died from this sort of operation after the hospital was warned that it was inappropriate.

MS McMILLAN: Well, Kemps was 20/12/04, the oesophagectomy on the 20/12/04.

COMMISSIONER: Yes, he was almost 18 months after that.

MS McMILLAN: According to Dr Woodruff, page 122.

COMMISSIONER: Thank you so much, doctor. We haven't actually seen this before?-- I'm terrible for filing. I have a system of putting everything away.

So, according to this, we have got Mr Kempst who died, which postdated your letter. I have got P16, again postdating your letter, but that operation appears to have been successful. P34 is Mr Phillips who predated your letter. P160 was successful, P170 who died in hospital, which postdated your letter. P18 - so at least two deaths from oesophagectomies after your letter. I take it that shouldn't have happened?-- Well, I am sad that it did happen. You need to understand, Commissioner, that this is an operation which is difficult and that's why it should be done in major centres with people who do sufficient numbers, but it is unfortunate that those operations proceeded.

But it is almost never an emergency procedure, it is almost never something that you have to do overnight to keep the patient alive?-- I can't remember ever getting an oesophagectomy for cancer as an emergency.

No.

MR ANDREWS: And the histology report for this patient P18 revealed nine of 14 metastatic nodes and stated that "macroscopically there were numerous enlarged involved lymph nodes identified at the gastro-oesophageal junction at the lesser curve and greater curve." You have included that in your letter, no doubt, for a reason. Can you explain? What was the significance?-- That really needs to be read in conjunction with the operation notes, and the issue I am trying to explore is whether the tumour was so advanced as to render the proceeding of the operation appropriate and partly, you know, the histology refers to microscopic examination, and when they refer to macroscopically, clearly they're talking about looking at it with the naked eye, and in reality that is what the surgeon would be doing, although there is the possibility of getting a rapid histology report at Brisbane - and I would assume a frozen section, as it is called, would be available in Bundaberg for any suspicious areas. And, so, when it is read in conjunction with the operation report, which if you are happy I could quote from.

I am content for that?-- Okay. The writing is difficult to read, and I apologise if I may not get this completely right. "Oesophageal" - "GOJ", gastro-oesophageal junction, "mass mobile and palpable surrounding LN", for lymph nodes, "palpable oesophageal wall and lesser curve of the stomach." So if this tumour had spread to the lymph nodes, then proceeding - once again I need to qualify I am not a surgeon but I have discussed this with surgeons, proceeding with the surgery may not be appropriate.

That's because whatever advantages would be achieved for the patient if the surgery was successful would be so short-term because the patient's life expectancy and quality of life is so impaired as a result of the metastatic evidence?-- Correct. So the patient would - this is a major operation. The patient will be in hospital for a long period of time, even if it goes smoothly, and if the patient is in the last few months of their life, then, to be frank, they would be

better at home with their loved ones rather than spending time in hospital trying to recover from this surgery, which will not be curative.

COMMISSIONER: And better off having palliative care rather than going through what is presumably a very traumatic operation?-- Absolutely.

D COMMISSIONER EDWARDS: And with high risk?-- Yes, yes.

MR ANDREWS: You have observed that a second surgical opinion would be required to decide whether with this finding, continuing with the surgery is appropriate. Now, though you read from the notes, I concede that the significance of it was lost on me. What you observed in the notes as opposed to the histology - well, yes, what you observed in the notes, was it sufficient to show that a second opinion was required in Bundaberg?-- No, sorry, Mr Andrews, I should clarify that point. I need to be careful that I don't exceed my specialty training, and that's something I am very conscious of. I know a lot about a whole variety of conditions, but I am not a trained surgeon and I know - I know you know what should happen and I can recognise things when they don't - when they aren't done properly, but I am not the expert. So what I am suggesting there is my view is that on the findings to hand, at least in the referral, including the histology and the operation note, that thought should have been given to not proceeding with the surgery, however I would advise talking to a surgeon who is very experienced in these conditions to get their expert opinion.

Are you suggesting that it is your opinion that having regard to the findings which appear in the notes, it would be orthodox for a surgeon to seek a second surgical opinion before proceeding?-- No, I am suggesting that the people who are looking into this case look into this point closely.

I see?-- And seek the advice of experts in oesophageal surgery to see if they concur with my non-surgical view.

Now, your concern about the need for a second opinion, is that level of detail something to which you'd have descended when speaking with Dr Keating?-- No, from memory, the discussion with Dr Keating was along the lines of the three major issues. Could I add that intensive care is a repository for cases that don't go smoothly and the issue in this case is not that the patient sustained a complication, the issue in this case is the patient shouldn't have had, in my view, the surgery at the venue that they were at and I - as you are aware, I've written a similar correspondence about another case. However, in my four years at the Mater, from memory they are the only two cases that I have made that point about. You know, this is complex surgery and these people tend to be unwell to start with, and you can expect a percentage of cases not to go smoothly, and the problem here is not that the patient did not go smoothly, the problem here is the patient had their surgery in my view at an inappropriate venue.

Thank you.

COMMISSIONER: In other words, the correspondence that you wrote is reflective of a degree of alarm at what went on here?-- Absolutely. And it is politely worded but it does include all the referral notes and operation notes, pathology report and CT, and from reading those, it is clear what the problem - you know, what the issues are. It is politely worded because it is written with a view to being handed on to possibly a number of people.

Yes?-- And clearly there are concerns if - if you place in writing issues in relation to competence and variety of things, there can be a number of issues which can spin off from that which can be personally quite traumatic, so really I could let the correspondence speak for itself in this case.

But the real point is that as an intensivist you deal on a daily basis with the outcomes of operations that go badly, for one reason or another, and this is one of two in over a period of several years that caused you so much concern that you went to the length of raising these issues?-- Absolutely, yes. And you need to remember I work in a tertiary referral hospital. So the usual way this works is someone looks at a patient and says, you know, "This patient is too sick to have their operation here, we will send them off to a tertiary referral centre where they will have their operation there." And, you know, because you are dealing with a select group of patients having complex surgery, often with multiple other medical problems, then the risk of complications are far greater. And so working in a tertiary referral hospital you can always expect people, after complex surgery, to come to your attention. And that's why I work at the Mater. That's my job, to look after those people - and other groups of patients, but those people in particular, to help them get through the issues that arise in the post-operative period.

You see, one of the pieces of evidence we have at the moment - I don't think it has been challenged or contradicted by anyone - relates not to this patient P18, but another of the patients who was actually referred from Bundaberg to the Royal Brisbane Hospital, and the Royal Brisbane Hospital refused to perform an oesophagectomy because the view was apparently taken that the patient was too unwell. And, in any event, even if the procedure was successful, would-----

MR DIEHM: Well, Commissioner, that isn't the state of the evidence, with respect.

COMMISSIONER: Isn't it.

MR DIEHM: No. The only-----

COMMISSIONER: The evidence we have heard on that is from Toni Hoffman, isn't it?

MR DIEHM: Yes, yes, Commissioner. That's precisely right. And the evidence was ultimately that she had no idea where

that patient went to. She had heard gossip, as it were. She couldn't even say from where.

COMMISSIONER: Yes.

MR DIEHM: That that had happened.

COMMISSIONER: I understand it is hearsay and we may well hear evidence to the contrary, but at the moment that's the only evidence on the subject, isn't it?

MR DIEHM: The evidence is helplessly vague, in my submission, Commissioner.

COMMISSIONER: Well, we have evidence, that Mr Diehm criticises, but the only evidence is that the patient was refused an oesophagectomy at the Royal Brisbane and went back to Bundaberg and had an oesophagectomy occur there. From your experience in a tertiary referral hospital, is that something that should occur in a provincial hospital?-- That story, if it were true, on the face of it raises grave concerns. It is interesting to note that in Lismore with five general surgeons, they had elected between themselves not to do this operation. The reason being currency, in that they couldn't guarantee that one of them could capture all the referrals for this operation from the area and they figured - and there is some reasonable evidence to support them - that you would need to do a certain number before you get an acceptable risk of complications. And so they had elected to continue to refer - and that's a much bigger hospital, two intensive care specialists, six ventilated ICU beds, and they had elected not to proceed with this - with that operation and refer them to Brisbane or Sydney.

Yes, Mr Andrews?

MR ANDREWS: The letter to Ms Skinner, you observe on page 2 what Ms Skinner said to you. Now, you are recalling a conversation that must be more than two years old. Can you be sure as to what Ms Skinner said to you when you handed her the letter?-- Okay. The - I followed this up. The first thing to say is writing a letter like that, despite the fact it is only two pages, takes a lot of work. I had to consult with doctors in Bundaberg and doctors at Mater, I had got the role delineation document from a senior nurse in the Northern Rivers of New South Wales, and I had spoken to her about the implications of that. I remember also speaking to a Lismore surgeon about the implications of that for him. The role delineation - can I just clarify that - that describes the hospital in terms of the robustness of different departments, how big they are, what they can support, and it is from that document that you can figure out what types of surgery are appropriate. At this stage - I think it is referred to in my letter - Queensland was just starting the process to develop a role delineation document. I think, from memory, Queensland calls it something different.

Are you referring to the part in your letter where you say in

the last line of the first page: "You are aware that New South Wales has an extensive role delineation process which can be used as a guideline to accrediting surgeons for different types of procedures in different types of institutions"?-- Correct.

Would the Queensland jargon for role delineation be credentialing and privileging?-- It is not - not directly comparable with that term. Sometimes there is a Queensland Health medical administration person who attends the hearings and they may be able to give us the full title for the similar document in Queensland, but at that time the document was, my understanding was in development, not even at draft stage.

D COMMISSIONER VIDER: Are you referring to the role delineation project that came out of New South Wales, I think it was in the middle 80s?-- I have a copy of the document that was sent to me by the senior nurse in New South Wales, which I could easily tender to the Commission if you would like. This was sent to me by the nurse - the note is undated - and I approached this nurse because she worked in one of the - she worked in Casino, a smaller hospital that did surgery where clearly role delineation of the hospital and what was appropriate to do in their theatres was quite - was looked at perhaps more closely than a major base hospital, and I would be happy to tender that to the Commission, if you would like.

COMMISSIONER: We would appreciate that. Doctor, will you want copies back of these, because I have kept hold of the other document you handed up not long ago?-- That is my only copy of the role delineation document. I would appreciate a copy of that back would be fine, if that's acceptable to the Commission.

Of course it is. Mr Andrews, what I will do is I will mark. Dr Cook's statement as exhibit 218.

ADMITTED AND MARKED "EXHIBIT 218"

COMMISSIONER: 219 will be the document headed Bundaberg Health Service District Oesophagectomy and Whipples Procedures, displaying months 1 January 2002 to 31 March 2005.

ADMITTED AND MARKED "EXHIBIT 219"

COMMISSIONER: And exhibit 220 will be the role delineation document from the Northern Rivers Health Service.

ADMITTED AND MARKED "EXHIBIT 220"

COMMISSIONER: The last two of those - I will hand them back to you, Mr Andrews, so they can be copied over lunch and the original returned to Dr Cook.

WITNESS: Could I just interrupt briefly to say that oesophagectomy list is from your website and I think it already has a number.

COMMISSIONER: Right. I haven't seen it in that form. If it is, perhaps it has had the names removed or something since I saw it.

MR ANDREWS: Doctor, you came to the topic of role delineation when addressing my question of whether you remembered the conversation you had with Jenny Skinner a little over two years ago?-- Sorry, I got a little off the topic there, but I needed to emphasise there was a lot of work put in to a two-page letter. There was no way I was going to let that lie without follow up. My recollection is that subsequent to writing the letter to Jenny Skinner - you need to appreciate that there is an agenda in what I have submitted of a meeting prior to writing the letter where the case was discussed. From that meeting the decision was that I was going to write to Jenny Skinner and she would carry it forward from there with Queensland - with Queensland Health. We were meeting on a regular basis and my recollection is that that had occurred. At that time there were regular meetings between the Executive Director of the Mater Adult Hospital, the Chief Executive Officer of Mater Health Services. So, you know, my boss, the person who looks after all the hospitals, and Queensland Health, and that would have been the venue that it would have been discussed, would have been my expectation.

My question is whether you remember what Jenny Skinner said to you after she'd received your letter? I see from your statement you say, "She fed back verbally that she'd forwarded it to the Southern Zone Management Unit."?-- That is right.

That's a statement that doesn't identify any particular person?-- That is my recollection of the conversation, and the Southern Zone Management - Queensland Health is divided into three zones. The Brisbane River divides the southern and the central zone, Mater reports to the southern zone managers, who were at that time Karen Roach with a 2IC of Tracey Silvester. I have subsequently become aware that other people's recollection of those issues may be different to my own.

Yes. Appendix A3 shows a pair of three e-mails. Do you have a copy of appendix A3 there?-- Yes.

Now, as I read the document, at the bottom of the page there is revealed an initial email from you to Dr O'Donnell, the Chief Executive Officer, in which you observe, among other

things, about patient P18, that in reality an "oesophagogastrectomy like P18 should not be done at a hospital without robust ICU back-up." As I look at the document A3, it suggests that your email to Dr O'Donnell seems to have been forwarded by Dr O'Donnell to Tracey Silvester with a copy to Jennifer Skinner and to you?-- That's correct. P18 is a famous patient for two reasons. One is because of the nature of the surgery and the institution he was referred to us from, but, secondly, because he was unable to be admitted to any Brisbane intensive care unit for many days, and that is in the referral letter from Bundaberg which I have included as part of my submission earlier on. There was an acute shortage of intensive care beds - and perhaps it is getting down into the weeds a little bit but there is an agreement for how much intensive care Queensland Health buys from the Mater, and we had - we were up to the limit on the number of beds we could supply to Queensland Health. P18 pushed us over the limit.

P18 pushed us over the limit but it was obvious to us that he needed to get out of Bundaberg, just on the story, and so we took him into a non-Queensland Health funded bed and I notified the Executive Director and the Chief Executive Officer that that had occurred with a view to then approaching Queensland Health for extra funding for the care of that patient. An intensive care patient, broadly speaking, is about $3,000 a day in terms of total - total cost. So - and so, that was the thrust of that correspondence. And it's important to note that my e-mail is dated the 20th of June, which is in fact before the letter that I wrote to Jenny Skinner. But, clearly, you know, we had been discussing this as an issue.

Now, Tracey Silvester, the person to whom Dr O'Donnell sent his own and your e-mail, what is that person's status within the zones?-- Karen Roach is the zonal manager and Tracey Silvester relieves for Karen Roach when Karen Roach is unavailable. I'm sorry, I don't have her full title.

So for the time being would she be the Acting Southern Zonal Manager?-- I assume the fact it was addressed to both Tracey - Acting, Tracey, and Karen being the zonal manager, she would have been acting at that time.

COMMISSIONER: Mr Andrews, I see it is 1 o'clock. Is that a convenient time for you?

MR ANDREWS: It is.

COMMISSIONER: Doctor, we might take the lunch break now. Are we hard pressed for time today? Should we have a short lunch or a regular one?

MR ANDREWS: A regular one, thank you, Commissioner. There may be some troubles filling Friday and so I'm not urging speed today.

COMMISSIONER: You will have to speak to the Premier because he's made it clear that we have to finish on time. All right. We'll adjourn till 2.15.

Before we do that, a matter that I feel I should raise, I guess out of an abundance of caution rather than anything else, but with all the suggestions about apprehension of bias and the like, I want to say something about the lady who has been appointed as the new Director-General, head of the implementation team, Ushi Shrieber. It would be well understood by everyone here that this Commission of Inquiry under its Terms of Reference is administratively linked with the Premier's department in the sense that we deal with the Premier's department for our Terms and resources/needs. In that context I've met with Ms Shrieber on I think four occasions. I've had a number of telephone conversations with her, probably 10 or a dozen telephone conversations, and other communications. Generally that has related to infrastructure issues, planning resources for the Commission of Inquiry, particularly arrangements for our travel to Bundaberg and to

Townsville, and appointment of lawyers - a secondment of lawyers, I should say, from the Crown Law office, appointment of counsel assisting and matters of that nature.

I just mention that in case it causes anyone concern that I've had those dealings with Ms Shrieber. I think the two Deputies met with her on one occasion only and I doubt that either of them has had any ongoing involvement in those sort of dealings, which are fundamentally of an administrative nature, but I mention those matters in case they do cause concern to anyone. If anyone wants to raise anything about that, they're welcome to do so. Thank you, Mr Andrews. We will adjourn till 2.15.

THE COMMISSION ADJOURNED AT 1.03 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.24 P.M.

PETER DALTON COOK, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews.

MR ANDREWS: Commissioner, I regret that I've just discovered that my version of Dr Cook's submission which has my blueprint for his questions for the afternoon seems to have been borrowed from the table, I suspect by one of the inquiry staff for photocopying. But, in any event, it's not here, which means that the sense of organisation which I'd hoped to impart will be temporarily absent.

COMMISSIONER: I'm sure no-one will notice, Mr Andrews.

MR ANDREWS: Thank you, Commissioner. Dr Cook, you had been speaking about the Mater and some of the problems that were concerned because the patient had been allotted an ICU bed that was not funded. Perhaps you could tell us: are the Mater health services different to those of Queensland Health?-- Yes. Mater - Mater is a private company which contracts with Queensland Health for the provision of health services for some of the campus. It is a collocated private and public hospital, perhaps one of the oldest in Australia, and a component of the Mater's work is done on a contract basis with Queensland Health, similar to the types of contracts that other hospitals, and including, I would imagine, Bundaberg, would operate under and similar conditions. So a certain amount of activity, a certain patient throughput for a certain amount of money. As a component of that there are some intensive care beds which are provided to Queensland Health. If the Mater exceeds its - the amount of money it spends on Queensland Health public patients, it isn't topped up. So the Mater is very careful at the end of every financial year to make sure that the activity is what Queensland Health had quoted for and also that the activity doesn't exceed that amount, because it - that is care that the Mater would have to fund out of their own pockets.

COMMISSIONER: Doctor, am I right in thinking it is the only privately operated public hospital in the state?-- I think that may have been the case in the past but I think - I think you'll find, Commissioner, that there are at least some others. Robina was for a while before - my understanding is Robina was before it closed and I think Noosa Hospital is an example of a private hospital which has a contract arrangement with Queensland Health. There may be others.

Right?-- But the Mater is a not-for-profit company and solely owned by the Sisters of Mercy, and the whole point of the Mater Hospital is to provide care for people who are unable to fund their care. So we provide charity care to people from the South Pacific who may need major ENT and facial and

plastic surgery and also health care for people who are asylum seekers who are not covered by Medicare. So what we have to do is run a business to get sufficient money to provide money for those services.

But the functions you just referred to, they're really part of the private hospital because that's not funded by the state government?-- Oh, well, it's part of Mater Health Services.

Yes?-- And in reality, Commissioner, the Mater makes no money from the treatment-----

Yes?-- -----of public patients and, in fact, usually loses money on the care of public patients. But money is made from the car parking and the coffee shops and a small amount from the private hospital and the pharmacy, which we can use for - for those sorts of purposes.

Yes.

MR ANDREWS: Doctor, the experience that you had in New South Wales working in hospitals where VMOs were numerous, can you tell us, does that experience lead you to make some recommendations?-- Absolutely. A large part of what we've been talking about is tied up with the difficulty in staffing Queensland regional hospitals. It's not easy to staff country hospitals in general, however, Queensland seems to have a - an extreme difficulty which doesn't seem to be mirrored in other states. When we talk about provincial centres, so major centres which perform significant volumes of surgery, the places to look for comparison are really the east coast states - Queensland, New South Wales, Victoria, to a small extent Tasmania. When you look at South Australia, Western Australia and the Northern Territory, they predominantly have one major centre which has all the facilities. When you look at a comparison between Queensland and New South Wales, which is where most of my experience is, New South Wales has much less difficulty staffing regional centres and that, in my view, largely goes to the way specialist medical staff are treated and the conditions under which they're employed.

COMMISSIONER: In New South Wales, it's almost exclusively on a visiting basis though, isn't it?-- In the major centres, with major teaching hospitals and research facilities, those centres would have staff specialists.

Yes?-- The New South Wales staff specialists award when I left had no provision for payment for after-hours and the expectation is if you're a staff specialist in New South Wales, it would be not a frequent occurrence that you would have to return to the hospital after hours because you would have junior staff of the seniority that could provide most of that care with some telephone advice. So that's the major centres which, to be frank, are mainly just centred in Sydney and Newcastle. The remainder of the centres are procedural centres, centres where the specialist medical staff have to do a lot of the work both in hours and after hours and those people are employed on a VMO basis, and the VMO payment that

they receive reflects their costs of practice. So, for instance, you know, it would be one and a half times the hourly rate of a VMO in Queensland but that reflects the fact they have rooms, pay indemnity, pay for staff and a whole variety of things like that. So it's a far more attractive way to practise and, in fact, many of the people who practise in Lismore come from Queensland.

I am aware of a report done by one of the universities in New South Wales regarding the economics of that situation which arrives at the conclusion that it's more attractive for the VMOs but it's also cheaper for the hospital system?-- I don't think you - I was just doing some of the maths on that and I think that's the answer that you can easily come to. If you take a staff specialist - you know, if you look at the ad, they say a package up to the value of 200, 250,000. Let's say 250,000. Assume that person is going to have nine weeks' leave, which accommodates annual leave and study leave, so they're going to be available for 43 weeks of the year, assume that the entire time in the hospital is for patient care, which it won't be but assuming that it was - it would be normally 50 per cent for a director and 75 per cent for someone who is not a director - but assuming it was all for patient care, so you multiply 40-hour week by 43 weeks per year, divide that into $250,000 and you come back with an hourly rate, which is - I haven't got the figure in front of me but I did the calculations within the last day or two. It's around $140 an hour. So, you know, a staff specialist is not a cheap way of employing a doctor under these circumstances.

And that's without even taking into account the on-costs for the staff specialist's long service and superannuation?-- Well, the package would normally include all of those things.

Right?-- But it is fair to say the other side of that is that the staff specialist would be a far more predictable - in a purely budgetary sense.

Yes?-- It would be a far more predictable amount to pay every year versus a VMO, where if the hospital is busy and you're operating all night, the VMO costs could exceed what you would expect. And so, on a budgetary - you know, when it comes to calculating out a budget, it is far easier for a staff specialist than it would be under the VMO system.

Right.

D COMMISSIONER EDWARDS: And the VMO and the staff specialist share the after-hours call?-- That's correct. It doesn't have to be an either or, and it may be - and certainly now in Lismore, following on from the indemnity crisis, some of the older VMOs elected to go and become staff specialists just so that they wouldn't have to keep the higher rate of premium paid for indemnity.

Insurance?-- Plus the tail and - and so the hospital works on a mixture and that - all people in that group, you know, are

happy with that as an arrangement.

And just for completeness, as I understand it, it not only applies to the Mater public agency of the hospital but also the Mater Mothers Public Hospital?-- Correct. Mater Mothers and Mater Children's.

And Mater Children's?-- Yes, that's correct, thank you. Mater Children's has a separate, private component.

Yes?-- But - and, you know, clearly I have no role in the Mater Children's.

No?-- But in the Mater Mothers, we take the sicker mothers and look after them in intensive care, so I do have an idea. But you need to remember about half the deliveries at Mater Mothers are private and half are public.

Thank you.

MR ANDREWS: Doctor, when you first went to Lismore was the attractiveness or the attraction of Lismore something to do with the conditions that you could obtain in New South Wales as opposed to those then available in Queensland?-- Oh, quite clearly, yes, without a doubt. And my older brother is an anaesthetist. He moved to Lismore - to be honest, I could see no career as a staff specialist in a Queensland hospital when I came out of my training in 1991 and I was pondering whether my future was in the United States and my brother contacted me from Lismore and indicated that it was a good place to practise and he was right and I went to Lismore and practised for eight years and returned to Brisbane because my kids went to high school.

So your return has been simply for the purposes of your children's education?-- I'm very happy at the Mater. I'm not employed by Queensland Health, and under those circumstances, the reality is we are back in Brisbane because of the opportunities for our children.

You've raised two points in the last minute or so. One of them was that you didn't see a career for yourself in Queensland as a staff specialist. Can you expand on that?-- Okay. Intensive care is a 24-hour service. It depends on adequate staffing to maintain a sustainable lifestyle. Queensland Health has a propensity to want to employ staff specialists. They are difficult to recruit for a variety of reasons and there are times when the staff specialists that are left have to work ridiculously long hours, and there was a time in Lismore we could see that Princess Alexandra Hospital, you know, maybe three or four times the size of Lismore Base, had roughly the same intensive care staffing as Lismore Base and, you know, that was - in my view that was unsustainable for the people there. I could give you a whole variety of other examples where because of difficulty with recruitment a large department becomes a small department with a small group of people still trying to provide continuous service at tremendous cost to themselves.

Now, some witnesses have opined that a satisfactory system is one where there is a mix of staff specialists with VMOs. I gather that if you didn't see a career for yourself in Queensland as a staff specialist, you were assuming that the work that fell to the staff specialist in Queensland would not be shared with VMOs?-- This was - we need to go back a way.

I suppose there aren't VMO intensivists, are there?-- Not many. There are some. But we need to recall that the decision the people make about their career paths is made towards the end of their specialist training and normally they embark on a career path and, to be frank, stick with it. If you work in intensive care or anaesthesia you may be more mobile than in other disciplines, but if I had been a surgeon and I had gone to Lismore, I would have had ongoing commitments to patients in the area that would have made it far more difficult for me to return to Brisbane. So, really, if we're going to recruit for Queensland Health hospitals, the focus has to be on people in specialists training, particularly those approaching the end of their specialist training. In 1991 the award in Queensland was very unfavourable and there were a number of crisis throughout the '90s in relation to staffing of Queensland hospitals. I feel I have been very fortunate in the career path that I have embarked upon and I have my brother to thank for that.

COMMISSIONER: Doctor, when you say unfavourable, are you talking about the direct terms and conditions of employment, the salary and other benefits, or are you talking more about the working environment?-- I think it's those two things plus the number of people who would be there to do the work. So could I just give one brief example. The Rockhampton Base department of Anaesthesia is a hospital and department that I know quite well. They have an establishment of five anaesthetists and they were covering anaesthesia, intensive care and the emergency department, and I realise that there are some issues in relation to some of those areas that are of interest to the Commission. I don't raise it because of that but it is just because it is something I know. It got to the stage where the department had two anaesthetists, one of whom was a deemed - my understanding was a deemed specialist who was in her 60s, and they were trying to provide a continuous service with, I think, a small input from some of the local VMOs but very little both in-hours and out-of-hours. And the specialists that were left were left because they had no options to go elsewhere and they had to try and provide the service. They raised concerns about that in terms of sustainability, patient safety, after which one of those interviews the suggestion arose that they would have more luck advertising for another Director of Anaesthesia. And so, the person who was the Director of Anaesthesia stood aside and they advertised for a subsequent Director of Anaesthesia. You know, it's mind blowing the naivety of it because anyone who applies for the job will contact the people who work there at the hospital, will get an idea of the lie of the land and will not be interested in going to a hospital like that, and I can speak with authority about Rockhampton Base because in the

last two months I have spent 11 days working up there trying to help them with their ICU.

And that's also been mentioned to us, the trouble recruiting for ICU at Rockhampton?-- Okay.

Can I run past you something. You may have been here when I mentioned this to Dr Nankivell earlier. One of the models that's been drawn to our attention is the model adopted in some regional hospitals in Victoria where instead of offering a staff position with a salary package of, say, 200,000, they'll offer a position with a salary package of 120,000 for three days a week with the option of doing two days a week in the private sector. Is that the sort of package that is going to be more attractive to get the target group you're speaking about, the recent graduates from in the college system?-- Commissioner, it's very complex. The problem with that type of arrangement is if you need to pay for your indemnity, you will only be exercising or gaining the income to pay that premium on two days of the week.

Yes?-- So that's the first problem. The second problem is, as part of that, and this is talking about surgeons and everybody not just anaesthetists or intensive care specialists, but if you need to run rooms, then it is unlikely that you're going to be running rooms effectively if you're only working out of the rooms for two days a week. So although there is some appeal in that approach, I think there are some obstacles that need to be addressed. And one thing I would put forward as perhaps a separate approach would be what works in New South Wales in the bigger centres and what they say is, "Well, look, you're a staff specialist here. We want 40 hours out of you, if you don't mind, per week. We want you to work a 10-hour day and you can do those 40 hours in five" - "in four days. The fifth day, you can come to work if you like but you can save up that", and so you get about 10 weeks a year I think, from memory, which you can use for activities outside the hospital. And what most - well, what some people do in New South Wales with those 10 weeks per year as - you know, they're getting their wage as a full-time staff specialist, living in Sydney and trying to pay off a Sydney mortgage, is they're flying all over the country to provide locum services to regional centres. Two weeks ago the intensive care specialist at Rockhampton Base came from Prince of Wales in Sydney and she was working I assume under those types of circumstances. And I think a lot of the problems in intensive care at Rockhampton have improved dramatically just over the last six months largely because they've been able to get conditions of service which are attractive to people who work in Sydney. And you could imagine that there are large number of staff specialists and they're interested in gaining extra income, they're prepared to travel, some are prepared to travel to do that and that's a system that worked well and that's a system that worked well while I was in Lismore. I had colleagues come and go and the gaps were filled with people on that sort of basis.

D COMMISSIONER VIDER: And that's a system with much more

flexibility in it?-- Oh, absolutely. Absolutely. To be frank, there would need to be an attitude change from Queensland Health's perspective if this was going to be implemented within Queensland because it is fair to say that a speciality doesn't sit very well with a 8 till 5 or, you know, 9 to 6 employment; there's a significant amount of after-hours. And in terms of safe hours, in terms of sustaining a lifestyle, it doesn't fit in neatly with a - you know, clocking in and clocking off - clocking out. There's a suspicion on Queensland Health's perspective, there has been in the past, and perhaps some of this has even been touched on in the inquiry, that you should be sitting at your - you know, in the hospital to work, and there needs to be some flexibility shown there. And what in my view as a staff specialist - and I don't want to go to Rockhampton to be honest; I'd prefer to spend time with my family. But in my view, what we need is to have a flexible approach where people are prepared to work in the country and get rewarded for it, get rewarded at rates greater than they do at major teaching hospitals in the city and people in the city get rewarded from going to the country for periods of time to help out with relief staffing. I'll just give you a brief look at the differences of practice in a capital city versus a place like Rockhampton, where Rockhampton you would be on with someone who is very, very junior and is unable to do anything whereas it depends who I'm on with at the Mater but it may be a senior registrar who is a couple of months off finishing their training. And so, if a patient needs an intervention done in Rockhampton when I'm working up there, then I have to jump out of bed and go in and do it myself whereas if I'm on at that Mater and our Registrar, who is very, very good, is on and he'll ring me and say, "This is what we've got. I think we should do this. What do you think?" and I'll say, "That's fantastic", hang up the phone and go back to sleep. They're different jobs. If you try to pay them the same amount, even with, you know, an allowance for coming in after hours, it's far less attractive working in those circumstances.

MR ANDREWS: Would that mean that it would always be an advantage, whatever your speciality, if the hospital in which you worked was an accredited training hospital for persons seeking to join that speciality-----?-- Oh-----

-----because you'd have reliable registrars or PHOs to whom you could delegate tasks to allow you to sleep?-- Oh, there are six or seven reasons why we should be moving towards having all - you know, all major hospitals as accredited training facilities. And this - this leads on to the fact that I think it's appropriate to identify hospitals that are significant centres for their drainage population and really put the resources into there to get these to this sort of level. But, you know, it is not just a matter of having registrars. Registrars come with a cost. The cost is training and supervision, but that training is not only for the registrars; it's also for the consultants. It improves the standard of practice in the hospital. If you have someone beside you who knows quite a bit about your speciality, who's actively studying your speciality and looks at something you

do and say, "Well, why do you do that?" and, even better, you know they were working a month ago at Royal Brisbane or PA or Mater and they said - you know, a delicate situation admittedly - "Down at the Mater what they were doing in this situation is something like this", and the consultant, who would practise in that regional centre for many years, would turn around and say, "That's really interesting. We'll try that. Let's see how that goes." So it works both ways.

COMMISSIONER: Or they've read the most recent papers or - there's an exchange of information. It's not all one way?-- Yes, absolutely, and it makes it a far more attractive and interesting hospital to work at.

D COMMISSIONER EDWARDS: And money is not necessarily the only matter in those considerations?-- Oh, no, not at all. You need to understand that a registrar is tremendous value in the hospital, because to replace a registrar with someone who is non-training like a career medical officer in that same position, you have to pay one and a half times the wage, and the reason that you can get the registrar for cheaper is because there is a certain capital component for the doctor in occupying that registrar position and so they're keen to do the job, but the pay rates - and we have looked at this at Mater in a variety of scenarios - the pay rates are significantly more if you go for a career medical officer who is not part of the training program. So the potential is there to get a better doctor, a more skilled doctor, a more experienced doctor, and potentially not to cost as much.

COMMISSIONER: And there's also, I infer, an element of - depending on how you look at it - either prestige for the doctor or a sense of putting something back into the community of being involved in training registrars in their own area of specialisation?-- Absolutely, but I said before there were about six ways - and I guess they're just coming to me as we speak, but it's important not to forget that exposure to rural practice is the way many of the doctors who end up in regional centres go there, and so people go to a country centre - and my wife is here today, and I'm not going to embarrass her, but the reason I have an attachment with Rockhampton is she comes from Rockhampton and I met her when I was up there as a medical student - and that's to be highly recommended, you know, those types of rotations. I know they've developed over time, but the people you need to capture are the people who are the training registrars who are from half-way through their training through to the end of their training, and if you can interest them in coming to your area, then a lot of the staffing problems will be alleviated.

And I guess the one thing that is even more important than capturing people at that level is retaining them once you've got them to the rural area, and we've heard quite devastating evidence about how Bundaberg built up to an extraordinarily high level of competence in their surgical department in the late nineties and early years of this decade, and all of that was lost. They lost their accreditation for teaching because for a variety of reasons they just couldn't keep the talented surgeons who were there?-- We've heard a little bit about political correctness this morning when I was sitting in the audience, but what I'm about to say is not politically correct either, but I need to prefix it by saying I'm a city based staff specialist. If you have a rural based specialist then - and I'm talking of having not a deemed specialist, but someone who has actually gone through the mill and got their ticket - then they are precious. They are precious. And they need to be looked after, and there has not been that view, in my

perception, from within Queensland Health. There's not been an appreciation of how important those people are. It's not a widget factory we run, you know, we're not part of a production line. It's far more like Qantas, and there are some people who work for Qantas who are crucial, and they're the guys that fly - and the girls who fly the planes, and you won't be able to run an airline if you ignore what they say. And we need to - particularly for that group, we need to reinstate them to a level of influence that is appropriate for their position.

When you say "a level of influence", you mean also in administration, not that - not in the sense of having a highly qualified medical specialist - whether that person is a surgeon or an obstetrician - doing the job of the District Manager, but at least having that person in a position where they're consulted and have input on major decisions?-- Correct. They need to know the District Manager. They need to be getting together with the District Manager on a regular basis, and they need to be able to voice their concerns about the current service provision, and those concerns have to be listened to and addressed, either fixed or feedback to say, "It can't be fixed, and these are the reasons."

Doctor, one of the suggestions that's been put to us is that until some time ago - a decade or more ago - it was a common career path for a very competent specialist - more often than not a surgeon - to become medical superintendent at a regional hospital and then be in the position of being an administrator part-time and a surgeon part-time. It's been put to us that that's really no longer practical, that the level of red tape necessary to run a hospital makes it impossible to have someone doing the job part-time and to have someone who isn't trained and experienced as an administrator running the medical side of a hospital. But at the same time, it's suggested that whilst it's essential to have the modern style Director of Medical Services, alongside that there should be some position - whether it's called the Chief of Staff, the Superintendent or the Chairman or whatever - that creates a top clinician in the hospital, someone who is at a level equivalent to or higher than the Director of Medical Services, who is a role model for the practising clinicians within the hospital, and who is an ultimate point of reference if there's a dispute or a disagreement or an issue of contention about medical issues?-- The actual form - where the boxes are and where the lines go is difficult to draw, but it's really an attitude. It's an attitude where, if you are an administrator of a hospital, to be frank, I don't think it matters whether you're a doctor, a nurse or an accountant, which are broadly the groups that do it, but you need to have respect for the other two groups, from whichever one you are in, and you need to foster the cooperation of those groups, and in my experience - and you need to foster that cooperation as equals. I can tell you in my own personal situation at Mater, I have a doctor CEO, I have a doctor in charge of the public side of things - she replaced someone who my understanding was had a nursing background in that position - and the person who is in charge of the private side has come over from Mayne

Health, but he started off in Mayne Logistics. But he is around the wards, he knows who everybody is - including the people in the coffee shop - by name, and he is there saying, you know, "Is there anything going on? Is there a problem here", and he's also banging on peoples doors saying, "Look, I don't understand what the implications of all this are. What do you think?"

I suppose one of the things that the Patel situation has highlighted is that once Patel became Director of Surgery at Bundaberg Hospital, he was really at the apex of the decision making from a purely medical viewpoint. In an administrative sense there was above him, for example, Dr Keating as Director of Medical Services, and above him Mr Leck as Regional Manager and so on, but none of them was really in a position to act as a Court of Appeal from Dr Patel's medical judgments. I don't say this in any sense as criticism of either gentleman. That wasn't their job. Really what is needed, particularly in a situation like that where you've got an overseas trained doctor in the Director's position and so on, is to have a clinician who is in not just a figurehead position, but who is recognised as being the chief clinician within the hospital to whom, for example, a junior doctor or a nurse or someone else can say, "I've got a problem with what Dr Patel is doing here. Can I talk to you about it? Can we address it."?-- My personal view would be a good Director of Medical Services should fill that role, and that is their brief, you know, to be that point of referral. Not just to - it's a liaison position between department policy and health care on the ground, and that person should be able to see the problems that are stemming from the policy on both sides and be able to go over to the clinicians and say, "Look, I know this is a bit of a problem, but the way we're going to get around this is this way, and it will just take this amount of time", at the same time as going along to the administration and the upper echelon of the Health Department and saying, "Look, this is a major problem here and this needs to be fixed."

Mr Andrews?

WITNESS: Sorry, Commissioner, just to follow on from what you were saying, it is a very difficult situation - and I can feel for the problems that the clinical staff had in Bundaberg. I feel for the patients in Bundaberg as well, but I feel for the problems that the clinical staff of all persuasions had in Bundaberg because it was a very difficult situation, and it raised the issue of who has the final say of what should happen under a variety of circumstances. So if there is conflict in what should happen under a certain circumstance, how does that get sorted out. That's of relevance to intensive care, because every patient in our unit comes to us from another doctor - in fact comes to us usually from a senior doctor in another discipline, and usually they're complex cases, and there can be different ways that these things can be sorted out.

MR ANDREWS: Doctor, with respect to intensive care, if there is a difference of opinion as to the treatment of a person who

has passed from the theatre to the intensive care ward, is there an accepted practice in Queensland as to who is entitled to decide the treatment? The former surgeon or the current anaesthetist running the intensive care ward?-- That goes to the heart of the problem, and that's the difference between Bundaberg and Brisbane. Bundaberg has no intensive care specialist. Intensive care is a specialty that was developed into a formal separate specialty about 25 years ago. There are roughly 400 in the country, roughly 400 in - 40 in Queensland, three-quarters of whom work in the public sector. None work in Bundaberg. So in Bundaberg you had intensive care practised as it has been practised in England in the past and the United States in the past, but my understanding is both those countries are really moving towards a more Australian style where you have one doctor responsible for the patient while they're in intensive care, and the doctor who referred them to intensive care is still involved, still visits the patient and makes recommendations as to what should happen to the patient, but can't write up medication, can't write up IV fluids and - but this is all done in a collaborative sense, you know, so there's-----

There's a person with the ultimate responsibility in that situation, where there's an intensivist in the Intensive Care Unit - the person with the ultimate responsibility and the final say is the intensivist?-- Correct.

In a situation like Bundaberg's where you had not a specialist intensivist, but an anaesthetist who was the head clinician in the ICU, is there a Queensland practice as to who has the final say? That person or the surgeon who operated on the patient?-- The answer is no, and it is a very, very difficult situation. I've been to Bundaberg ICU and I met the anaesthetist who had control of the ICU up there-----

There's room for improvement in the system, isn't there, if a protocol is established?-- It's more complex even than that, because United States surgeons have significant exposure to intensive care as part of their training and so you could imagine a situation - I can't speak with authority on this, not having worked in the US - you can imagine a situation where there would be brisk discussion as to appropriate management of patients under those circumstances, and I guess what I would do under those circumstances is, you know, try to sort these things out with collaboration and discussion, and clearly that's step one. There's-----

Doctor - sorry, please proceed?-- Step 2 would be pulling rank, which is not possible in Bundaberg. If you're not an intensive care specialist you can't play that card, and - but pulling rank works on both sides, because if the surgeon says to someone - about someone in my unit that they need to go to theatre and have an operation, I don't have the authority - I don't have the background to say, "No, they don't", and then the third way is referral to the literature, which you can do online and - or there are ways of invoking a third umpire.

Doctor, there was another topic you raised, and that was a reason that you came back to Queensland - one of the reasons was that you could obtain employment at the Mater and not in Queensland Health. Was that truly a matter of significance for you?-- I don't think I'd work well in Queensland Health. I don't think I would have worked well in Queensland Health over the last four years.

Was it a matter of significance for you at the time of your return?-- Oh, absolutely.

What were the features of distinction that cause you to make that judgment?-- So in short, why did I not want to work for Queensland Health?

Yes, when you were prepared to work for the Mater on presumably a similar kind of pay structure?-- Yes. The Mater is - you know, it's a significant complex of seven hospitals combined, but in reality it's all on two campuses at South Brisbane and Redland. It has one CEO who I know and who I can ring. They are the kind of person - as all the administrators at Mater, if you present them with a difficult problem, a couple of alternate solutions, they will hear you out, and together will work on addressing the problem in the most sensible way.

And how does that contrast with what you anticipated to be the Queensland Health position?-- Well, I was a registrar in Queensland Health. I had looked at becoming a staff specialist in Queensland Health and - although this is in the early nineties - and had elected not to do that, and I still am now part of Queensland Health committees. So I meet with the other intensive care directors for the southern zone once a month, and so I have ongoing exposure to Queensland Health. My view is that - I could say a whole lot of things that you would have heard before. You know, they're not responsive, and shooting the messenger, you know-----

You mean the administration is not responsive when you have an example such as the one that you've just recently given? That is, where you confront the CEO with two alternatives, you'd anticipate that at the Mater you'd quickly have a resolution?-- Absolutely.

If you confronted your line manager in Queensland Health with two alternatives, do you accept that you might not receive a resolution?-- It would be difficult. There would be a lot of other considerations, and I think you've already heard evidence from people who work within Queensland Health. I guess I would point to the academic who put in a submission to this Inquiry from the Gold Coast about some of the difficulties he's had in making a transition from New South Wales to Queensland-----

It's your experience-----?-- -----and that doesn't surprise-----

It's your experience that I'm more concerned about?-- Well, I didn't work with Queensland Health because I anticipated that there would be those sort of problems.

And you talked of-----

COMMISSIONER: Mr Andrews, perhaps - accepting the force of what you say about not having worked at least recently within Queensland Health, can I ask you about what would be important to you if you were ever to consider a job at Queensland Health, and would one of the things be a responsive and transparent decision-making structure?-- Oh, absolutely. There would be a number of things. Adequate staffing, I would think. No-one should work a roster of less than one in four, which becomes one in three when someone goes on leave, whereas one in three becomes one in two, which is close to unsustainable, and it's more a matter, to be frank, of respect. In my own case, if I give an opinion as to what's appropriate, under certain circumstances my view is that that doesn't get the weight that it should.

MR ANDREWS: Do you mean in Queensland Health it doesn't-----?-- No.

-----but at the Mater-----?-- Absolutely.

-----by way of contrast, your opinion is treated with some respect?-- Yes.

D COMMISSIONER VIDER: One of the observations that I would make, partly from what you are saying and from what other witnesses have said to us, is that at the Mater you've said that you can go to the CEO and say whatever it is that is of concern to you, or it may be for additional resources or whatever. That's one step, if you like, that you have to move to make contact, get some resolution, whatever. So therefore the Mater has autonomy. In other places where intensivists may be employed, you would have to go through several layers in the bureaucracy, perhaps, before you could actually present your request to someone that is likely to be able to make a decision. That might take months?-- I'm familiar with some of that because - to say that I don't work for Queensland Health is perhaps not entirely accurate, because my time in Rockhampton over the last couple of months was working for Queensland Health on a contract basis. But - I could show you the paper trail, but the assistance that I ended up offering to - I ended up working in Queensland Health within the last two months - I think late May was the first time I went - I actually originally got in touch with Rockhampton to see if the Mater could help them with intensive care service provision in August '03.

MR ANDREWS: Do you mean you made the contact to make an offer of help?-- Yes.

COMMISSIONER: And it took 18 months or more to-----?-- Well, during all that 18 months, Commissioner, they had problems with their intensive care. There were a lot of

toing-and-froing as to exactly how they were going to address those problems, but it's difficult to help people if they are somewhat reluctance to accept the help. But I have - I've almost emptied my bag of files that I brought, but I do have an e-mail that I sent to Rockhampton and Bundaberg in August '03, preceding a visit that I did to both those hospitals, to inquire as to whether we could help, and in the end I suggested the conditions that Rockhampton would have to offer for assistance with staffing of their intensive care at Christmas. Nothing happened - these are now round figures - it was Christmas that I told them what they had to do, and it was about April or May that one of the senior medical staff started pushing for this. It was late May I was supposed to go up and do the first four-day weekend up there. I wanted to do the first one just to ensure that everything went smoothly because I had concerns, and it was - I left home 24 hours before I had to catch the plane to Rockhampton to go to work at the Mater, and I needed a piece of paper in relation to indemnity from Rockhampton that I couldn't get, and the District Manager wasn't prepared to sign, despite the fact that the Director of Medical Services had already signed a similar piece of paper, and it had to go to Brisbane and I had to ring John Scott and eventually we got it all sorted out.

Doctor, is the answer to some of these problems - I don't mean the complete answer, but at least a partial answer - to give regional hospitals a level of autonomy which in some ways is similar to that of the Mater? I mean, the Mater, in dealing with public patients, obviously can't fix its own budget. It's got a limit to the money it can spend and so on, but within those sort of overall constraints, decision making is within the hospital structure. Would Rockhampton, for example, be a better place if the decision making was taking place on the ground rather than in Brisbane?-- Okay. I guess in short the answer to your question is yes, but with some qualifications. First of all, I don't think you should look at Rockhampton. I think you should look at an area, and the area should reflect the funding - sorry, the drainage of patients in that area.

Yes?-- So the current system has a hospital here and a hospital there and a hospital over there, and that's not the way we need to plan the system. What we should be doing is having an area with a senior executive responsible for that area, with the budget for that area in terms of health care and living in the area, and therefore you need to go to that person to make your argument as to what should happen, and this has enormous advantages. I've spoken a lot about New South Wales, and I guess that's just because that's what I know, and there may be other systems that work well elsewhere, but as part of my submission there was a three page summary on the Resource Distribution Formula, and if you're happy, I would like to just briefly touch upon the issues that come from there, because what they've done-----

I don't want to discourage you, but we've read what you put in writing, and I think it speaks for itself?-- Okay. We can leave it at that, but what they've done is funded the area with a senior executive in the area to make decisions about what happens within that area. They not only have to pay for care locally, but they have to pay for care for their patients when their patients get looked after externally. If they send someone to Brisbane, they pay for their care in Brisbane.

D COMMISSIONER VIDER: Just further to that, if you look at an area then and the number of hospitals that may be in that area, it would be very helpful, no doubt, if you therefore had a clear delineation of the role and the level of service that each hospital in the area could provide. And that would also, no doubt, address the blurring of professional boundaries where you get two physicians or two medical officers being unsure of who owns the patient. For example, where you don't have intensivists and you have got an intensive care that's functioning, role delineation could certainly help define some of the services and the nature and level of work that goes on in a particular hospital?-- Certainly. I think that has a lot of merit. In Central Queensland, that executive would not only be responsible for inpatient and outpatient care - and I think that's important in their area of referral - but they would have responsibility for Rockhampton and Gladstone, so you can figure out what Gladstone needs and potentially even supply it with, you know, some people who may work part-time at Rockhampton, part-time Gladstone.

We have also heard evidence there is a need to create networks?-- Correct.

So that, you know, in a particular area you know who your major tertiary referring hospital is, but more importantly they have an expectation that they will receive patients from that area and it is not always then playing around with beds?-- Correct.

D COMMISSIONER EDWARDS: Doctor, could I also ask you in some of the private discussion - not private, so much, that we had at Bundaberg with medical staff, they indicated that a lot of the reasons they had been given for failure to get quick decisions or decisions in a reasonable time is because the processes of the Health Department, and similarly to the hospital, were so complicated, difficult, and they were continually advised if they didn't follow the procedures, there was a risk that the CMC could be advised that there was a flaw in that process and it could have been referred, and not probably - not necessarily followed up. Are you aware of that kind of culture between Queensland Health that therefore makes the representatives of the health system very careful, delaying decision-making and not even making decisions?-- Certainly I am aware of delaying decisions. To be honest, I am not sure if it is fear of issues like the CMC or if it is that junior people are appointed to fairly senior administrative positions at some of these hospitals, and so therefore a reluctance to make decisions without referral centrally, to say, "Look, is this all right?" And what we need is someone on an appropriate package to attract someone who can then have the authority to plan health delivery for that region, and if you are doing it in terms of referral patterns, you should be able to provide services for everyone in the region as appropriate.

COMMISSIONER: If you will excuse me a moment, doctor. Mr Andrews, are we still expecting Dr Fitzgerald this afternoon?

MR ANDREWS: No, no longer, Commissioner.

COMMISSIONER: I was concerned we might keep him waiting.

MR ANDREWS: Doctor, you spoke of your perception that in Queensland Health there was a shoot-the-messenger culture. Was that a perception that you have in 2005 or one that you had in 2001 when you chose to return to the Mater?-- Both.

Thank you.

COMMISSIONER: What's the source of that perception?-- I meet - as I said before, I meet regularly with other Directors of Intensive Care in the Southern Zone. I am concerned that issues of importance are not raised at the meeting because of concern about people's career. You know, if you are committed to Queensland - if you are employed by Queensland Health, then there are - it is possible to see that there are people who have spoken up and no longer work for Queensland Health, perhaps is the most benign way of describing it, and I think some of the people who work for Queensland Health are conscious of that.

MR ANDREWS: Thank you. So they are the two - the only two differences, the dysfunctional decision-making process by line managers and the sense of shoot-the-messenger culture for those who have criticisms of the system.

COMMISSIONER: And the doctor also mentioned staff shortages, which, of course, make things unattractive.

MR ANDREWS: Yes, indeed?-- I guess support services. You know, the fact that if you work in a Queensland Health hospital, something may not be available, and if you think it should be available then it can be a struggle to achieve that. And that could be anything from a sound wave test on the heart to reporting on X-rays.

COMMISSIONER: I must say, doctor, listening not just to your evidence but to evidence of a number of other doctors we've heard from, including some who preceded you this week, if I were in that position, the thing that I would find most frustrating is that I just wouldn't be able to provide the services that I want to be able to provide to the patients. All of the other things you talk about are factors that bear on that, but that's the ultimate point, that there is no patient focus in any of this decision-making?-- That's a fair comment.

MR ANDREWS: You have another point of comparison, and that's to do with the system within Queensland public hospitals of rewarding for weighted separations. Can you explain what that process is-----?-- Okay.

-----and why you regard it as unsatisfactory? It does seem, if I understand it correctly, to be at least superficially rational that if a procedure has a significant level of

complexity, that more money might be allotted to a hospital that deals with so many complex procedures?-- Mmm. I will go through it quickly but as simply as I can. And this is my understanding, and, you know, anyone would be welcome to contradict me if they view it otherwise. Hospitals are assigned a budget. The budget is conditional on reaching a certain amount of activity. So you need patients times complexity. So you can do a whole lot of cataract operations or hernia repairs, or you can do a few oesophagectomies to reach the target that you need to get to. If you fail to reach the target, some of your budget is taken away from you. So the problem with that - as a system, this is a great way of ensuring that the hospital doesn't take its budget and then just not do any work or not do as much work as perhaps it could. There is always an emphasis on turnover, which is important, but the problem with that equation is that there is no eye on quality. So if an issue is raised in relation to an issue of quality, then the people who need to look at that closely, in my view, have a conflict of interest under that system. They have a conflict of interest because they are the guarantors of adequate quality - you know, they have oversight of what happens in the hospital, whether they be the District Manager or the Director of Medical Services. But if they restrict the scope of practice in their hospital, then they may not get as much activity as they would otherwise. If they don't reach their goal in terms of budget, then money is taken off the hospital. So the very people who have the role in supervision are risking problems in other areas if activity decreases.

COMMISSIONER: In your written statement, in the last paragraph on page 2, you put it in terms of "Queensland Health hospitals being penalised in a budgetary sense if sufficient surgery is not achieved." Based on the evidence we have heard from other witnesses, though, it has struck me that it is worse than that. Hospitals are rewarded for doing complex surgery, including surgery that is beyond their level of competence?-- Basic - basic underpinning of the system is a budget and a goal. You get your goal, you get your budget. There are some augmentation programs which exist which mean you can get more money if you do more activity, depending on what health department policy is at that time.

Yes?-- But the basic problem is the emphasis was on activity with no eye to quality.

Well, the reward for doing the procedure rather than achieving the outcome?-- Correct.

D COMMISSIONER VIDER: And it is fundamentally based on a business model, not a patient-centred model, because it is highly selective in the patient classification. What happens to the 86 year old patient with pneumonia?-- Yeah, quite clearly.

COMMISSIONER: I wonder, doctor, you are referring us to the New South Wales regional system where a regional hospital for a particular catchment area bears the cost of referring a

patient to a tertiary hospital if necessary. In a sense, that's the same problem, isn't it, because that region's budget is going to be penalised if they don't attempt the surgery themselves?-- But they don't have the outgoings that they would have to - for providing the surgery. But if you understand, they wouldn't have to provide the operating theatre, the anaesthetist, the surgeon, the post-operative intensive care bed, the ICU nurse 24 hours a day. So all of that expense wouldn't be expended locally if they did that. And what it tries to do is encourage the regions to look at services and see if they can come up with business models and, you know, clinical models where it makes sense to develop the services locally. So if they look and they see they are transferring a lot of neurosurgical patients to Brisbane, then the question is if they sent all the neurosurgical care at one hospital, whether that hospital could justify having a neurosurgeon. So it gives them a way of comparing what the options are. And, you know, even taking into account the family dislocation associated with transfer to Brisbane, it may be that it is better for the area, if that continues to happen, or alternatively it may be that it's more efficient to have a local neurosurgeon who can provide that care, and if that person is working in the public and private sector locally, then that may be an attractive job. And if I could just say one more thing, in these areas historically they have tried to run two separate systems - one private, one public - and that makes, it a very unattractive system for people coming out of their specialist training, when other States don't try to do that. They have a blended system where you can go to a provincial town and work in both sectors.

MR ANDREWS: You have had a concern, doctor, about the complexity of general surgery performed at the Hervey Bay hospital also and that arose out of a Whipples procedure patient surveyor who came to the Mater in March. You alerted-----

COMMISSIONER: Mr Andrews, just since you have come to that, it is on page 3 of the statement. The patient name is mentioned there. Perhaps we can refer to that patient as Ms G.

MR ANDREWS: Thank you, Commissioner, yes.

COMMISSIONER: Obviously, Hervey Bay is a little out of our direct area of interest, save to the extent that it is, as it were, similar facts of a problem that's not isolated to Bundaberg that exists in other parts of the State. Given it is not within our direct area of relevance, my inclination was to allow what the doctor has said about that in his written statement to stand as it is, without teasing out any further oral testimony about those issues. Unless, of course, Mr Andrews, or for that matter Dr Cook, there is anything particularly you want to bring to our attention?-- I guess, Commissioner, the point I was making about the Hervey Bay case - and I have to say there are - these are two letters I have written in four years about two separate cases. I don't make a habit of this. I am worried that doctors who work in the

country may never send another patient to the Mater again if they view this as a regular occurrence. The - in relation to the recommendations that the Commission has to come forward with, mechanisms of receiving, processing, investigating and resolving complaints about clinical practice and procedures of Queensland Health hospitals", and I think the importance of the Hervey Bay case is the different way I handled it and the prompt resolution that happened as a result.

MR ANDREWS: You did write directly to the Central Zone Zonal Manager, Mr Bergin, rather than writing through the Southern Zone in the anticipation that the news would pass to the central zone?-- Yes. As you are aware from the CV, I am in the military as a reservist, and I am aware of chain of command issues, but there are times when you need to go outside the chain of command, and I guess normally what I would do is go through the chain of command as it relates to Queensland Health first. But having been aware of the events in Bundaberg and that very little had happened following my first letter, I wanted to be sure that the message got through in relation to this.

What made you believe that very little had happened following your first letter? Did you find another oesophagectomy patient at the Mater?-- Well, this is 2005 and I think by that stage issues had been raised in Parliament.

25th of March 2005 was when Ms G was transferred to the Mater. You-----?-- The letter was written on the 20th of April to Dan Bergin.

Yes, and you had immediate - an immediate positive response from the Central Zonal Manager that there would be no further surgery of this complexity at the Hervey Bay Hospital?-- That's correct. I need to say that I haven't visited Hervey Bay Hospital. All I know is it has four intensive care beds, two of which are ventilated capable. So can look after patients with complications from complex surgery. And, once again, this is an operation with a close association between frequency of performing the procedure and outcome.

COMMISSIONER: Mr Andrews, we might take a short afternoon break, if that's a convenient point.

MR ANDREWS: Very convenient.

THE COMMISSION ADJOURNED AT 3.31 P.M.

THE COMMISSION RESUMED AT 3.56 P.M.

PETER DALTON COOK, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews?

MR ANDREWS: Doctor, at page 4 of your submission you speak of systems of accountability and I see that peer review is something you regard as one of three systems of accountability that's significant and in your view the most important of the three. You then discuss the outcome data, and at the bottom of the page 4 you make an observation which I would like you to clarify. You talk about "valid and accurate data needing to be compared to the private health unit of Queensland Health that carries out", et cetera. What is it about the Queensland Health data that's worthy of comparison?-- Okay, I use that as an example. Going through the transcripts, I could think of better examples from what has already been heard at the Commission on the same point.

COMMISSIONER: Yes?-- Just - before I could say anything about what happens after the event to follow up forms, which hasn't been ideal, I think it is always essential to say prevention is the most important thing here, and the prevention - the way these things are prevented in Australia is by having very difficult and onerous training programs. So that in the world standing, Australian specialists are highly qualified when they come out of their training program. Added to that, in terms of prevention, is maintenance standards program, which certainly both colleges I am a member of insist upon to hopefully avoid the types of problems that I am referring to. In relation to outcome data, specifically with the private health unit of Queensland Health, there is some correspondence in my submission. I had concerns when I arrived in Brisbane that they were asking for raw outcome data, so the - essentially the percentage mortality that I have in my intensive care unit - and my percentage would be five per cent at Mater Private, and the State average for private hospitals would be 3 per cent, and I would get a nice letter from Queensland Health saying can I explain the difference. Well, it is silly. You know, I shouldn't have to explain the difference, for anyone who has thought about it, because it depends on what's wrong with the patient, how sick they are, and how sick they were before they got sick in other ways. And if you work at the Mater Private, which is a leading haematology oncology hospital, which particularly concentrates on leukemia, we know from examination of our data if you have leukemia and you are admitted to Mater Private intensive care, your chances of leaving hospital are one in two. And I can tell you the care is of good standard, but the problem is people with that diagnosis who get that sick are

not - are in a lot of trouble. Now, I have gone into the private health unit with the Executive Director of the Mater Private Hospital and explained all this to them. I have also forwarded to them the data that we collect, which is the AORTIC data, which stands for Australian Outcome Resource Tool for Intensive Care, which looks at the patient's diagnosis. It looks at how sick they were on admission to intensive care, and it looks at what underlying medical problems they had, and it can give you a probability of someone with that diagnosis surviving to leave hospital. So we collect that data. It is very onerous to collect and we employ a point 8 FTE person, full-time equivalent, to collect that data. And in relation to historical American controls, our results are excellent and I am very proud of them and more than happy to put them in the submission. However, I have explained that to Queensland Health and they say, "Well, we have to collect the data. It is the rules." I say, "Well, why don't you ask for this data?", and they say, "Well, we can't insist that everybody collects this data. We know it is difficult to collect." So every six months we have to give them information as to how many of our patients have died.

MR ANDREWS: And do you mean to say that that's the only - it is that raw mortality data that you are feeding to Queensland Health, and as far as you can see it is of almost no benefit?-- They appreciate it is of no benefit and they have indicated that to us, but they are more than happy - they have a legislative requirement, was their answer, to collect the data. But if I could just go a little further to point out that, you know, there was a quality coordinator - just from going through the transcripts, there was a quality coordinator at Bundaberg Hospital during the time of interest to the Commission, and there was problems with picking up that there were problems in the hospital despite data being collected. And I guess that is a much better example of relying on outcome data to ensure quality. Really, data is an important component of what we're talking about, but it is data that's collected appropriately and resourced. So you need - you know, it just can't be tacked on to the end of someone's busy day, the fact that they have to do this and it has to be interpreted carefully. And some of this is quite sensitive. And if it got out to the papers that the Mater mortality was slightly higher than the rest of Queensland's private ICUs, which is the data we're giving Queensland Health, then that could reflect badly on the Mater, but the reality is-----

It is because of the kinds of patients that you have in your ICU?-- Absolutely.

D COMMISSIONER VIDER: But collecting data is never a means of itself?-- No.

It has got to be a means to the end if you don't do something?-- The data needs to be reviewed by a group of people who understand what's going on, and to be frank, I think there is a significant role for a consumer advocate in that as well, and it has only been recent that AORTIC data has been shared from Queensland Health public ICUs with Queensland

Health itself.

COMMISSIONER: Really, though, doctor, what has to happen, as I look at it, is that there has to be a standard data collection and audit system throughout all the public hospitals. You can't continue to have each hospital decide for itself what software and what system it is going to use, and that has to be world best practice. You can't skimp on that sort of thing, because unless you have a full data retrieval system, you are never going to pick up the trends and patterns that will identify problems?-- Okay. I agree with that, Commissioner, but I also would go a step further to say that it needs to be interpreted with care.

Yes?-- And I think it needs to be interpreted with clinicians and I think it needs to be interpreted with clinicians also with consumer input.

Yes?-- And de-identify data only should be released. So at the level it is interpreted, you know, problems should be identified if any exist and they should be investigated. You must remember if there is a mean here, and you are here and that's the good side, well, that's great. But potentially half the units could be on the bad side of the mean and still within acceptable practice. So just because the figures may not be ideal, may not represent there is a problem that needs to be investigated further, and all this is very sensitive, and reading in the paper that there are problems being highlighted with data collection which may in fact not be real, tends to mean that everybody is somewhat reluctant to continue with the process, and there have been examples of that in Queensland.

Doctor, you have mentioned a couple of times the role of consumer advocate, and I read what you had to say under subheading C, "Complaints body". This is on page 5 of your submission. May I say that I accept entirely what you say about the undesirability of having complaints handled by an external body, some of the anecdotal statistics that we receive suggest that well over 90 per cent of complaints can be addressed satisfactorily if they were dealt with within the hospital rather than referred externally. My concern, though, is that when we're talking about complaints as such rather than just things like analysis of statistics, one of the difficulties that seems to have come through very loudly in the evidence is that when people make complaints they didn't know who was handling it, they didn't get the feedback, the process was not transparent, and my view is that there has to be a complaints handling system, and what I have suggested on a number of occasions is an authority - which for discussion purposes I will refer to as a health sector ombudsman, whose function is not to handle complaints in the sense of addressing them or attempting to resolve them but will simply receive complaints, ensure they are recorded, ensure they go to the appropriate body for resolution, which may well be the hospital itself or a - even a compartment of the hospital, Director of Surgery, or whoever it is, will say, "Let us know in 60 days what you have done in relation to the complaint.

If it is resolved we'll record that and notify the patient accordingly. And if it is not being properly addressed, we'll then escalate it to the appropriate body, be that the Medical Board, the Health Rights Commission, Queensland Health, the management of the hospital or whoever." So, as I say, whilst I take the force of your comments about the failure of the Health Rights Commission here in Queensland and similar bodies in other States, what would you say about the desirability of that sort of ombudsman's role?-- Could I suggest a description - just so that I understand this - it is possibly a clearing house-----

Clearing house?-- -----in a central repository that directs the complaint to the appropriate person, gets the feedback from the appropriate person and gives that feedback to the person making the complaint?

I guess that's a fair description. I see it as having three functions: (1) to receive and record complaints; (2) is to distribute them to the appropriate bodies; (3) is to follow up within a particular time-frame to ensure that the complaint has been properly dealt with and the complainant has been properly notified?-- I think that that has a lot of merit, and the analogy I would use is with clinical safety and quality unit at the Mater Hospital. The Mater - one of the issues in relation to the Mater is with medical indemnity, and the Mater - it has varied over time but my understanding it is not currently covered by the public indemnity, and that only covers a bit of the portfolio anyway. We do tertiary obstetrics, so very, very sick people having babies. So this is a minefield for potential litigation, and we have done a lot to beef up our clinical safety and quality unit, including employing a hospital-based lawyer. But the best part of the entire system, from a user's perspective, is that these people are devoted to the system. That is their job, the people who work in that unit. So if they are notified, they will continue to follow up the process and you can be guaranteed that there will be a result. It may not necessarily be the result that I think is appropriate. You know, it will be the best result for the organisation, but the follow-up of issues that are identified is not dependent on the individual clinician once it is notified to the clinical safety and quality unit.

I have to say, doctor, you have raised another issue that's of great interest to me and that relates to indemnity insurance. One view is that the reason Queensland Health has been able to get away with having people like Dr Patel is that it doesn't have indemnity insurers breathing down its neck, as no doubt you do at the Mater and other private hospitals do. It simply has the entire assets of the State of Queensland behind it to satisfy any professional indemnity claims that may arise. Do you find within the Mater that the relationship with your professional indemnity insurers in fact enhances accountability and responsiveness to complaints and that sort of thing?-- I think the short answer is yes. There was a period of time where it was proving difficult to get medical indemnity insurance for the Mater, and a variety of strategies

were introduced to address that, including a greater emphasis on risk management, and, in short, they have been successful, and the climate, in terms of medical negligence, has changed during that time as well.

Yes?-- But I think a lot of the change could be traced down to the emphasis that's placed on risk management.

MR ANDREWS: At the Mater do you in fact demonstrate to your indemnity insurer the risk management processes that you have in place with a view to negotiating reduced costs of insurance?-- That is my understanding, although you have to understand that this is somewhat removed from my clinical practice.

COMMISSIONER: Yes.

MR ANDREWS: At the bottom of page 3 of your submission you were making a point that "experienced clinicians can recognise practice which diverges from usual management." And that seems a simple proposition. But within the same paragraph you allude to Dr Aroney at the Prince Charles Hospital and Dr Blenkin in relation to the Hervey Bay Hospital. You don't make yourself clear. What is it about those two practitioners that you were trying to emphasise?-- Well, I have read the report of orthopaedic services at Hervey Bay Hospital. In my view - if you are interested in my view on that - you know, there was significant issues there that needed to be addressed. The orthopaedic surgeons who raised that found it difficult, and I think the same would apply to Dr Aroney, who I know has raised concerns with cardiology at Prince Charles and now no longer is in the employ of the Prince Charles Hospital.

Your proposition is that experienced practitioners should be given more respect when they have serious concerns to raise?-- Well, I think they need to be listened to and, you know, we were talking about Queensland Health handling of complaints, and, you know, shooting the messenger was one of the descriptions. So I guess there is a reluctance on behalf of people who work for Queensland Health to highlight, even in constructive terms, some of the problems that they may see when they see that things haven't gone smoothly for other people who have.

You make the point on page 6 that increasing the number of specialists within Queensland is not sufficient to solve the problems that are here. What solutions do you propose with respect to funding?-- Well, I guess this goes back to the model of funding. You know, we had - we have already discussed health funding in New South Wales and I think there is - there are models elsewhere in Australia that should be looked at for regional health funding. And I think that that type of change of structure to Queensland Health should be seriously entertained. I did have an interview with two people from the parallel running inquiry into Queensland Health, Forster committee, one of whom indicated that the resource distribution formula, a unit of Queensland Health,

had been looking at that for a period of 12 months and it was in a discussion with Mark Waters.

And you make an observation on page 7 comparing the public hospitals on each side of the Tweed and the staffing difficulties. Are you aware that there are difficulties at the Gold Coast Hospital?-- I am but I'm not an expert on it. My brother is an anaesthetist in private practice at the Gold Coast and he had previously worked at Tweed Heads. But I think it's worthwhile in that environment looking at a direct comparison of the two systems in terms of availability of staffing and throughput of the theatres, accepting that the Tweed is a much smaller hospital than Gold Coast, and any findings from that should be used to improve efficiency.

COMMISSIONER: Doctor, I think it's well-known, at least anecdotally, that there are doctors who live at the Gold Coast but are quite happy to work in the private system in Queensland, for example at the John Flynn Hospital, but won't work in the public system in Queensland and yet work as VMOs at Tweed Heads and even at Murwillumbah, and there would be numerous examples, I suspect, of doctors in that situation?-- Yes, yes. It is what I would do if I lived at the Gold Coast, Commissioner.

MR ANDREWS: Doctor, you appended D4, which was a newspaper article. I'll have it put up on the monitor and ask you which of the items within it are ones which are opinions that you hold. I've coloured them to distinguish one topic from the next?-- Mmm.

The first is that many specialists in Queensland leave the system discouraged and disappointed with practising medicine as employees of Queensland Health?-- I agree entirely.

The next is that there's good evidence that Queensland Health has actively tried to reduce the number of VMOs working in the public hospital system. Well, let me break that into two propositions. Is it your perception that the number of VMOs working in the public hospital system is reducing?-- I'm going back to Dr Molloy's testimony where he described, I think from memory, 250 VMOs in the Queensland Health system, which seems a surprisingly small number.

COMMISSIONER: I think that was 250 full-time equivalent VMOs?-- Oh, full-time equivalent, okay.

But that's my recollection?-- Even that is a surprisingly small number.

MR ANDREWS: Do you have anything that you can advise us of which would suggest that there's an active policy within Queensland Health to reduce number of VMOs working within the system?-- I've not seen a policy on that basis but I think the end result speaks volumes, and if you're an administrator, then a reasonable strategy is to reduce labour costs and-----

Well, if you're an administrator concerned not to exceed your budget?-- Correct.

The next item is that, "They're productive, working at much

the same pace as in a private hospital and that that creates unwelcome costs for administrators as patients are treated rather than deferred." That observation, is that an opinion that you hold yourself?-- That's deeply offensive to people who work in the public system but in my view it's true.

"The effect has been particularly severe in regional areas"-----

COMMISSIONER: Well, I'm sorry, Mr Andrews, I'd like to follow up because I suspect both of the points made by the doctor need elaboration. I don't read this article as saying that VMOs are more competent or better, they're better people, better doctors, than staff specialists. What I read it as saying is that, in effect, because of the routines and systems and so on that they're used to utilising in private hospitals, they can be more effective when they find themselves in a public hospital?-- I guess they're more attune to throughput of patients, and throughput of satisfied patients, and that has spin-offs for the efficiency of operating public hospitals.

I guess the offensiveness is if you read this as comparing a specialist, an Australian trained specialist with the same qualifications who's a VMO with one who's a staff specialist. Dr Nankivell was making the point that that's the wrong comparison. The comparison we should be making is a VMO such as in Bundaberg, the likes of a Dr Thiele or a Dr Anderson, as against the possibility of bringing in a staff specialist under an Area of Need system, and if that comparison is made, then the point is even more clearly correct I assume?-- The reality is that in the private sector there is an association between productivity and income.

Yes?-- And there is - that link for a staff specialist is not there.

And also a link between quality and income. If I can personalise this, I see specialists in the medical profession as being a bit like my own profession at the Bar. Barristers don't get briefed except by solicitors and solicitors don't brief the barrister unless he or she is at least adequately competent. It's the same with specialists in the private sector. A specialist will not get referrals from a GP unless they're up to it?-- Oh, absolutely. And incompetent specialists in private practice could easily starve.

Yes. And, in any event, won't get visiting rights at the private hospitals and is simply going to go out of business very quickly?-- Yes, yes.

MR ANDREWS: The next proposition is that the effect has been particularly severe in regional areas where there used to be strong working relationships between the local hospital and community doctors?-- Correct.

Is that your opinion?-- Absolutely.

And have you seen that first-hand?-- Rockhampton would be the classic - and this goes to the heart of trying, in regional centres, to run - in regional centres that are difficult to recruit staff to anyway, trying to run two separate systems, one public with staff specialists and one private with private doctors, and it decreases a lot of the attractiveness of rural practice and makes recruitment for those centres even more difficult. Could I just add before we go any further, the authors of this, David Wish used to be an anaesthetist at Inverell in New South Wales before returning to Brisbane and Charles Elliott was a general practitioner at Pomona just north of Nambour.

Well, speaking of general practitioners, it's next in the item which really covers two topics but one is to allow GPs back into Queensland provincial hospitals. Can you explain that concept?-- I don't know if provincial hospitals - "provincial" is the right adjective to use there, and this goes to - I visited the Commission on Monday afternoon to familiarise myself with proceedings. At that time there was a doctor from Dalby who was giving evidence who had been a scholarship holder as I had and, Commissioner, you asked the doctor about some of the details of the Queensland government scholarship scheme.

COMMISSIONER: Yes?-- And although there is some merit to the scheme, I think that the need for junior doctors to go and staff these isolated hospitals is overplayed in Queensland and the reliance should be more on attracting general practitioners to the town who can work both in general practice and work at the hospital as VMOs. That way you get a far more stable population of doctors in the town. You get a population of doctors whose skills would match the local hospital's needs. And it is not the situation where if you're a junior doctor going to a three-person - three-doctor hospital, you know, which may be a procedural centre for taking out appendices and things, you turn up as a very junior doctor, there may be someone who is a little bit more senior to you and a medical superintendent who is somewhat senior and has some procedural skills, well, if the medical superintendent goes on leave then there are two junior doctors who are expected to provide the service. My personal view is that that's not a standard that should be accepted in Australia in this decade and, so, what we need to do is look at addressing that to the point where we can get a stable group of doctors working in the town to provide those services.

And, Doctor, being frank about it, and I know that what I'm about to say would bring howls from people on both sides of the politics but the point has to be reached when you start questioning whether a town the size of, say, Cunnamulla can sustain a hospital in the traditional sense. It was different when there was a dirt road from Cunnamulla to Charleville and it took three hours to get there, but now with sealed roads and helicopter and fixed-wing retrieval, one does start to wonder whether the traditional country hospitals are sustainable?-- I think that there is a lot of merit in that

type of argument. I can't speak specifically about those towns. I've never been to Cunnamulla.

And perhaps it's unfair of me to pick on a particular town. For all I know Cunnamulla may more than justify - continue to justify having a hospital in its current form. I just picked that example quite at random?-- The example I would use would be the town that I did my payment back of my scholarship and it had been a mining town. The mine had closed, most people had left and there were about 250 people in the town itself and there was an equivalent number on farms, but it was the quietest job I've ever had and I'd go to an Aboriginal community 40 kilometres away and work very hard. But now they've both got doctors and you would wonder what the role of that hospital is now and what that doctor's doing, but there's very little in the way of mechanisms that that can be addressed. In New South Wales, and this is going back about eight or nine years, there was a committee headed by Ian Sinclair that toured around the country to these types of hospitals and asked the community what they wanted and they're developing multipurpose centres where the ambulance has moved up to be at the hospital, where there's perhaps less emphasis on acute care beds and more on aged care and so the role of the hospital is changing to reflect the needs of the community. One of the advantages, and I'm sorry if - I feel as though I'm going to harp a little bit here, but one of the advantages of having a senior bureaucrat with an area responsibility who has to pay for the health care is it allows that type of situation to be addressed. So if he can see that the role of a hospital can be changed appropriately and he can work the community through the consultation process to get that to be achieved, then he can keep the money from that and maybe get a neurosurgeon or, you know, provide a coronary angiography service locally or maybe a better helicopter retrieve service to cover for the fact that this hospital will no longer have an emergency department.

In that context there has been a lot of discussion in the media recently about the concept of the nurse practitioner. Do you have any views about the suitability of that as a solution in, particularly, remote rural areas that may not be able to attract or justify a full-time GP?-- This is a complex question. I think the reality is we've always had nurse practitioners; we just didn't call them that. We've always had areas where there were nursing staff alone, particularly in Cape York. But also in my experience at the Aboriginal community, I was 40 kilometres away, I could hardly race out there and intervene in a life-threatening emergency. And we sorted out a lot of things by phone. My understanding - and that's 20 years ago since I was in the bush. But my understanding is, since then, a lot of the approach to that situation had been protocolised and had improved dramatically. So the extremely isolated registered nurse practising with remote supervision is one situation but I think the reality is there is a - that is - is being used as - by a thin end of the wedge to expand the role of nurse practitioners and I think that we risk - I think we risk problems with that because - and having worked in the United

States as - with nurse anaesthetists for instance, I think there's not a clear idea of the advantages and limitations of that approach in this country and I am concerned that there could be bad outcomes as a result.

MR ANDREWS: Doctor, the next point in the third column seems to be discussing the hope that if there were more visiting medical officers, there would be a greater chance to detect any incompetencies in a fellow doctor. Now, in the case of an overseas trained doctor, is it the case that if, for instance, rather than having two senior medical officers employed as surgeons, if you were to have, for argument's sake, one and two VMOs from the town, there'd be more opportunity to detect incompetence?-- I think there are - there are two aspects to that. One is for peer review you need a quorum. You know - it could be argued that one of the things that we're seeing here is the lack of a quorum at peer review. By a quorum, I mean not only bodies but bodies with the appropriate qualifications. And if you had to present a case that had gone badly that extended beyond possibly the scope of the hospital, then it may be that your colleagues would say, "Oh, my goodness, what did you do that for?", and it possibly was that that may have been one of the mechanisms that this type of issue could have been addressed. The second one is, having worked as an immigrant doctor in the United States, that if it is not your country it is very difficult to confront people, you know, particularly if you are there on a fairly tenuous visa and-----

COMMISSIONER: Particularly if you can't work outside the Area of Need to which you've been appointed?-- Correct. Whereas if you were a VMO, you have a practice and this is just a component of your practice and, you know, if you want to stand up and say, "Look, I don't want agree with this", you are on far steadier ground.

And more particularly, if you work in a system which rightly or wrongly has a system of shooting the messenger?-- Absolutely.

MR ANDREWS: "Continuity of care is assured" is the next point. Is that referring to the ability to avoid dislocations if a staff surgeon quits?-- Well, I think so-----

Or is it something else?-- -----if you just look at the number of surgeons that have been employed as staff surgeons in Bundaberg say over the last decade, and whereas it's more likely that a surgeon who works in both the public and private sector may have more of a commitment to the town and may stay in the town and, you know, I think that that - that is very important.

The next topic seems to speak for itself. The next, that there were 3,000 VMOs in public hospitals in New South Wales in 2002 and 726 in Queensland. That's a topic about which you've already expressed a view. And the final topic, which is that the money spent on overseas full-time doctors would be better spent on VMO positions?-- I think it's more than that.

We need to recruit the overseas doctor, we need to get them here, we need to orientate them and all that is money that could be spent on people who could live in the community. And I can tell you, if you live in the community, you know, you have a commitment to your patients but the commitment is even stronger once you buy a house in the community because if you live in the community, you just can't afford to have a bad outcome. And, you know, the example I use with my children is to point out to them, now that they're old enough, that if I had anaesthetised someone in Lismore who was someone important or who was a child and they had a bad outcome, it may have resulted in us having to leave the town. And I don't know if practice would have been possible and living in the community would have been possible after something like that occurred. Now, that wasn't the reason that - fortunately, I didn't have those things occur but it is another incentive and it is something else that that drives you to quality care.

COMMISSIONER: And in addition, Doctor, the expenses you refer to are recurrent. If $15,000 is spent this year to find a surgeon to bring to Bundaberg and that surgeon leaves after 12 months, then there's another 15,000 next year?-- Mmm, correct.

And another 15,000 the year after?-- Correct.

MR ANDREWS: Doctor, a final point you make, not from this article, is that the consequences in Bundaberg are something that might have been an anticipated outcome from what you regard as a policy of Queensland Health instituted in the late 1990s called Reversal of Flow. Can you explain that for us?-- Okay. I got exposed to Reversal of Flow as an outsider practising in Lismore as Director of Intensive Care. My time at the University of Iowa was during my stay in Lismore. So I practised in Lismore and while there, I went to the University of Iowa and then returned to Lismore, and when I returned to Lismore there were problems transferring patients to Brisbane tertiary referral hospitals. And, I'm sorry, I just can't find the relevant correspondence.

Doctor, it's likely to be D6?-- D6, correct.

While you're looking for it, is reversal of flow a concept whereby instead of having large numbers of patients transferred from regional areas to major metropolitan areas for health care, the flow of patients was directed - they were, rather, intended to remain in the regional areas?-- Correct. The idea was that, broadly speaking, to do a hernia repair at Royal Brisbane is dearer than to do the same operation at Caboolture because at Royal Brisbane you have to pay for the infrastructure of the hospital which includes the MRI scanner and the very large pathology laboratory whereas to do it at Caboolture, it can be done on a cheaper basis. So we will decrease the size of Royal Brisbane Hospital and encourage those patients to get their health care in the periphery.

And that's sounds a commendable thing to do?-- Well, it does,

to the general population it seems very attractive because they have the possibility of getting their health care delivered closer to their home. The problems arise when you have complex health care which exceed the capacity of smaller hospitals. Having downsized the tertiary referral hospitals, you don't have the capacity to admit the patients to those hospitals, and if I could just quote a couple of sentences from Richard Ashby, the - then the Acting Executive Director of Medical Services-----

Is this his letter to you of the 17th of September 1999?-- Correct.

I can have it put up on the screen if you like?-- So if we start at the next page, page 2 - oh, sorry, no, sorry, that would be fine. "We have advised that our hospital is to rapidly reduce its scope of focus predominantly on the Queensland Health central zone. We have been advised to reverse the flow of patients from other zones and regions as part of demand management and the context of reduced activity and budget levels. You've been aware of media reports that RBH is currently closing some 70 inpatient beds, two operating rooms, 40 outpatient sessions per week and four intensive care beds."

Was that to initiate the reversal of flow process?-- To encourage patients to get their health care in the periphery and to remove money from the Royal Brisbane budget and move it to peripheral centres where their health care could be delivered. So the next page goes on, "The Queensland government has required Royal Brisbane to significantly downsize, including the elimination of unfunded activity. This includes inter alia a 20 per cent reduction in critical care beds, operating room capacity, surgical services, medical staff infrastructure in anaesthesia and intensive care. We been instructed to reverse the flow of patients from zones and regions where those centres are funded to provide secondary and tertiary services to their respective populations." The important thing of the timing of these is this is when Royal Brisbane and PA were undergoing redevelopment. This is not a feature unique to Royal Brisbane. It was just that Royal Brisbane were somewhat candid in their description of what was happening at their hospital.

D COMMISSIONER EDWARDS: Wasn't this neurosurgical transfer?-- The question was in respect to neurosurgical transfers, which was our biggest problem from Lismore, but the response really related to general hospital funding. You need to remember that New South Wales Health actually pays for the care of patients transferred across the border, as Queensland Health pays for the care of the patients who are looked after in Tweed Hospital. That's a complex area, but that does occur, and the federal government looks at those patient flows and adjusts the grants to the States appropriately. So in my view this is not unrelated to the reason we are all here, because we've got a number of things that have come together. We've got a downsizing of the tertiary referral hospitals to the point where they had difficulty accepting complex surgery for being done. I can tell you that if you need to have a Whipple's procedure performed at PA, the figures are there's only one in three that get their operation done on the day as advertised. The remainder are cancelled. It may be done tomorrow or next week, and it's not put off for months, but only one in three can get in because they need the operating theatre, they need the anaesthetist, they need an intensive care bed, and all those things need to come together. So we've got problems with capacity of tertiary referral hospitals in the setting of a provincial centre where there were few peers for peer review, the issues in relation to the surgeons, and then at the same time we have the issues we've already spoken about about the conflict of interest between the budget and activity. I think this-----

MR ANDREWS: Would I be right in thinking that if money is directed from the major metropolitan hospitals to the regional hospitals, and if they are obliged, if they want to retain those budgets, to spend the money each year, then there will be an almost subconscious imperative to continue doing even the more complex surgery rather than the simple hernias that would have been ideally suited to reversal of flow?-- Well, I'd change the emphasis slightly. There would be - it would be essential for them to do enough surgery to keep the money that they're getting, and if they do more complex surgery they

have to do fewer operations.

And you responded to Mr Ashby's letter, although I see this response seems to be to Mr Abernathy?-- I was gobsmacked by the letter I got back. It was dangerous to my patients, and I try to be a good advocate for my patients, and there was no way I was going to take advice like this. I felt as though - I'm not sure why Dr Ashby wrote to me in such a candid way. I wasn't sure if he wanted the issue raised in a wider forum. I'm sure he had no concept that it would be a forum like this, but I'm not sure if he wanted it raised in a wider forum or just because I was out of state, I may not have been important in his eyes. But there was no way that this could stand. So-----

You wrote to the coroner?-- I wrote to the New South Wales Deputy State Coroner, Mr John Abernathy, who I'd already discussed the issue with, and my concern was that he may be able to exert some pressure to get this corrected.

You didn't want your colleague, Mr Ashby, to be hung out to dry over what you thought might have been an unstated policy decision, so you sent a reply to Dr Rob Stable, then the Director General of Queensland Health, to make sure he was aware of what you were being told?-- That's correct.

At the time you wrote to Mr Abernathy, you noted that your letter to Dr Stable was acknowledged, but you didn't receive a reply?-- And I still haven't.

I have nothing further for Dr Cook.

COMMISSIONER: Thank you, Mr Andrews. Mr Lyons, we have a system here - I know you're new to these proceedings - where the counsel representing a witness has the opportunity to adduce further evidence-in-chief if you wish to do so, and also an opportunity to re-examine before counsel assisting, if you wish to do so, following cross-examination. So at this stage, is there any further evidence-in-chief you wish to adduce?

MR LYONS: Perhaps I can assist, Commissioner. While I am appearing on instructions from Dr Cook's employer, I'm not actually representing Dr Cook. Ms Gallagher is looking after his interests.

COMMISSIONER: I see. All right. Ms Gallagher?

MS GALLAGHER: Thank you, Commissioner. There was not sufficient opportunity at the speed the witness was sworn, that was all, so I figured I'd wait until a bit later on. So formally I would seek leave to appear for Dr Cook, a member of AMAQ.

COMMISSION: Yes.

EXAMINATION-IN-CHIEF:

MS GALLAGHER: There is one question I would like to ask. You finished with Mr Andrews in respect of things you would suggest are cumulative in how things have occurred to bring us all here. You suggested there was, in respect of reversal of flow particularly - it arose in that area - the few peers issue, the issues in respect of the surgeons themselves, a conflict of interest between budgetary imposition and duty of interest in the sense you must spend the budget you're given to get the historical funding, if you like, rather than, say, outcome funding for the next year. But was I to understand there was an earlier point you made as well that perhaps goes there, which was - I think you describe something in the event of perverse incentive to actually bring more income to the area by increasing your elective surgery list in terms of how much activity you did there as well?-- Okay. My understanding of this - and this is a long way removed from the intensive care unit, but I do sit in meetings where this is discussed. My understanding of this is you get a budget, you have to do a certain amount of surgery, which is patients times complexity, to get that budget, and if you do less you get some of the budget taken off you. However, there are incentive schemes separate to that which is a separate mechanism where you can put in bids to say, "I can do so many of these procedures", and you may get extra funding for those procedures. But the real issue is the person who has to keep an eye on the quality is concerned if the number of patients operated on is reduced, particularly in terms of complexity, because they may not subsequently get their budget.

COMMISSIONER: Ms Gallagher, I think it's fair to say we heard quite some evidence about this in Bundaberg from people who are probably more intimately familiar with the system than the present witness. I'm not stopping you from following it up if you wish to.

MS GALLAGHER: It was the only question. It was inconsistent with the previous answer he'd given, in my view. Thank you.

COMMISSIONER: Mr Andrews, for tomorrow, I understand there's a witness who has been given a definite appointment.

MR ANDREWS: That's correct, Dr Kariyawasam.

COMMISSIONER: And he's travelling down from somewhere to be here tomorrow.

MR ANDREWS: He is travelling from the Gold Coast, but I assume that he has other clinical commitments based upon the expectation that he'd give his evidence at 9.30. I can't be certain of it. It's an assumption.

COMMISSIONER: Dr Cook, would it suit your convenience to come somewhat later tomorrow? How long would we expect Dr Kariyawasam to take?

MR ANDREWS: I'd have thought an hour and a half would be enough.

COMMISSIONER: Let's be pessimistic and assume it's two hours, 9.30 until 11.30.

MR ANDREWS: I have been wrong with every estimate by always estimating too short a time.

COMMISSIONER: Yes, but then I'm mainly to blame for that, so I can't criticise you for those mistakes.

MR ANDREWS: And I'd never disagree with you, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. 9.30 tomorrow, Dr Cook, would that suit you?-- Absolutely, and I am contactable if the situation changes.

If you leave your mobile number with Mr Scott if he doesn't have it, and we will try and give you as much advance warning as possible if you're going to be held up any longer. Otherwise, ladies and gentlemen, we'll adjourn until 9.30 tomorrow.

MR ANDREWS: Thank you.

THE COMMISSION ADJOURNED AT 4.50 P.M. TILL 9.30 A.M. THE FOLLOWING DAY