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Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR R DOUGLAS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 26/08/200

..DAY 50

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

THE COMMISSION RESUMED AT 10.09 A.M.

COMMISSIONER: Mr Andrews.

MR ANDREWS: Good morning, Commissioner. I call Jonathan Joiner. I understood that Dr Jayasekera was a telephone witness. Now, I understand that each of the witnesses are telephone witnesses. In the circumstances, the call has to be placed.

COMMISSIONER: Yes.

MR ANDREWS: Good morning, is that Dr Jonathan Joiner?-- It is indeed.

Dr Joiner, my name is Andrews, counsel assisting the Bundaberg Hospital Commission of Inquiry?-- Right.

Doctor, do you have a Bible handy?-- I do indeed. It's in my hand.

Thank you. That's very convenient.

COMMISSIONER: Dr Joiner, this is Anthony Morris, the Chairman of the Commission of Inquiry. I'll read over to you the form of oath and if you agree what's said, can I ask you to say at the end, "So help me God"?-- Rightio.

JONATHAN JOINER, SWORN AND EXAMINED VIA TELEPHONE LINK:

MR ANDREWS: Dr Joiner, do you have a copy of your statement sworn on the 24th day of June 2005?-- I do, yes, it's here now.

Is that a four page document of 13 paragraphs?-- Yes, it is. Yes, that's right, yep.

Dr Joiner, are the facts set out in that document true to the best of your recollection?-- Yes, they are.

And are the opinions you express in it honest opinions that you hold?-- Yes, they are.

Commissioner, I tender a copy of Dr Joiner's signed affidavit.

COMMISSIONER: Yes. The statement of Dr Jonathan Joiner will be Exhibit number 307.

ADMITTED AND MARKED "EXHIBIT 307"

MR ANDREWS: Dr Joiner, you obtained a degree in Medicine in 1983 from the University of London, a Diploma in Anaesthetics in the United Kingdom in 1990 and you were registered to practice in Australia as a general practitioner in 1989?-- That is correct.

And have you since practiced with a special interest in Anaesthetics?-- Yes, that's correct.

Are you still a visiting medical officer at the Bundaberg Base Hospital?-- Yes, I'm still a visiting medical officer at the Bundaberg Base Hospital.

During Dr Patel's time at that hospital, were you performing five sessions per week in theatre in anaesthetics?-- That's correct.

And Dr Carter was at that time your line manager?-- Yes, that's also correct.

And you worked with Dr Patel about once every two weeks; is that the case?-- Yes, that's true.

Can you recall generally how Dr Patel related to staff?-- At times Dr Patel was very forceful, he was loud and occasionally at times quite intimidating.

Now, that forceful nature, did it have any effect on the sorts of procedures that Dr Patel chose to perform?-- I think Dr Patel liked to get his own way, and consequently in him sort of being sort of a forceful character, my feeling is he did sort of push through cases which were questionable.

Do you recall an occasion in April or May of 2003 when you became aware that Dr Patel was proposing to perform an oesophagectomy?-- Yes, I was aware of that. At the time, Toni Hoffman, who was in charge of intensive care, came to speak to me in the absence of Dr Martin Carter who was on holiday and also at that time there were some concerns from senior theatre staff that Dr Patel was considering performing an oesophagectomy at the Bundaberg Base Hospital in theatre.

And did you form an opinion about whether an oesophagectomy was an appropriate procedure to perform at that time at that hospital?-- I'd been working in the hospital for 12 years and we hadn't performed that type of surgery for many years and I listened to Toni and the theatre staff and in the absence of Martin Carter, I also felt that perhaps these patients should be transferred to a larger tertiary hospital where the surgery could be performed. At the same time, an article was published coincidentally in the British Journal of Anaesthetics which also confirmed our concerns. The article stated that oesophagectomies performed in smaller numbers at smaller hospitals who were only doing three or four or five a year had specifically high mortality rate than oesophagectomies performed in larger tertiary centres that

were performing 20 to 30 a year, and all of that was taken on board along with the concerns of the intensive care and theatre.

Once you'd taken all of that aboard, what did you determine to do?-- Once we'd taken that on board, I made an appointment or rang to see Darren Keating, Director of Medical Services, who - and we had a meeting in his office.

Can you recall whether this was before or after the surgery that was proposed had taken place?-- This was before the surgery had taken place with the concerns that I've just expressed being brought up.

Do you recall whether you saw Dr Keating alone or in company?-- I was on my own with Dr Keating.

Can you tell us - well, did you pass on your concerns to Dr Keating?-- I spoke to Dr Keating and we had a good discussion about the whole situation. I passed on the concerns of intensive care and mentioned the concerns of theatre staff and in the absence of the Director of Anaesthetics, Intensive Care, I told Dr Keating that we thought maybe it was inappropriate to perform the procedures at the Bundaberg Base.

Was Dr Keating receptive to your suggestion?-- Yes, indeed, he was, he listened intently and was receptive.

Did he give you any indication as to whether he had formed a view?-- I think he would have obviously liked to discuss that further with Dr Patel.

I'm wondering, Dr Joiner, whether during your meeting with Dr Keating, he indicated to you whether he'd made a decision or indicated to you what he proposed to do?-- My understanding was that he would take it on further and talk to Dr Patel about the issue.

I'm curious: did you take the matter up with Dr Patel yourself?-- No, I didn't, not directly.

Can you explain why?-- I felt it was a better forum to take it to - take the concerns of intensive care and theatre directly to the Director of Medical Services.

Was that choice of yours-----?-- Yes.

-----to do with internal protocol? I notice that in the absence of your line manager, who I assume was Dr Carter, I assume Dr Keating would have been your line manager; is that correct?-- That's correct.

Well, was your choice to go to Dr Keating dictated by line management matters or personality matters?-- I just thought that was the right thing to do. Darren was, you know, in overall control of the hospital and any concerns with regards to surgery or any other issues should be directed towards Dr Keating.

Thank you.

COMMISSIONER: Doctor, may I ask, from reading the contents of your statement, I have the impression that you felt taking the matter up with Dr Patel would be ineffective in any event?-- I think at that early stage it would be difficult. This was within the first couple of months of Dr Patel having been in the hospital. I dealt with him on a few occasions but I still felt that taking issues on this type of - taking this issue would have been better going to Darren than to talking to Dr Patel.

And doctor, I'd also like to ask this: your choice to take the matter to Dr Keating suggests that you had a high level of confidence in Dr Keating; would that be right?-- Absolutely.

And given that there has been some at least indirect criticism of Dr Keating in these proceedings, I'd like you to explain in some detail, if you'd be kind enough, your views about Dr Keating and why you felt so confident in his handling of the matter?-- In the absence of my line manager, as we've just said, Dr Keating would have been the next step for a concern to be taken to, and I had no reason not to do that in any way whatsoever. The department at that time was staffed by a large number of locums in the absence of Martin Carter, and Director of Medical Services is the chap in charge of the hospital, therefore, that's why I approached him.

Thank you.

MR ANDREWS: Dr Joiner, would it be the case that when you approached Dr Keating at a time when Dr Patel was relatively new to the hospital, so to was Dr Keating relatively new?-- That's correct.

You told the Commissioner that you had confidence in Dr Keating. Would it be fair to infer that within the first couple of months of Dr Keating's time at the hospital, you were not in a position to judge whether he was a competent line manager or not?-- Obviously Darren Keating was our new Director of Medical Services, but he'd been appointed to the position on his merit and I presume that he was a very competent individual having come from other hospitals, and because of that and because of the systems, he was the obvious person to go and talk to about these issues.

And he was receptive and - to your meeting?-- Yes, he was.

After that meeting, did the oesophagectomy proceed?-- I understand it was - yes, the oesophagectomy did proceed.

Did you take the matter up with either Dr Patel or Dr Keating when you learned that the procedure had taken place?-- I didn't take the issue any further. I'd expressed the concerns that we'd talked about and presumably the final decision had been made by Dr Patel and Dr Keating and the anaesthetist who had anaesthetised the oesophagectomy patient.

In June 2003, was there another oesophagectomy procedure at the hospital?-- Yes, there was.

Did you have anything to do with the procedure in surgery?-- The initial surgery I had - I did not have anything to do with the procedure. Subsequently, the patient had a couple of complications which resulted in him going back to theatre on two occasions.

Were you in the ICU at the time?-- He was in the - I was - I was in ICU on that occasion on the second time that he went back to theatre for a breakdown of the wound and subsequent leak, and the patient came back to intensive care and required continuing ventilatory support in intensive care.

Dr Joiner, do you recall whether you had advance notice of this second oesophagectomy, that is, this oesophagectomy on a second patient?-- No, I did not have any advance notice of the second oesophagectomy, no.

After the - let me take you back to the first oesophagectomy patient. After that procedure, do you recall whether you accompanied Toni Hoffman to see Dr Keating?-- I'm not aware that I went to see Darren Keating again until we had concerns over the oesophagectomy in June that I wanted to transfer out to the Royal Brisbane. My recollection is that I did have two meetings with Darren Keating.

Now, your second meeting with Dr Keating was with respect to the second oesophagectomy patient; is that the case?-- It was with respect to - I cannot confirm the numbers but it was certainly with respect to an oesophagectomy patient that - the oesophagectomy performed in June, I think, of that year.

And is this the patient you speak of in paragraph 7?-- Exactly, yes.

You arranged a meeting with Dr Keating?-- Yes, I did.

Dr Patel was present?-- Yes, he was.

What was it that you saw Dr Keating about?-- The patient was requiring - the oesophagectomy patient had been back to theatre a couple of times after the initial operation requiring ventilatory support and intensive care support. The decision was - it was discussed with Dr Patel and the intensive care staff and myself and we - the intensive care staff and myself felt that the patient, who was obviously going to require ongoing intensive care support, should be transferred to an intensive care unit at the Royal Brisbane, and I initially found - I initially discussed this with the Royal Brisbane and we found a bed or they said a bed was available in their intensive care unit to transfer the patient down to Brisbane.

Dr Joiner, your opinion formed about the need for a transfer to Brisbane, was it an opinion based upon the clinical needs

of the patient or upon the demands, working demands on the staff at Bundaberg?-- Certainly the clinical needs of the patient meant that this patient would require ongoing intensive care support for a number of days.

I'm curious to know whether you thought there would be better care capable of being provided for the patient in Brisbane?-- Certainly the intensive care in Bundaberg provides excellent care to patients, but for longer ongoing treatment of complicated patients, it's better to transfer such patient to a larger tertiary hospital as the Royal Brisbane, and we also had the pressure of bed numbers in our level one intensive care. Taking all of those issues into consideration, it was considered both for the patient and considering staffing issues too for long term ventilatory patients at the hospital at Bundaberg, this patient should be transferred to the Royal Brisbane, and having discussed that with the Royal Brisbane, they accepted the patient and were happy to take him.

What did Dr Patel do when he learned that you'd made this arrangement?-- Dr Patel confronted me in the corridor between intensive care and Theatre and was exceptionally unhappy about the whole situation and told me in no uncertain terms that if the patient was transferred to the Royal Brisbane, he would resign from the hospital.

Did he explain why this was so important to him?-- He did not explain any further but felt that it was, from his point, an inappropriate transfer of the patient to Brisbane.

D COMMISSIONER VIDER: Doctor, it's Deputy Commissioner Vider here. I'm just curious to say at the time of this conversation, this patient had already returned to the operating theatre twice?-- That is correct.

Because of-----?-- Complications.

-----complications?-- Correct.

And Dr Patel didn't think that that was at all unusual, strange or one reason for transferring the patient out?-- He obviously felt that it was inappropriate.

COMMISSIONER: When you say - sorry, this is Commissioner Morris: when you say he obviously felt that it was inappropriate, was it in fact obvious to you that he felt it inappropriate or did it cross your mind that the real reason for not transferring the patient was so that a tertiary referral hospital in Brisbane wouldn't become aware of the level of skill which he had shown in performing this operation?-- I don't think that really really crossed my mind at this stage. I was confused why he was sticking his heels in to such an extent with regard to transferring the patient out. He even refused to talk to the surgeons down in Brisbane, which was a proviso from the intensive care team down there, that a surgical referral should also be made to the surgeons in Brisbane so that they could take on his surgical - take on the surgical care alongside the intensivist

who's looking after this patient, and that obviously made things even more difficult because without surgical referral of speaking to the surgeons down there, it also made a transfer almost impossible.

With the benefit of hindsight and as someone who worked regularly with Dr Patel, do you now have a different view or a different explanation for his conduct?-- Well, I think with hindsight and retrospect we all do, yes.

Yes, thank you.

MR ANDREWS: Was there any professional or any reason consistent with proper professional practices for keeping that patient in Bundaberg?-- There was no reason to keep that patient in Bundaberg. The feeling for talking to Toni Hoffman and the intensive care staff and myself, we felt that this patient was going to require ongoing intensive care treatment which was being performed which should be performed in Brisbane.

So you went to see the Director of Medical Services at a meeting at which Dr Patel was also present?-- Correct, correct.

Can you recall what you told Dr Keating?-- We discussed the patient. We discussed what was going on with the patient from what I can recall and that we'd arranged an intensive care bed in Brisbane for this patient and that Dr Patel was not happy for the patient to be transferred out to Brisbane.

And did Dr Patel maintain his contrary stance, that the patient should remain in Bundaberg?-- Yes, he did.

In the circumstances of that meeting, can you say whether Dr Keating would have been given two conflicting views, one of yours and one of Dr Patel's?-- The patient was discussed and both sides and both views were put to Dr Keating.

Now, did Dr Keating tell you - or did he make a decision?-- A decision was made at the meeting that a compromise should be made and the patient - should hold on to the patient for another couple of days and then review his clinical condition.

In the circumstances that confronted Dr Keating at that meeting, are you able to express an opinion about whether that compromise appeared reasonable, that is whether-----?-- It was a difficult situation. Dr Patel was being exceptionally awkward in that situation. My feeling was that Dr Keating handled it pretty well, but when you are dealing with someone as forceful and someone who is threatening to resign his position in the hospital, it is a very difficult situation to deal with. We had an ill patient and that was the decision that was made, to compromise.

Thank you. After that decision was made, the patient's condition did not improve, I gather?-- Correct.

And some time passed before a decision was made to transfer the patient to Brisbane?-- That's correct.

When that decision was then made, I gather that even Dr Patel was in agreement?-- I think his hand was forced by that time.

You were unable to effect the transfer, is that the case, or-----?-- I was no longer looking after - I was no longer on intensive care on the day that that decision was made, but I gather that after a couple of days, which was the compromise, when we tried to get the patient to Brisbane we lost our intensive care bed which was a problem of the lack of intensive care beds.

Eventually, do you understand the patient was transferred to Brisbane?-- Yes, the patient was eventually transferred to Brisbane.

And died there?-- I gather the patient stayed in Brisbane and then didn't pass away until January of that - later on in January of the next year. So I gather that he did survive his period in Brisbane.

Thank you. You speak at paragraph 9 of patient P44?-- Yes.

Is it the case that a nurse asked you to attend the ICU to turn off that patient's ventilator?-- Yes, that's correct.

Now, are you able to say whether that was an initiative of the nurses or whether that nurse had been instructed by someone else?-- It was - it was - the nurse had been instructed, obviously, by somebody else and that was Dr Patel.

You were uncomfortable about turning off the ventilator because you hadn't - firstly, you hadn't dealt with the patient yourself and because there had been no formal brain death tests conducted?-- That's correct. I was uncomfortable. I didn't have a clear history of the patient. This was 8 o'clock on a Sunday evening and I was asked to go

into the hospital and switch his ventilator off, and I was uncomfortable about doing that.

The next day you had discussions with Dr Berens about the need to conduct brain death tests?-- That's correct.

You had discussions with Dr Carter, and do you recall that Dr Carter indicated to you that there was a CT Scan that clearly showed the patient was brain dead?-- Yes, I can remember that. Dr Carter did.

You didn't yourself look at the CT Scan to confirm that Dr Carter's opinion was correct?-- No, I didn't.

But there would be no opportunity for confusion with a CT Scan, would there? It is a simple matter to determine whether or not a patient is brain dead?-- Certainly taking the whole clinical situation into account, as Dr Carter did with a CT Scan, and taking the history and what has happened, it is fairly conclusive with regards to whether the patient is brain dead or not.

COMMISSIONER: Doctor, this is Commissioner Morris again. In relation to this patient, I think I should make it clear that our concern isn't the fact that Dr Carter ultimately took the decision to take that patient off life support. I take it, from your statement, you agree that ultimately that was the right decision for Dr Carter to take?-- Correct.

The issue is not whether or not that was the right decision, but the fact that Dr Patel apparently put pressure on Dr Carter to take that decision - not for clinical reasons, but to make a bed available in the ICU for one of Patel's own patients. Is that consistent with your understanding of what occurred?-- I think that's right. Certainly the phone call that I received on Sunday night was to that effect, that my understanding since was that Dr Patel had required an intensive care bed the following Monday and as this patient was still on a ventilator, there would be no bed for him to perform the surgery.

And it was your decision not to make that decision but to refer it to Dr Carter?-- Correct.

And you were then criticised and disparaged by Dr Patel for not doing what he had demanded that you do?-- That is correct.

Yes, Mr Andrews?

D COMMISSIONER VIDER: Doctor, it is Deputy Commissioner Vider again. After this situation occurred, did any opportunity exist to discuss that - to review this situation or to debrief from it, or whatever, either with the intensive care staff or further down the track to take it up at an M&M meeting?-- Sorry, with regards to?

To the turning off of the ventilator? What I am getting at is

these sorts of clinical situations very often, where there is differences of opinion, cause concern to participants in the care of the patient and it is not uncommon for people to come together, either in the intensive care unit or more formally at some sort of clinical review forum, and discuss their concerns so that it becomes, if you like, a review, but a learning opportunity, and people feel free to state how they were feeling, what their motivation was that led them to take the particular course of action that they had proposed. Were any opportunities such as that available in Bundaberg?-- Oh, certainly, in the anaesthetic department we have regular M&M meetings with regards to morbidity and mortality from cases that occur in the theatre environment and occasionally in intensive care. Cases are brought to the meetings to be discussed and those sort of - those - that meeting is designed as a forum between the anaesthetists to discuss complications and problems and outcomes.

And does that review process that's engaged in worthwhile?-- Oh, definitely. It is a learning tool for all anaesthetists, at whatever level, to see how patients are managed, and to look at the basic management, and understand the problems and complications that were ongoing that occurred in each case.

The M&M committee meetings that you attended, who chaired those?-- We have a meeting in the anaesthetic department every Thursday morning with Dr Carter as the Director of Intensive Care.

Would there ever be a joint meeting with the surgical staff?-- No.

Would you think that would be advisable, to have a meeting at times with the anaesthetists and the surgeons?-- I think that's probably a very good idea.

Something to think about for the future?-- Indeed.

COMMISSIONER: And, doctor, speaking only for myself, I find it a particularly abhorrent situation that you were put under pressure to take another person's life when you weren't satisfied that that was the correct clinical decision at that point in time, and then ridiculed for your concern over that patient and the request made of you by Dr Patel. Was this a matter that you considered raising with your line management, with Dr Carter or with Dr Keating, or with anyone else in the hierarchy?-- Well, at this stage we knew Dr Patel was a very forceful character and would carry on in this way, I suppose. I felt that I had sort of not done anything wrong from my end, and I stuck to my guns with regards to my clinical feelings and understanding and therefore I didn't take it any further.

I suppose my concern is that you obviously, if you will permit me to say so, had the courage and the commitment to do what you regarded as the right thing for your patient, but the concern would be that perhaps there were others who would more easily succumb to pressure from Dr Patel, and if he was going

around the hospital demanding that patients be put to death so that he could have facilities available for his surgery, that that was something that should have been brought to the attention of the hospital management?-- In retrospect, looking back on what's happened, you are probably correct there, yes.

And, please understand, I don't mean that in any sense as criticism of you, it just strikes me as the sort of thing for the future that it would be important that a process be in place that people who are put under pressure like that have the opportunity to have it reviewed by hospital management?-- Yes, definitely.

Thank you.

MR ANDREWS: Dr Joiner, patient P44, of whom we have just been speaking, the urgency to obtain that patient's bed was said by you to have been to create space for a proposed oesophagectomy patient. Is that the case?-- That's what I understand, yes.

I gather, then, that the practice of performing oesophagectomies continued after the patient that you had discussed with Dr Keating in the presence of Dr Patel. I wonder did the debate continue about the propriety of performing that procedure in Bundaberg?-- I assume with the arrival back of Dr Carter, that those concerns would have been discussed further with Dr Keating but I was not a party to those discussions.

I see. Was it really for Dr Carter to consider the propriety of caring for patients in the ICU after such complex operations?-- Well - sorry, he was the Director of Intensive Care and Anaesthetics, yes.

Thank you. I have no further questions, doctor.

COMMISSIONER: Doctor, this is Commissioner Morris again. I want to raise with you something that's not really covered in your statement but it is an issue in respect of which we would certainly appreciate your comments. I gather from your statement that you - your origins and your initial training were in the United Kingdom. Was your decision to come to Australia, and specifically to Queensland, the result of the decision to migrate, or were you, in a sense, headhunted to come to that position?-- It was a decision taken by myself to migrate to Australia.

Right. You mention in the statement that you currently work as a visiting anaesthetist at the Bundaberg Base Hospital as a VMO. Have you always been a VMO or was there any time when you were employed full-time at the hospital?-- I initially worked as senior medical officer for three months in the hospital - I think that was back in 1993/94 - and then took up a visiting medical officer position.

One of the suggestions that's been raised in submissions received by us and in evidence from other witnesses is that

one way of attracting more specialists to Queensland, both from other parts of Australia and from overseas, is to make it easier for specialists coming to Queensland to fit into the system of both public and private work, by, for example, giving Queensland Health the flexibility to advertise VMO positions on the footing that the successful applicant will also have a right of private practice for a number of days a week, and that the applicant will be supported in setting up a private practice in conjunction with other hospitals to fill the need in that community. From your perspective, as someone who came to Queensland from the United Kingdom, and someone who has ultimately followed that course of setting up a private practice whilst doing VMO work at the hospital, can I ask your views on that topic?-- I think that's an excellent idea. Of the time I have worked as a visiting medical officer at Bundaberg, certainly there has been very much an anti-VMO feeling from Queensland Health in respect of commodity, and a VMO should not be employed. My position continued to be looked at, continued to be looked at with regards to coming back on-----

MR ANDREWS: The shorthand writer, Commissioner, can't hear all of those words, and I wonder-----

WITNESS: Sorry, I will speak up, I am sorry. Certainly there was a feeling amongst - certainly myself there was anti-VMO staff at Queensland Health that they were expected to employ. We had some VMO come - some anaesthetists looking at jobs at Bundaberg prior to all this who were interested in visiting medical officer positions - Australian-trained anaesthetists - and they were definitely not given the opportunity or funding provided for these specialists to be employed, and on a couple of occasions they were looked at and gone away. I hope-----

COMMISSIONER: Sorry, doctor, you are breaking up again. I think it is the quality of the line rather than the level of your voice. I wonder whether we might try redialing and seeing if we get-----

MR DIEHM: I got the impression the doctor might be using a speaker phone.

COMMISSIONER: Doctor, are you on a speaker phone?-- I am indeed. Do you want me to switch to a landline?

That might help?-- Hang on a second. Is that clearer?

That's much clearer?-- Sorry about that. Certainly I think from a visiting medical officer's point of view, there have been a couple of specialist anaesthetists in the past couple of years or so who have come through Bundaberg and been interested in doing VMO positions in the hospital, but there were no sort of fundable positions available for them, which I think is a great tragedy, because had there been, those sort of specialists would have probably stayed in the Bundaberg area, as a lot of private practitioners are still quite interested in sort of providing services for the public system. Those sort of issues I think are a tragedy.

We've received evidence that suggests that there is actually an extraordinary level of medical talent available in the private sector in Bundaberg. For example, amongst the surgeons we have heard about Dr de Lacy, Dr Thiele, Dr Anderson and others who have been there from time to time. I take it those are people you have worked with in the private hospitals?-- Yes, indeed, yep.

And would you share the view that's been expressed that it is a misfortune, to say the least, that the services of surgeons of that quality are not available to public patients in Bundaberg?-- Absolutely. It is a tragedy that they are not.

Yes. Thank you for that, doctor. I will ask Deputy Commissioner Vider-----

D COMMISSIONER VIDER: No, I have nothing further.

COMMISSIONER: And Deputy Commissioner Sir Llew Edwards?

D COMMISSIONER EDWARDS: I have nothing further.

COMMISSIONER: Doctor, I will now invite counsel to cross-examine, and each counsel will tell you their name and who they are representing. Mr Harper, is it convenient for you to go first?

MR HARPER: Yes, Commissioner.

CROSS-EXAMINATION:

MR HARPER: Thank you, Dr Joiner, my name is Justin Harper. I appear on behalf of the Bundaberg Patients Support Group. I would like to ask you some questions about the article which you referred to in your evidence today. Could I ask you do you recall where that article was published?-- It was published in the British Journal of Anaesthetists.

I take it that's a reputable and well renowned publication?-- Indeed it is.

Right. It is a publication which would be available to at least all the specialist anaesthetists at the hospital?-- It is a publication, amongst many journals and publications, that are available, yeah.

Okay. Can I ask, you are quite certain that that article appeared before that April/May 2003 period?-- It was slightly uncanny because at that time that this issue was going on, I actually showed the article to Toni Hoffman in intensive care.

Sorry, you showed it to Toni Hoffman in the ICU?-- Yes.

And that was at the time when she was expressing her concerns about the performance of the oesophagectomies?-- Correct.

Could I ask have you had the opportunity, before you gave evidence here, to refresh your memory about that article? Have you read it recently?-- I did look through the article a few weeks ago, yes.

Okay. Could I ask you then would it be - would it be possible for you to provide a copy of that article to the Commission? Would that be difficult?-- No. That should be fine. With regards to copyright, I am not sure if I can photocopy it or not, but we will sort something out.

COMMISSIONER: I suspect we're exempt from copyright anyway?-- That's no problem.

Thank you.

MR HARPER: Could I ask you, you gave evidence that it revealed high mortality rates in smaller hospitals rather than as opposed to tertiary hospitals?-- That's correct.

There is no doubt, is there, that Bundaberg would have been a smaller hospital within the terms that the article referred?-- That's true.

Can I ask who else did you discuss that article with?-- At the time mainly Toni Hoffman.

Right?-- And some more senior nursing staff in the theatre environment. It was the theatre environment, some of the more senior nursing staff in the theatre environment, and also intensive care who were concerned we were performing these procedures.

Did you discuss it with Dr Carter?-- I didn't discuss that with Dr Carter, no. I was on holiday at that time.

Okay. Did you at any stage subsequently discuss it with Dr Carter?-- I think - I cannot recall.

So you don't recall ever having it discussed at the anaesthetic M&M meetings?-- No.

Okay.

COMMISSIONER: Did you bring it to the attention of Dr Keating?-- When we had our first discussion about the deaths that I just mentioned.

You mentioned it?-- In the discussion I didn't have the article in my hand-----

I am sorry?-- An article recently-----

The line seems to be breaking up again. Perhaps we should try redialing and seeing if we get a clearer connection?-- All

right. I will put the phone down.

Thank you. Dr Joiner?-- Hello, yes.

That does sound better. Before that interruption you were responding to my question as to whether you drew that article to the attention of Dr Keating. Can you repeat your response, please?-- My understanding was that I did mention the statistics in the article.

MR HARPER: Could I ask you - sorry, it is Mr Harper again. Could I ask you, then, the statistics in the article, the higher mortality rate, do you recall what percentage higher rate it was?-- My understanding was that it was in the region of up to 10 per cent.

And did that occur to you at the time as a particularly high percentage?-- The reason I went to see Dr Keating, having spoken to intensive care staff and discussed it with them, I felt that it was inappropriate to be performing that type of surgery in Bundaberg.

And the concern was about the complication rate as well as the workload issues for ICU?-- Correct.

Right. But you didn't show Dr Keating the article in its entirety?-- No.

But you did refer him to its essential findings?-- To some of the statistics in the article, yes.

And the statistics being the higher complication rate in smaller hospitals?-- That's correct.

Now, after the oesophagectomy in May of 2003 do you know what the outcome of that was, what the outcome for the patient was?-- My understanding - my understanding was that the oesophagectomy performed went very well.

Right. Okay. So then you come again to June 2003 and there are some complications which arise from this?-- That's correct.

Can I ask: are you aware whether the complications which occurred in the June 2003 one were the sorts which were referred to in that article?-- The specifics of the type of complication were - it was more a generalised morbidity and mortality statistic that they talked about with regards to the increase, not specifics of type of complication but generally an increase in overall complication and death rate.

Okay. And you then went and met with Dr Keating and Dr Patel about this patient's specifically?-- With regards to transferring the patient to Brisbane, correct.

Did you take the opportunity then to discuss with Dr Keating again the concerns about a - arising from that article?-- No.

No. Did you think it appropriate at any stage to talk to Dr Carter about the concerns generally about performing oesophagectomies?-- I think at the end of the day it was - as a visiting medical officer, I originally put my concerns forward and at the end of the day it is not my decision whether the type of surgery should be sort of performed or continued to be.

Okay. But can I ask: you mentioned earlier this is an article which appeared in the - I think it was the British Journal of Anaesthetics?-- Yes.

Wouldn't that be precisely the sort of thing you would discuss with Dr Carter?-- Certainly - as I said, at the end of the day, those sorts of decisions were not - they are not my decision. I'm sure the experience that the other specialists

had - the other specialists had in the hospital, that they would take all that on board and make a decision as to whether this type of surgery should be continued or not.

But also, can I say that given Dr Carter was the head of the ICU, it didn't occur to you to discuss the concerns with Dr Carter?-- I think Dr Carter was aware of the concerns.

He was aware of the concerns?-- Yes.

But you didn't - you didn't bring this article to his attention or discuss it with him?-- No.

Can I just ask one final question. The patient on whom the oesophagectomy was performed in June 2003, you gave evidence that that person ultimately died in January 2004. The death to your knowledge, did it arise from complications from the surgery or from the patient's original condition?-- I'm afraid I can't answer that to be honest.

Okay?-- I'm not sure.

Thank you, Doctor, I have nothing further. Thank you, Commissioner.

COMMISSIONER: I'm sorry, Mr Farr, I didn't ask at the outset whether you're representing Dr Joiner.

MR FARR: No, in fact, we're not. I believe it is the AMA.

COMMISSIONER: Right. Ms Gallagher.

MS GALLAGHER: In any event, thank you, Commissioner, I have nothing further in examination-in-chief for the doctor.

COMMISSIONER: Thank you. Mr Farr, would it suit you to go next?

MR FARR: It would but I have no questions.

COMMISSIONER: Thank you. Mr Allen.

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Joiner, John Allen, appearing for the Queensland Nurses Union. If I can try and clarify the chronology of events in relation to concerns raised by yourself and others regarding oesophagectomies in mid-2003?-- Right.

Have you been supplied with copies of any patient records of the relevant patients?-- No, I haven't.

Have you been asked to turn your mind to the names of the patients who underwent oesophagectomies?-- No.

Or to consider the patient code that's been used in these proceedings?-- No.

All right. Well, given those limitations, we'll do our best to try and clarify matters. There is evidence that a patient code P34, Mr James Phillips, underwent an oesophagectomy on the 20th of May 2003, operated upon by Dr Patel and that he actually died on the 21st of May 2003?-- Right.

Now, it would seem that that is the first oesophagectomy undertaken by Dr Patel at Bundaberg Base Hospital. The evidence also indicates that another patient P18, Mr Grave, was admitted for an oesophagectomy on the 6th of June 2003 and he was ultimately transferred from the Bundaberg Base Hospital on the 20th of June 2003?-- Right.

And that patient would seem to be the second patient who had undergone an oesophagectomy and I expect the one that you have referred to in relation to the compromised decision to hold him for a couple of more days in ICU before being ultimately transferred?-- That sounds correct.

Okay. So we have got this period then between the first oesophagectomy on the 20th of May and the second one on the 6th of June 2003?-- Right.

Now, I want to try and place your conversations with Dr Keating and others around those dates. Now, are you quite certain that you first raised concerns with Dr Keating before the occasion of the first oesophagectomy?-- Yes.

Okay. And that would also mean that it was before the first oesophagectomy that you had spoken to Toni Hoffman where she shared concerns with you?-- Correct.

And you'd spoken to senior theatre staff?-- Correct.

Were they nursing staff?-- Yes, they were.

Do you recall the identities of any of those persons?-- No.

Okay. But it was a shared concern amongst the nursing staff in ICU and theatre that operations of that complexity would be outside the scope of practice of the Bundaberg Base Hospital?-- That's correct.

And it was before that first oesophagectomy that you took those concerns to Dr Keating?-- That's correct.

Your recollection is that that first meeting with Dr Keating, you weren't accompanied by Ms Hoffman?-- No.

All right. Now, in any event, you weren't then subsequently involved in the surgery in relation to the first oesophagectomy patient?-- That's correct.

And you obviously weren't aware of the outcome of that surgery?-- That's correct.

Now, Ms Hoffman has given some evidence that after the date of the first oesophagectomy but before the second oesophagectomy, she accompanied you to a meeting with Dr Keating in which both yourself and Ms Hoffman raised concerns about the ability of Bundaberg Base Hospital to cope with oesophagectomies in light of the fact that Dr Patel had indicated that he wanted to do a second oesophagectomy. Are you able to comment upon that?-- I certainly confirm that Toni Hoffman confirmed - we discussed in detail. And as I've said before, with those concerns and with some of the senior nursing staff concerns, we arranged an appointment to see Darren Keating. Now, I'm not aware that Toni came with me on that occasion but I certainly expressed her concern and theatre concerns and my concerns. The actual time factor, there obviously is a little bit of confusion, sorry.

Well, could it be the case that you had a meeting alone with Dr Keating before the first oesophagectomy and then another meeting between the two oesophagectomies accompanied by Ms Hoffman?-- From my memory - my memory and my understanding is that I only had one meeting with Dr Keating.

Could you be mistaken as to whether or not Ms Hoffman accompanied you to that one meeting?-- I could be but I was under the impression I was on my own.

Could you be mistaken as to whether or not it was only one, not two meetings with Dr Keating?-- I'm pretty sure it was only one meeting with Dr Keating.

In any event, Ms Hoffman's recollection of a meeting between yourself and Dr Keating which she attended was that Dr Keating indicated that Dr Patel was a very experienced surgeon, familiar with this type of surgery and that it was important to keep him in the hospital. Do you recall Dr Keating expressing sentiments such as that during your meeting with him?-- No, I don't.

Do you recall him expressing such sentiments to you at any stage in relation to the concerns you were expressing?-- No.

Do you recall him saying anything to the effect that it was important that staff worked with him and accommodated his desires?-- No, that didn't come out in the meeting with him. Not that I recall.

That, perhaps, was consistent with the sort of attitude that led to the subsequent compromise after the second oesophagectomy of keeping the patient there for another couple of days?-- I think that the compromise was made in response to a forceful surgeon who was threatening to resign probably.

Well, if we could just look at that compromise. This is a matter where after the second oesophagectomy the patient has

had complications involving a number of returns to theatre for wound dehiscences and leaks; is that so?-- Yes, correct, yes.

And the decision you describe as a compromise was to hold on to the patient for a couple of days and review his clinical situation?-- Correct.

Now, there was no sound clinical basis for such a decision or such a compromise as far as you could see it?-- My feeling was that the patient would have been better off in Brisbane.

The only basis you could see for that compromise was to mollify Dr Patel?-- Yes, yes, I'd say that's probably true.

So as far as you saw things in your clinical judgment, the clinical care of the patient was compromised so as to mollify Dr Patel?-- The patient was getting the best possible care he could have done in Bundaberg from the intensive care staff.

Yes, I'm not suggesting otherwise. But you've agreed that there appears in your judgment to be no sound clinical basis for not transferring the patient to Brisbane?-- I think the decision was made to transfer the patient to Brisbane and in retrospect, we should have got the patient out instead of hanging on to him for a couple of days. It was seen that the decision was correct because the patient was eventually transferred out after three or four days anyway.

No, I'm asking about the circumstances at the time this compromise was reached, Doctor?-- Yes.

There was no sound clinical basis for, at that time, holding the patient for another two days to see how he went?-- There probably wasn't, no.

That decision was simply made because Dr Patel was agitating to the contrary?-- Well, that's your interpretation.

Well, that is the case, isn't it? Could you see any other reason?-- I think Dr Keating was in a very difficult position, to - to try and sort of do what was best, obviously, for the patient and do what was best for the hospital. He had a surgeon who was threatening to resign and was being aggressive and being - being totally irrational and at the end of the day, the compromise situation was that he would provide the patient with the best possible care that the Intensive Care Unit could give it and we would see how the patient went over the next 48 hours.

Doctor, I'm not suggesting it wasn't a difficult situation for Dr Keating but the fact of the matter is that the compromise that was reached was one which compromised the clinical care of the patient so as to mollify Dr Patel?-- I think that's possibly - that's a difficult one to answer. I mean, I think sort of, possibly, that's the case.

They're the two oesophagectomies in mid-2003. Did you subsequently, after that, express any concerns to Dr Keating

regarding surgery of that nature being carried out at Bundaberg Base Hospital?-- Once the Director of intensive care was back, he did not - Dr Carter basically took over, sort of, when he was back from holiday and those sort of concerns and issues would have been taken up between the intensive care director Dr Carter and Dr Keating.

So you were not asked for you views?-- No, not after I originally expressed my views and expressed some of the concerns from the intensive care staff, no.

And just briefly, in relation to patient P44, you didn't see the CT scans yourself?-- No, I didn't.

Or, indeed, any radiology reports?-- No, I didn't.

What are the protocols that you were concerned should be carried out?-- Certainly, my feeling that - as I expressed before, of being called in at 8 o'clock on a Sunday evening to put a patient on a ventilator was inappropriate and that's before the sort of protocols or procedures could well be taken the next morning when the director of intensive care arrived on the unit, and that's why I didn't come in and-----

No, that's fair enough?-- Yes.

But is there some type of formal protocol that's applicable in those circumstances or not?-- Well, certainly there's the clinical situation which has to be taken into account. Protocols are a bit of a grey area, I think, with regards to sort of strict protocols on - on whether to perform brain death tests or not. Certainly on a patient who is being transferred, then there are strict guidelines with regards to doing any brain death tests. On a patient on a ventilator, clinically brain dead due to all of the other clinical indicators, then obviously after discussions take place with the patient's relatives, switching of the ventilator is an acceptable thing.

Just that in paragraph 10 of your statement you say brain death tests are conducted by two specialists working together to run a series of tests which take between 30 to 60 minutes. On what basis do you say that's the usual procedure?-- Those procedures I think, if there was any concern from relatives or any concern that the patient was not brain dead prior to a ventilator being switched off, then obviously those tests are clinical tests which are undertaken by a chief specialist. If there was the case of any sort of organ transfer from patients who are on a ventilator, then it is mandatory that brain death tests have to be performed.

You mentioned the tests are prescribed by a professional body. Does that mean that the College of Anaesthetists actually publish some type of procedure?-- Brain death tests are a test - a sort of series of test are performed and they're recognised by all college of surgeons including anaesthetist intensivists.

But is there some type of document or publication one can go to?-- As far as I'm aware there are certain guidelines provided by that college to - to the tests that should be performed, yes.

And is that the Joint Faculty of Anaesthetists and Intensive Care-----?-- Yes, certainly they have - they have good guidelines to the procedures and protocols which should be performed.

Thank you, Doctor.

COMMISSIONER: Mr Devlin.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin. I represent the Medical Board of Queensland, Dr Joiner, good morning?-- Morning.

Doctor, in relation to the first patient of whom you spoke, if it is to be - turn out that it was Mr Phillips, and I take it you don't remember the patient's name at all, the Commission has received evidence that Dr Carter was the anaesthetist for the oesophagectomy. Does that accord with your recollection or not accord with it?-- I really cannot recall, I'm sorry.

Does it in any way affect what you've said already? I think you've said that your recollection was that Dr Carter was on leave?-- That's right. I thought he was, yes.

All right. Well, Dr Carter - if we've got the right patient, Dr Carter says he was the anaesthetist. Does your recollection tell you whether or not Dr Miach had a role in the management of this patient?-- No, I cannot recall that, I'm sorry.

You don't recall any role of Dr Miach?-- No.

Thank you. Now, in relation to the second patient then-----

COMMISSIONER: Just pausing there if I can, Mr Devlin. If it were the case that this was a patient of Dr Miach's from the renal ward or from the medical ward, do you think it's likely that the concerns you expressed, for example, to Dr Keating would also have been conveyed by you to Dr Miach?-- I'm not sure on that, whether his concerns were - whether - what, from Dr Keating to Dr Miach?

No, I'm sorry, I'm not - Mr Devlin is suggesting to you that this patient might have been a patient of Dr Miach's or Dr Miach may have had an involvement in the care of the patient?-- Yes. Yep.

If that had been the case and if you were aware that that was the case, would you have considered it appropriate to convey to Dr Miach about the surgery proposed to be undertaken with the patient?-- Once again, in my position in the hospital as a visiting medical officer, my concerns were taken up in the absence of Dr Martin Carter. Dr Martin Carter is the director. If he felt it was appropriate, he'd convey it to Dr Miach.

Thank you for that. Mr Devlin.

MR DEVLIN: Just on that matter also, the Commission has received evidence, if we're talking about the same patient, that you expressed to him, to Dr Carter that is, your reservations about this kind of procedure being conducted at Bundaberg. Do you have any recollection of doing that in the context of this patient?-- No, I don't.

Thank you. Now, in relation to the second patient, if we have the correct one for June 2003, you said in your evidence-in-chief that Dr Patel refused to talk to the surgeons in Brisbane. My only question is this: did you witness that refusal or were you told about it by someone else?-- I was told about it by somebody else as it complicated the issue of trying to transfer the patient to Brisbane.

Can you nominate the source from whom you received that specific information?-- No, at this stage I can't remember.

Thank you. In the meeting that you say occurred with Dr Keating and Dr Patel, did Dr Patel repeat to Dr Keating his threat to resign over this patient?-- My understanding was that he did.

Well, what do you mean your understanding? You were there; do you recall him doing that?-- Two years ago. I certainly remembered - I certainly remember standing in the corridor, as I said before, between theatre and ICU and Dr Patel as having said in no uncertain terms he'd resigned if he transferred the patient to Brisbane.

Okay. You're clear on that one and understandably so because you're in a one-on-one with Patel. Perhaps you're not so clear whether he repeated that to his - as it were, his boss?-- That's - I think that's a fair - a fair thing to say.

Fair enough. Now, in relation to this second patient, do you have any recollection of a role being played by Dr Younis in the patient's subsequent care?-- My understanding was that this patient went back to theatre on two occasions after his initial surgery. I think that Dr Younis took the patient back to theatre on the first occasion. I took the patient back to theatre on the second occasion.

Sorry, did you take you say you took the patient back on the second occasion?-- I did.

Is it likely that Dr Younis played a role in the management of the patient together with Dr Patel after that?-- He could have been in charge of intensive care for the day when the patient was transferred out but I'm not sure.

All right. Thank you, Doctor. Still stay with us, please. I think another counsel has some questions?-- No worries.

COMMISSIONER: Mr Diehm.

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Doctor, it is Geoffrey Diehm, counsel for Dr Keating. I too want to explore with you the chronology of the history of oesophagectomies-----

COMMISSIONER: Mr Diehm, before you start on that. How long do you expect that exercise to take?

MR DIEHM: Commissioner, it's a counsel's estimate of 15 minutes.

COMMISSIONER: All right. Well, I'll double that. We might take the morning break now and, Doctor, would it be convenient for us to call you back at, say, 20 to 12?-- Yes, okay. No problem.

COMMISSIONER: Thank you?-- Bye.

We will adjourn now.

THE COMMISSION ADJOURNED AT 11.26 A.M.

THE COMMISSION RESUMED AT 11.50 A.M.

COMMISSIONER: I should deal with a housekeeping matter while we're waiting for the rest of counsel to return. It may be recalled that earlier this week we had a closed session to discuss a person and their capacity as a patient and that person's medical condition. Despite the fact that the camera and microphones were turned off, it's been brought to our attention that there was a live feed to the ABC. We're grateful to the ABC for bringing that to our attention and we're particularly grateful for the journalists who became aware of it for their help in maintaining the confidentiality of the matters that were discussed at that time. But to protect those journalists from any pressure they may have to make use of information, I'll now make a formal direction that the matters discussed at that closed session shall not be reported or broadcast outside these proceedings. Does anyone wish to raise anything arising out of that?

MR ASHTON: No, thanks, Commissioner.

COMMISSIONER: Thank you Mr Ashton. Mr Andrews. Yes, we'll redial.

JONATHAN JOINER, CONTINUING VIA TELEPHONE LINK:

COMMISSIONER: Dr Joiner?-- Hello.

This is the Commission of Inquiry again. I'll now ask Mr Diehm to conduct his cross-examination. You'll recall that he represents Dr Keating?-- Yes, thank you.

CROSS-EXAMINATION:

MR DIEHM: Thank you, doctor. I wanted to go firstly over the chronology concerning oesophagectomies. You mentioned in your evidence that oesophagectomies had in the past been performed at the Bundaberg Base Hospital but not for a few years?-- Yes.

And there is evidence before the Commission that there was, however, an oesophagectomy performed at Bundaberg in March of 2003 by a Dr Faint; were you unaware of that procedure?-- Actually now - I did actually, now you bring that up I do recall that, yes.

And that patient apparently had a successful outcome?-- That's correct.

All right. Now, you in your statement, without the aid of any records obviously enough to assist you with identifying patients, but in your statement you seem to be talking about two different oesophagectomy patients as has been canvassed with you, one in about April or May of 2003 and one in June of 2003, and as Mr Allen has taken you through it, it would seem that the June of 2003 patient accords, generally speaking, with being a patient by the name of Grave who has been the subject of evidence before this Commission; I think you had agreed with that proposition?-- Right.

Doctor, I'm wondering whether you would agree with the suggestion that the circumstances that you've been describing regarding what seem to be referred to as two different patients in your statement, in fact concern the one patient, that you're mistaken in the suggestion made in paragraph 4 that your concerns arose in about April or May of 2003 but rather that your concerns about an oesophagectomy patient were ones that arose in June of 2003 concerning Mr Grave; are you able to comment about that?-- Well, I certainly remember having two meetings with Dr Keating, one was concerning presumably we're talking about Mr Grave were the issue with transferring him to Brisbane.

Yes?-- And I certainly don't remember having a discussion with Dr Keating prior that. My understanding it was the matter with regard to the oesophagectomy of Mr Grave.

All right. You see, you're obviously confident that the conversation, the first conversation that you're talking about was one that arose in circumstances where Dr Carter was on leave?-- Correct, yep.

And you can be clear about that because if Dr Carter wasn't on leave-----?-- I wouldn't be, that's right.

-----you wouldn't be having the conversation?-- That's correct.

Now, as Mr Devlin put it to you, the evidence before this Commission is that Dr Carter - and there's evidence from Dr Carter himself?-- Yep.

Dr Carter was the anaesthetist for the patient Phillips who was the first oesophagectomy patient operated on by Dr Patel on what I recall as being the 19th of May 2003?-- Right.

So if that's right, then any concerns that you had discussions with Dr Keating weren't about that patient?-- Well, obviously that's the case, yes.

Now, is it also right to say that before you met with Dr Keating to discuss any concerns about oesophagectomy patients, you had already had discussions with Toni Hoffman?-- I certainly had discussed it with Toni Hoffman, that's correct.

Yes. And if her evidence is that her discussions with you

about concerns regarding oesophagectomy patients occurred after Mr Phillips' operation, then again, that's another basis upon which you might accept that your conversations with Dr Keating were ones that surrounded the care of the first oesophagectomy patient, Mr Grave?-- Again, I was under - I was under the belief, firm belief that I'd spoken to Dr Keating prior to any oesophagectomy being performed, not that we'd already had an oesophagectomy that had died.

All right. But it may simply be that after this passage of time, you're a little unclear about some of these chronological details?-- Well, certainly - I mean, as I said, I remember talking to Dr Keating on two occasions, that's right, the exact date, well, it was two years ago.

Okay. Doctor, with respect to the discussions that you did have with Dr Keating, can I suggest to you-----

COMMISSIONER: Sorry, Mr Diehm, before you go on.

MR DIEHM: Yes.

COMMISSIONER: I am concerned to clear up this uncertainty in the evidence, and I wonder if I could ask Dr Joiner: you tell us that you have a clear recollection of two separate discussions with Dr Keating, and you have a clear recollection that they were two separate discussions about two separate patients?-- The second discussion was with regard to a specific patient who was in intensive care that we wanted to transfer to Brisbane.

Yes?-- The first discussion was whether we should be discussing oesophagectomies in the hospital.

Is it possible that those were discussions about the same patient once before the operation took place and once after the operation when you were discussing transfer of the patient to Brisbane?-- I'm not aware that that was the case, no. I was under the impression that we discussed oesophagectomies per se as to whether we should be performing them and not that specific patient.

Well, that's why I wonder whether the first discussion took place in the context of the same patient but before any operation had been performed when you raised your concerns about whether that operation should be undertaken, and then with reference to the same patient after the operation you then became involved in a discussion about removal of the patient to Brisbane; is that a possible explanation?-- That is possible.

Thank you.

MR DIEHM: Thank you.

And doctor, you recall having an interview with representatives of the Crime and Misconduct Commission accompanied by representatives of this Commission?-- Yes, I

do.

And in that meeting, which was recorded and there's a transcript that's been made available to some parties, but in that meeting, it seems that you've referred, having referred - this is on page 7 for anybody who has the document - having referred to a discussion with Dr Keating about oesophagectomies, you say, "And I think in discussion with - with obviously with Dr Patel, it was decided that the operation should go ahead in Bundaberg and I had no further part in the decision-making on that and I understand one of the very good locums we had from - he was a Canadian anaesthetist performed the procedure with Dr Patel." You were then asked, "Do you know who that was?" You say, "Off the top, I can't remember his name, he was doing a locum while Dr Carter was on holiday but what proceeded from that case was that the patient unfortunately had proceeded to have two leaks from the oesophagectomy site and went back to theatre on two further occasions." So I suggest to you that when doing your best, obviously, as you could when you were recalling the chronology to the people at the CMC in that interview, your recollection was that your discussion with Dr Keating about whether these procedures should be going ahead was in fact in reference to the patient who had the returns to theatre, that sound like the ones you describe concerning Mr Grave; does that assist you at all?-- Not really-----

All right?-- -----I'm sorry, no.

I won't take it any further, doctor?-- No, you're right.

Doctor, now, with respect to discussions you did have with Dr Keating, can I suggest to you that the sequence of events is different as to that which you have recalled, in that you did have two meetings with Dr Keating concerning your issues regarding oesophagectomies but that they occurred on the one day, that is, on the 17th of June 2003 subsequent to Mr Grave undergoing his operation but at the time that you had concerns regarding his need for transfer to Brisbane. Now, I take it from your evidence that your recollection is different than that?-- I still maintain that I had two meetings and one would be with regard to transferring the patient out who had complications and a separate meeting prior to that was with regards to performing oesophagectomies in the hospital.

Yes. And I suggest to you that the first meeting on that day was one which you had with Dr Keating alone, that is, no-one else with you, and that in that meeting you did raise your concerns about whether or not Bundaberg should be performing these sorts of operations, and which you raised as a second concern your view that the patient needed to be transferred from Bundaberg to Brisbane but that Dr Patel disputed that?-- I still maintain I had two separate meetings with Dr Keating with regards to those issues that we've discussed.

COMMISSIONER: Are the details just put to you consistent with your recollection of the second of those meetings?-- The second meeting certainly concerned transfer out of that

patient from intensive care, and prior to that, and obviously this is the confusion, I accept, with the time difference between the first meeting I had with Dr Keating, but there were definitely two meetings that I had with Dr Keating, one was a good few weeks prior and then the second meeting with regard to transferring out the patient of intensive care.

There is another possibility that occurs to me: you see, Mr Diehm has suggested that the first oesophagectomy performed by Patel, that Dr Carter was actually the anaesthetist for that first operation, so it occurs to me as a possibility that that arose whilst Dr Carter was away, and you took your concerns to Dr Keating but Dr Carter had come back by the time the operation actually took place?-- Yes.

Is that a possibility?-- Yes, I think that's probably what happened, but - yes.

MR DIEHM: Except, doctor, that Dr Carter's evidence is that he was on leave, not in the time leading up to the operation on Mr Phillips, but that he was on leave at the time of the operation upon Mr Grave and in the lead-up to it. So that would make it consistent with your concerns being raised concerning the patient Grave rather than the patient Phillips; would you agree with that?-- I mean, certainly there were concerns with the patient Grave.

Yes.

COMMISSIONER: But it would also be consistent with your recollection that you had two separate discussions, one which occurred whilst Dr Carter was absent and one which occurred after Dr Carter had returned and after the operation was performed?-- Yes, that's correct.

MR DIEHM: Well, do you recall it that Dr Carter was absent at the time of only one of your meetings with Dr Keating or is your recollection that he was absent at the time of both meetings?-- Dr Carter would have been absent on both meetings with Dr Keating because if Dr Carter would have been there, I would have approached Dr Carter directly with regard to whether we transfer the patient to Brisbane and I would have discussed it directly with Dr Carter if he'd been there with regards to whether we should be doing the oesophagectomy, so on both of the times I saw Dr Keating, Dr Carter obviously wasn't in the hospital.

COMMISSIONER: So that suggests that both discussions were over a period of a maximum of three or four weeks while Dr Carter was away?-- Yes.

Rather than one meeting in April or May and then another meeting in June?-- Yes, no, that's right. Any meeting I would have had would have either been to talk to Dr Carter who was in charge of the department, and in the absence of Dr Carter, this is why the intensive care staff came to me, and in the absence of Dr Carter while on holiday and I went to see Dr Keating and also the decision to transfer that patient to

Brisbane would have been without Dr Carter being present in the hospital.

So it is sounding like Mr Diehm's probably correct, that both discussions related to the same patient but you maintain that they were some time apart?-- Apart, indeed.

One before the operation and one after the operation?-- That's right.

Yes.

MR DIEHM: Doctor, with respect to the second meeting that you had with Dr Keating concerning the patient Grave and specifically concerning the issue of transfer, and as you've referred to which in that meeting there was a compromise, as it were, that was reached, that meeting took place, I suggest to you, after Dr Younis had reviewed the patient for the purpose of providing a second opinion as to whether he should be transferred or not; are you aware of that?-- I wasn't aware of that.

Was - I take it you say Dr Younis wasn't present at the meeting?-- No, he wasn't.

And you're unaware of Dr Keating having made an arrangement with Dr Younis for Dr Younis to carry out that assessment to assist Dr Keating in deciding what to do about the conflict between yourself and Dr Patel?-- I wasn't aware that Dr Younis was involved, whether Dr Younis was involved in the eventual transfer out of the patient a few days later, but I wasn't aware that that was the case on the specific day that I'd spoken to Dr Keating and we'd had discussions with Dr Patel about the issue.

All right. Thank you, doctor. And clearly enough, if Dr Younis reviewed the patient and formed a view that it was reasonable to hold the patient in Bundaberg for another one to two days to see whether or not the patient improved, as Dr Patel claimed that he would, then from a clinical point of view, the decision to keep the patient in Bundaberg, objectively speaking, appeared sound; would you agree?-- Well, the patient was eventually transferred out.

Yes, it may have transpired that the decision proved to be wrong, but from a clinical point of view, that was a reasonable course to take, wasn't it?-- Yes, it is, but I wasn't aware that Dr Younis was involved in it.

Thank you. Now, I suggest to you that - and I'm going back to a proposition that I appreciate you don't accept, doctor, but I need to take you - take these matters up with you: that the first meeting, as I've suggested to you, occurred on that same day as the second meeting in which you met with Dr Patel and Dr Keating, and that at that meeting, Dr Keating, having listened to your concerns, as you have described them, said that he would look into the matter; is that right?-- This is with regard to the patient Grave, whether we should transfer

to Brisbane?

Yes, that he would look into that issue?-- Yes.

And I suggest to you, with respect to your concern about - and perhaps I'll rephrase this and try and put it more neutrally. Regardless of when this first meeting with Dr Keating took place, do you agree with my proposition that Dr Keating's response to your concerns about oesophagectomies being performed at Bundaberg was that he would discuss the matter with Dr Carter and with Dr Patel?-- That was my understanding, yes.

Now, obviously he was going to have to wait for Dr Carter to return from leave to be able to discuss that issue with him?-- Yes.

Thank you. In terms of the meeting at which Dr Patel was present with yourself and Dr Keating, acknowledging your answer to Mr Devlin that you couldn't be too sure about what Dr Patel said to Dr Keating in terms of threatening to resign, my suggestion to you is that Dr Patel did not make that threat in the presence of Dr Keating; do you accept that?-- That's a possibility.

All right. But he was certainly forceful with respect to his view about the management of the patient?-- Definitely.

You tell us that you worked or work, generally speaking, five sessions a week in anaesthetics at the Bundaberg Hospital?-- That's correct.

Given your professional background, would it be reasonable to assume that you tended to be involved in the more routine surgery rather than the more difficult surgery?-- That's correct.

But nevertheless, you would have had occasion, I suggest, to work with Dr Patel in surgery a lot of times?-- That's right, Dr Patel and I performed a lot of general surgery.

And with a lot of different patients?-- Absolutely.

Now, that presumably provided you with some considerable opportunity to make observations about the standard of Dr Patel's clinical care?-- Yes, yep, indeed.

Now, doctor, I don't want to be unfair to you, I accept that you're not a surgeon and you're not making a surgeon's assessment, but nevertheless, you're quite experienced in your profession and you would like to think that if somebody is obviously incompetent, then it would be apparent to you?-- Yes, I think that's true.

Aside from the prospect that you might detect something, from a technical point of view, during the course of surgery, you were also in a position to, generally speaking, over a long period of time, make observations, anecdotally, about the

course of patients' success post-surgery for Dr Patel?-- Yes, yep.

And in particular, if there was an unusual trend with respect to complications, that would be something that you would expect to become apparent to you?-- Immediate complications within the framework of the operating theatre, yes.

Oh yes, doctor. I mean, for instance, if a cancer had been missed during surgery and that didn't become apparent to anybody until 12 months later, for instance, that's obviously not something you're going to become aware of?-- No, that's right.

But problems, for instance, with wound breakdowns, wound dehiscences, not necessarily in every case, but if you were - if it appeared that there was, or - I'm sorry, I'll rephrase that - if there was a strong pattern or trend in that respect, you would expect to become aware of it?-- Yes.

And the same with unexpected returns to theatre?-- Yes.

And unexpected admissions to ICU?-- Yes, that's correct.

And clearly enough, doctor, if you had become aware of those things, you would have raised your concerns with somebody?-- Yes, that's true.

Is it fair to say, doctor, that perhaps not until very late in the time of Dr Patel's tenure at Bundaberg, such things didn't become apparent to you?-- I think that's the truth for all of us, yes.

Yes. When did you first - and aside from the specific issue that you've raised concerning these oesophagectomies - when did you first become aware or first develop a concern in your own mind about Dr Patel's clinical competence?-- I think this was probably, anecdotally, and it was towards the end of his tenure on the cases involved of the oesophagectomies that unfortunately resulted in the patient having bled to death and, anecdotally, on the case with regard to the young boy, I recollect at that stage I think we - anecdotally, sort of doubts were beginning to think that that's not quite right.

You also gave some evidence about your observations about Queensland Health's apparent attitude towards the engagement of VMOs, and, as I understood what you were saying, your experience was that there was a reluctance on the part of Queensland Health to engage private specialists who may have been available in Bundaberg for performing VMO work in Bundaberg?-- That's absolutely correct.

Now, that trend or pattern that you have referred to, that habit, is that one of longstanding, in your experience?-- In the 11 years I have been working in Bundaberg, there has generally been a feeling that VMOs are too expensive to employ and have not been employed. I can remember a memo from a few years ago implying that Queensland Health were actively trying not to employ visiting medical officers, but that was going back some years ago.

Certainly before the time of Dr Keating?-- Definitely. It has been a longstanding - I have been in Bundaberg for 11 years and constantly during that period my employment has been looked at throughout in regard - in terms of reduction in-----

Your understanding is that this isn't something that's as a result of decisions of local managers, but rather as brought about as part of budgetary pressure upon them from within Queensland Health?-- Yes, that's my understanding, yes.

There was an anaesthetist who - private anaesthetist who came to Bundaberg during Dr Keating's time and came to work at the hospital for a short period, do you recall?-- Yes, I do.

Dr Keating was able to appoint that anaesthetist who was a member - I am sorry, I will ask you one question at a time and not several. Are you aware that that particular anaesthetist was a member, not only of the College of Anaesthetists, but also of the College of Physicians?-- Yes, that's true. That's correct.

And Dr Keating was able to squeeze the figures so as to appoint that doctor as a casual. Do you recall that?-- I do recall that.

The doctor also - his wife was a paediatrician. Is that within your recollection?-- Yes, that's correct.

And Dr Keating was also able to find work for her at Bundaberg?-- That I am not sure of.

But unfortunately the doctor left after a short period of time. Is that your recollection?-- Yes, that's true, yeah.

He moved from Bundaberg. Does that fit with your understanding of things?-- He was in Bundaberg for a short period of time, yes.

And, for personal reasons, decided to leave Bundaberg?-- That's correct.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Mr Ashton?

MR ASHTON: No, thank you, Commissioner.

COMMISSIONER: Ms Gallagher?

MS GALLAGHER: No, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, Commissioner, thank you.

COMMISSIONER: Anything further?

D COMMISSIONER VIDER: No, thank you.

D COMMISSIONER EDWARDS: No.

COMMISSIONER: Doctor, thank you very much for your assistance this morning. I can assure you that your insights into the tragic events involving Dr Patel have been tremendously valuable to us and we thoroughly appreciate the time you have taken to provide us with the benefit of your recollections. I will formally excuse you from further involvement in the proceedings?-- Thank you. Thanks very much.

Thank you. Mr Andrews?

MR ANDREWS: Commissioner, Dr Jayasekera is treating patients and needs about 10 minutes' notice. It is a question for you as to whether we will start him now or adjourn him to another day.

COMMISSIONER: How long do you expect his evidence will take?

MR ANDREWS: An hour.

COMMISSIONER: Is that in chief or all up?

MR ANDREWS: All up. He doesn't speak of any patients who are of - and accordingly I expect - well, he speaks of only one patient, I might say, but that was before Dr Patel's time.

COMMISSIONER: Yes.

MR ANDREWS: It is conceivable, I suppose, that the Patients Support Group may have some questions of him.

COMMISSIONER: I would have guessed, Mr Ashton, that you would want to explore some of the issues?

MR ASHTON: Yes, I wouldn't think at great length, but there are a couple of matters mentioned in the statement that I will need to explore, I think, Commissioner.

COMMISSIONER: Look, in the circumstances I think we will deal with his evidence today. We will adjourn for 10 minutes, come back at 12.30 and do our best not to eat too much into the lunchtime. Ms Edmond is coming back at 2 o'clock, is it?

MR ANDREWS: I believe it is 2 o'clock, Commissioner, yes.

COMMISSIONER: Is it going to cause serious pain around the Bar table if we have a half hour lunch today?

MR DIEHM: We will finish early anyway, I think, Commissioner.

COMMISSIONER: Yes. We will stand down for 10 minutes.

THE COMMISSION ADJOURNED AT 12.23 P.M.

THE COMMISSION RESUMED AT 12.30 P.M.

COMMISSIONER: Mr Andrews, I understand there is a complication?

MR ANDREWS: Dr Jayasekera may be giving his evidence on his car phone.

COMMISSIONER: Right.

MR ANDREWS: But he will be parked.

COMMISSIONER: Well, let's try. But having had the experience this morning with the previous witness on a landline and the poor quality of reproduction, if it doesn't work we will know fairly quickly and then have to reschedule the doctor.

MR ANDREWS: We have got also the benefit of Dr Jayasekera's accent.

COMMISSIONER: Yes.

MR ANDREWS: Good afternoon, Dr Jayasekera?-- Good afternoon.

Is it Lakshman Kumar Jayasekera?-- That's right, yes.

It is David Andrews calling, doctor. You have spoken with me once before?-- Yes.

I am counsel assisting the Commission. Can you hear me?-- I can hear you very well, thank you.

COMMISSIONER: Doctor, is it convenient for you to give evidence now?-- Yes, I will stop the car. I am in my car.

Can I ask you whether you are happy to take an affirmation?--

Yes, sure.

LAKSHMAN KUMAR JAYASEKERA, ON AFFIRMATION, EXAMINED VIA TELEPHONE LINK:

COMMISSIONER: Thank you. Mr Andrews?

MR ANDREWS: Doctor, do you have with you a copy of your six-page statement?-- I have it with me.

It was-----?-- But - sorry?

It was-----?-- Sorry, can you hear me?

I can hear you?-- Yes, I have it in front of me.

Thank you very much. Doctor, are the statements in it true and correct to the best of your knowledge?-- Yes.

Are your opinions in that statement honest opinions?-- Yes.

I tender that statement - a copy of that statement, Commissioner.

COMMISSIONER: Yes, the statement of Lakshman Jayasekera will be Exhibit 308.

ADMITTED AND MARKED "EXHIBIT 308"

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: And, doctor, a number of witnesses have referred to Dr Lucky. Is that how you are commonly-----?-- I am known as Lucky, yes.

Thank you.

MR ANDREWS: You had obtained your fellowship of the Royal College of Surgeons in Edinburgh in 1983, you had sat for and passed the Australian Medical Council examinations in 1996, and you were a Fellow of the Royal Australasian College of Surgeons, and were made such in 2000. Is that correct?-- All that is correct.

COMMISSIONER: Mr Andrews, the statement largely speaks for itself. You might find it easier to confine yourself to anything you want expanded or clarified.

MR ANDREWS: Very much easier, Commissioner, thank you. Doctor, I would like you to recall your experiences with

Dr Anatoli, the person described in paragraph 23 of your statement, a Russian doctor. Do you recall asking Dr Nydam whether this new doctor should be supervised, is that the case?-- That's right. What happened with Dr Nydam, he was on leave, I think, and we had this doctor - I think he was Russian trained and-----

Doctor, Jayasekera, would you slow down, please? A shorthand writer takes down all that is said within this room and you are speaking more quickly than she can cope with?-- Sorry. Sorry about that.

COMMISSIONER: Mr Andrews, I am concerned because of the quality of the connection that this is not going to be successful. I have in mind, particularly that some of the things said in this statement could be regarded as reflecting adversely on Mr Leck, and possibly others, and I think it is only fair that Mr Ashton not be at a disadvantage in cross-examining. Mr Ashton, how do you feel about that?

MR ASHTON: I am happy to persevere, Commissioner, but I am in your hands.

COMMISSIONER: Well, if you are happy to persevere. Mr Andrews, I am inclined to let the statement speak for itself and give Mr Ashton that opportunity. And if, Mr Ashton, you feel it is being unsuccessful, you let us know and we will make other arrangements.

MR ASHTON: Thank you.

MR ANDREWS: Thank you for that intimation. In the circumstances, I will abbreviate my examination-in-chief, but there are one or two matters that I wish to ask the doctor about. Doctor, if you had been appointed Director of Surgery at the end of 2002, would you have remained at the Bundaberg Base Hospital?-- Not really. That's not the reason why I left the hospital.

Yes?-- Yes, I left because I had to travel about 400 kilometres, and that's about four hours' drive, and my family was living in Brisbane, so-----

COMMISSIONER: Please stop. This is hopeless. I am sorry, doctor, because of the telephone connection, what you are saying just can't be understood. I think we're just going to have to reschedule your evidence to another occasion. I apologise for any inconvenience that causes you?-- Sure.

MR ANDREWS: Thank you, Commissioner. In the circumstances, doctor, the inquiry staff will make contact with you again to find a time convenient to you and the Commissioners for you to give evidence. It is likely to be some time after Monday the 5th of September?-- That's all right.

COMMISSIONER: Doctor, do you live in Brisbane now, or at the Gold Coast?-- I live in Brisbane but I travel every day up an down, but when I am on call I live there.

Is there a day - not next week but in the two weeks after that when you will be in Brisbane and you can come here to give evidence in person?-- Um, I should be able to but I will have to take a day.

I will ask staff of the inquiry to get in touch with you and work out a day that suits you so that you can give evidence here in Brisbane?-- Good, yes.

Thank you?-- Thank you very much.

COMMISSIONER: We will now adjourn till 2 p.m.

THE COMMISSION ADJOURNED AT 12.40 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.03 P.M.

WENDY MARJORIE EDMOND, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Thank you, Ms Edmond, for returning. Mr Douglas.

MR DOUGLAS: Commissioner, when we ceased the hearing last night you will recall that there was ventilated an endeavour to obtain further information from Queensland Health about those waiting lists.

COMMISSIONER: Yes.

MR DOUGLAS: In the last hour we have received a letter and some material from Queensland Health. That material is being copied at the moment.

COMMISSIONER: Right.

MR DOUGLAS: It may well be that as a result of that communication, that the matter can be dealt with in another way which won't involve dealing with this issue. I can't be sure about that until I see the annexures. The most appropriate course I think, Commissioner, would be for the other cross-examination to ensue and I can deal with that matter when that concludes.

COMMISSIONER: Thank you, Mr Douglas. Mr Tait. Your five minutes begins now.

MR TAIT: That was before yesterday. There are two preliminary matters, please, Commissioner. First on page 4992 of the transcript, I found an error. I didn't get beyond there last night. It's at line 31 and the question I asked said, "Bundaberg failed in 14 of the 17 categories." It's come out as "1 of the 17 categories". It's a typing error.

COMMISSIONER: That will be noted.

MR TAIT: Thank you. Second, I have obtained a copy of the questionnaire which Ms Edmond referred. I've provided a copy to everyone at the Bar table and specifically to Ms Edmond's solicitors and I tender that if it's appropriate.

COMMISSIONER: Yes, thank you. You wouldn't happen to have three copies so the Commission can look at it.

MR TAIT: I certainly do. Three copies plus one for the file.

COMMISSIONER: I can't for the moment see the bit where it says, "We would like to have more money", but perhaps we'll be taken to that.

MR TAIT: Thank you. Ms Edmond, you have seen a copy of that questionnaire maybe only a few minutes ago?-- Mmm-hmm.

It was, I think, five years ago that that questionnaire was sent out and in the time that you were Health Minister, there were many questionnaires about hospital systems. Do you accept that that was the questionnaire that related to that report?-- Yes, Mr Tait, and I also accept that I think that I probably only saw part of it at the time, that part that did relate to budgets.

All right. And you accept that that questionnaire seems like a fair attempt to obtain information not a biased one?-- Oh, it would appear so from where I've seen it now.

Yes, thanks-----?-- I have only had a chance to have a quick look at it.

But as I say - you were asked a question about a questionnaire that you hadn't seen for many years?-- Mmm-hmm.

And you've now had a chance to see the one in actual proof?-- Yes, I have.

All right.

COMMISSIONER: Is it your recollection that your staff or the department only showed you bits of it five years ago which led to your-----

MS DALTON: Well, I'm sorry, Commissioner. She didn't say the staff only showed part of it. She just said she didn't see it. I just have a concern that there is an implication that the senior bureaucrats nameless are continually letting the Minister down.

COMMISSIONER: That's why I asked either her staff or-----

MS DALTON: Well, no, she says she didn't see it but you seem to have assumed that it was her staff that didn't show it to her. I'm sorry, maybe it's just semantics but I'm-----?-- Commissioner, maybe I could clear that up. I can't recall whether that bit is the bit that stuck in my mind or whether I only saw that bit. I can't be sure of that this long after the day.

COMMISSIONER: Thank you?-- I don't think anyone tried to conceal it from me.

The document "Questionnaire for Hospitals Use" by the AMAQ will be Exhibit 309.

ADMITTED AND MARKED "EXHIBIT 309"

COMMISSIONER: Yes, Mr Tait.

MR TAIT: Thank you, Commissioner. Ms Edmond, the point we finished at last night, it shouldn't be thought that the AMA and you were always at loggerheads, were you?-- Oh, not at all. We had a lot of meaningful negotiations. I think you were involved in some of them, Mr Tait, about medical indemnity. I think we were all trying to come to satisfactory arrangements.

Yes?-- And the number of issues that you had to deal with as you indicated from day to day were many?-- Absolutely.

And to some extent unpredictable?-- Unpredictable and widespread.

Yes. Now, I was - before the comments I shouldn't have made last night, and I apologise for making them, I was going to outline to the Commissioner where I was heading-----?-- Mmm-hmm.

-----in my questions and the point is that I can take you to a large number right back in 2000 of adverse comments about the Bundaberg Hospital?-- Yes.

Of course, there were adverse comments about other hospitals as well. It's easy for me to single out Bundaberg now because that's what I'm looking at. You said yourself that you were a Minister who was pretty keen to press public servants or the people advising you to get the truth?-- Mmm-hmm.

That you didn't - I'm not saying you doubted them but you - you wanted to try to establish things for yourselves?-- Yes, I was. I'd talked to people on the ground.

You'd agree, no doubt, that as it has transpired, the problems at Bundaberg were pretty deep and pretty serious?-- We knew that Bundaberg had a longstanding recruitment issue, that had been going on for years, and were trying to address that but I think it became even more than that. It sort of gets into a cycle. If you have a shortage of staff, it puts an extra load on the staff that are there and that can compound all of the problems you're facing.

Certainly. In a news release on the 29th of November 2001, an AMAQ news release, the then president Bill Glasson said that, and I'll read it to you, "A second surgeon has resigned from Bundaberg Base Hospital fed up with poor work conditions along with the hospital's constant funding shortfalls and its irresponsible management. Young graduate doctor Sam Baker resigned from his position as staff surgeon at Bundaberg Base Hospital yesterday. He has been working at the hospital for just 11 months." It goes on to talk about Dr Charles Nankivell, and I think you know-----?-- Yes.

At least know of Dr Nankivell?-- Yes, I do.

Did it - did you appreciate at the time the apparent

seriousness of the problems at Bundaberg or is that now something we can see with the benefit of hindsight?-- I appreciated a lot of concerns of Bundaberg, particularly a recruitment problem. Dr Nankivell had forwarded, I think to Dr Stable, a letter and, I'm sorry, I'm just trying to drag it back, in which he said he couldn't continue. I think he was an older man, he couldn't - I hope I'm not saying the wrong thing there.

Older than Dr Baker?-- Yes. He couldn't continue doing as much on-call as he was being asked to do because of the shortage of staff and that while he was still very keen to work in Queensland Health, he couldn't continue in Bundaberg where I think he was doing about one in two, one in three on-call because of that shortage of staffing, and he in fact asked for a transfer to - and he moved to Logan Hospital and continued in the public service there.

Yes. Dr Glasson went on and said, "The Queensland government's Cabinet meeting to be held in Bundaberg this weekend was an opportune time for the Health Minister to address the crisis at Bundaberg Base head on. I would suggest that Minister Edmonds schedule an appointment with management and medical staff at the hospital during her visit to the city." Regardless of whether you knew of Dr Glasson's call, do you recall now whether in November 2001 when you had a Cabinet meeting at Bundaberg, you did go to the hospital to try to find out for yourself about the problems?-- I think while I - I mean, there's two things that happened at that and I'm pretty sure it's a cabinet - community cabinet meeting at which these two happened because we did them all the time. Dr Strahan and the secretary of the local medical association came as a delegation to speak to Dr Stable and myself and the District Manager at the community cabinet meeting as a delegation and while I was in cabinet, Dr Stable, and I'm sure you'll be able to ask him, went up to the hospital to talk to staff and meet with the staff up there. I can't recall if on that occasion I went to Bundaberg Hospital but I had been on others.

Ms Edmond, the problem I'm trying to get is that right back then, the very same sort of issues we've heard about in this inquiry were at least known to some people and they seem to have gone on for three or four years. How can we as a community address this problem in the future? If someone like you couldn't get to the bottom of it, what is the solution? Is it, for instance, that doctors at hospitals should have direct access to the Minister?-- I think one of the issues, Mr Tait, and I'm not trying to obtuse here, the key issue is that there weren't enough doctors at the hospital. That was the issue, we knew that was the case and we were doing everything we could to recruit but you can't actually force people to go to-----

No?-- -----hospitals and that was - to me - to my understanding, that was the biggest issue. That was the issue that Dr Nankivell raised and I think it was the issue that Dr Baker raised. So neither of them directly with me.

COMMISSIONER: Ms Edmond, I appreciate you're at a real disadvantage because you're trying to recall things four or five years ago whereas we have the benefit of having heard evidence over the last 50 days of sittings. But the evidence that we've heard indicates that what you've just said wasn't factually accurate in the sense that there were people willing to act as VMOs as surgeons at the hospital, Dr Anderson was one of them, who feel, rightly or wrongly, that they were driven out by the - by a Queensland Health attitude that discouraged and didn't accommodate visiting medical officers, and we heard again just this morning that reinforced by another man who was and continues to be a visiting medical officer of the hospital but testified to the fact that throughout his 11 years in Bundaberg, there has been this sense amongst the visiting medical officers that they're not welcomed at the hospital?-- I can't comment on - I'd prefer not to comment - I think Dr Anderson was a very different case with due respect, Commissioner, and I don't think it's appropriate that we go down that track. I'm sure - it's old history. I'm sure he'd rather it was rested.

MR TAIT: Well, if it is the case, and I don't want to debate witness by witness with you either - it would take too long; it wouldn't be fair to you - but if it is the case that the Commission finds there was in practice a feeling that VMOs or other people wanting to go to work at the hospital weren't welcome, that would disappoint you?-- Yes, it would and I'm totally unaware that there was any attitude to discouraging VMOs at Bundaberg Hospital.

Yes. Ms Edmond, the problems that you had to face obviously involve balancing competing interests whether it's funding or almost any other problem?-- Mmm.

The indemnity crisis as you discussed, a problem of what rights to take away from people who are injured in hospitals as opposed - or by automatic practitioners as opposed to making the whole system sustainable in terms of insurance. It was a balancing act?-- Always.

Always. In Townsville, you - with the disclosure about the bogus psychiatrist-----?-- Mmm-hmm.

-----again it was a balancing act. What, balancing the rights of the patients and, as you discussed yesterday, with the - trying to achieve the right outcome?-- Trying to care for people who were vulnerable because of their illness.

Yes?-- Yes.

Rightly or wrongly, you came to the conclusion you did?-- Yes, I did.

But with the best of intentions?-- Yes.

All right. Now, can you advance any suggestions as to how we can avoid particular trouble spots becoming so entrenched in

the future? Is it that the AMA should be more active? Could they have been more active?-- I think it is - it is very difficult. I mean, until - I think - I think a lot of these problems are almost unsolvable until we've got enough good quality graduates coming through who are taking up those positions. While there is such a shortfall, while we are having to take people from other places, it's always going to be a problem and I think one of the things I was thinking about in the middle of the night last night, Commissioner, is perhaps we had so much focus on overseas-trained doctors from Third World countries that when somebody put up their hand from the United States, for example, who'd spent most of their working life in the United States, perhaps it didn't send off the same beacons that if they were coming from another country where we knew less about their training and less about their culture.

Sure. Do you think though that with 15 per cent below the national average funding as there was when you started as Health Minister, even if there was a risk of poaching staff from interstate, I don't mean - or people who might have gone interstate, coming to Queensland instead, that to get an expenditure where we were up to the national average might have helped?-- My understanding was that in hospital funding we actually did get it up by the time I left to pretty close to the national average.

Yes?-- I'd have to go back and look at the productivity Commission figures and analyse them. I haven't had the opportunity to do that but my recollection is that we'd come a long way towards doing that. There were still some other areas where we weren't in the community sector but my understanding was on hospital budgets, we were about - we had moved from being at the bottom to up to about national average.

See, now looking back on it a year and a half since you left politics, it must be a terrible disappointment to you to see the health system in Queensland in the state that it's in given the efforts you put in?-- Mr Tait, I actually talk to a lot of people out in the system still. I've got a lot of friends who are working in the system. I think anyone who went around our hospitals and talked to people and saw the wonderful things that are happening would say, "Yes, it's under pressure, yes, there are isolated problems", but I don't believe - I don't believe that it's a systemic problem that means the whole system should be dumped as some people are suggesting.

I'm not suggesting it should be dumped but I am suggesting that it is a systemic problem. I agree that if you ask almost any patient, they will have stories of wonderful, dedicated nurses and caring doctors?-- Mmm-hmm.

But the system where you wait 10, 12 hours in casualty just to see someone is really one which must be disappointing to you?-- Emergency - emergency department figures were another area that we started publishing-----

Mmm?-- -----each year as part of the ministerial program statements for the estimates committee and budget hearings, and those figures show that, again, there is a prioritisation of emergency department figures and there is a lot of work being done on that. In recent years there was a huge increase in the number of what we call category four and five which are GP type patients and that was largely linked to shortages of GFs, particularly after hours and particularly in some areas.

Mmm?-- And we saw it - a blowing out of that area. It was still pretty much across the board fairly good rates of being seen in that higher categories, in the categories where there was more urgent need for care.

Well, that's - that's your perception of it?-- Definitely.

So, I take it you're not - I'm sorry-----?-- I was going to say that's not only my perception of it. That's what the statistics show.

Mmm. Anyway, the health system as it is to you is therefore, I take it, not a disappointment?-- I think there are disappointing aspects of it and I think one of the most disappointing aspects is the fact that the tragedy in Bundaberg has occurred, particularly as I took a lot of effort - put a lot of effort into setting up a very good complaints system which some people said was probably the best in Australia.

Mmm?-- I also put in place legislation to give coverage to doctors who wanted to discuss problems within the system. And by that, I mean problems within their own sphere of knowledge in terms of quality of care.

Yes, yes?-- So if a doctor had a question mark about another doctor, he could make comments and it would be covered for protection.

It didn't seem to work too well at Bundaberg though, did it?-- I think that's one of the greatest disappointments that I have.

MR DOUGLAS: Excuse me, could I interrupt, Mr Tait?

COMMISSIONER: I don't think you are. I think Mr Tait just finished.

MR TAIT: I just finished.

MR DOUGLAS: Mr Commissioner, as I indicated before Mr Tait commenced, counsel assisting - my staff I should say, has received correspondence from Crown Law that came from the health department. The content of that correspondence, I had arranged for it to be copied and distributed. Certainly everyone at the Bar table here has it. I had copies made for you Commissioners as well, for yourself and the Deputy Commissioners.

Having considered the correspondence and having discussion with some at the Bar table, having regard to the fact that the correspondence in part asserts certain facts, I think it apt that that material not be tendered unless and until someone from the health department comes along to explain matters and also gives evidence as to those assertions. I have a concern that it would be unfair if it was otherwise. I wanted to make that clear at the earliest possible opportunity. I don't believe that's going to hamper the completion of Ms Edmond but it may - it may entail, I'm sorry to say, Ms Edmond perhaps coming back on another occasion, perhaps even by telephone to deal with the matter.

COMMISSIONER: I'm very keen to avoid that if at all possible.

MR DOUGLAS: I understand.

COMMISSIONER: Mr Douglas, you're a little bit late, in the sense that I did get a copy, which has now been retrieved from me, and read through it very quickly. There is certainly one aspect on which I think Ms Edmond's comments are needed and that's the suggestion in the correspondence that a decision was made by the general manager health services in - I think it said January 2003 to cease collecting data. Obviously, that person will be given an opportunity to put their own evidence about that matter, but I think it's important that we know from the then Minister whether that was done to her knowledge and, if so, with her approval.

MR DOUGLAS: Thank you. There are only annexures to this document, which are being copied at this very moment. They are quite extensive and that's the reason they're not here. I say that for the benefit of the parties at the Bar table.

COMMISSIONER: I think the best way to handle this is do what would be done in a Court, and that is to mark the document for identification on the basis that I have absolute confidence Crown Law would not have written that correspondence on behalf of Queensland Health unless it accorded with their instructions. So it will be on the assumption that counsel at least anticipate that a witness or witnesses will be able to support the assertions which it contains.

MR BODDICE: Commissioner, I had had discussions with my learned friend Mr Douglas just before we started and had said, in view of the letter which has been sent by the Commission, which whilst it's dated the 15th of August, actually was sent today-----

COMMISSIONER: Yes.

MR BODDICE: -----the 26th of August, and said, "We will provide a witness who can deal with these things so everybody can understand it and, yes, those matters can be addressed at that time."

COMMISSIONER: All right. But in the meantime I think the

letter should be marked for identification and Ms Edmond should be given an opportunity to peruse it, to discuss it with her legal representatives, and to provide any response that she considers appropriate based on her state of memory and knowledge of its contents?-- Thank you.

MR DOUGLAS: Thank you, Mr Commissioner. Apropos also what's been said in that regard, as presently advised I would have thought it apt that the witness who has been foreshadowed in response to correspondence from me today would have to give evidence or should give evidence before, say, Professor Stable and Dr Buckland give their evidence. Otherwise - there is an element of the chicken and the egg about that office.

COMMISSIONER: Of course. But that's inevitable in any Commission of Inquiry. If that witness has produced a statement before Monday week, then that - that will give witnesses-----

MR DOUGLAS: It may.

COMMISSIONER: -----like the one you've mentioned, a fair opportunity to know the propositions or allegations which are being made and to respond to them. I don't see any - any downside in adopting that course.

MR DOUGLAS: Yes. In that regard then I think it does behove or it's incumbent upon the department to provide that statement at the earliest possible opportunity. Certainly prior to Professor Stable and Buckland supplying their statements, and I know a great deal of work has been done, at the moment I anticipate those statements will be available early next week. Can I indicate that for those at the Bar table.

COMMISSIONER: Yes.

MR DOUGLAS: And everything that Mr Boddice has said about our discussions is entirely correct as well.

COMMISSIONER: As I would be confident by having you confirm it.

MR DOUGLAS: Thank you.

COMMISSIONER: Ms Dalton?

MS DALTON: Commissioner, I have some concerns in relation to this unofficial waiting list issue, and that is after yesterday's proceedings, I have very specific instructions that as the Minister's evidence was in not this specific document, and I'm referring to Exhibit 306.

COMMISSIONER: Yes.

MS DALTON: There were statistics kept as to outpatients waiting appointments.

COMMISSIONER: Well, Ms Dalton, may I address your concern by saying this: as the evidence currently stands, what you tell us are your instructions are entirely consistent with the evidence given by Ms Edmond.

MS DALTON: That's right.

COMMISSIONER: So it's not something that need trouble her. If there's to be a witness from Queensland Health at some stage to say something different, then you'll have the opportunity to cross-examine that witness.

MS DALTON: That's certainly right. I'd like to explore with Ms Edmond the type of documents they are-----

COMMISSIONER: Yes.

MS DALTON: -----to perhaps focus, and that I have a concern that it might be unfair to do that until I see the documents annexed because I don't know what's annexed to that except to say that it does not seem to relate to outpatient appointments generally, just surgical outpatients.

COMMISSIONER: Yes.

MS DALTON: And, of course, Exhibit 306 relates to far more than that.

COMMISSIONER: Indeed.

MS DALTON: And I really do have concerns that Queensland Health has not provided the documents that on my instructions are in its possession as to these matters, and it's - and no doubt the reason you've taken so much with the issue is that it's an important one.

COMMISSIONER: Look, it is an important one. I'd like to say, in case anyone has assumed otherwise, that despite a couple of stoushes which I had with Mr Boddice at the very early stage of proceedings, the level of cooperation that we've received from him, his two juniors and their instructing solicitors from Crown Law has been absolutely exemplary and we appreciate that.

We're now looking at issues which occurred some years ago and probably weren't at the forefront of people's minds when document gathering took place for the purposes of this Inquiry, so these sort of hiccups are inevitable. My concern at the moment is that we proceed in a way that's fair to everyone. What I have in mind, Ms Dalton, is fortunately we're not too pressed for time this afternoon, so take perhaps a longer break than usual, let you examine the documents, let you take your instructions, if necessary.

MS DALTON: Thank you.

COMMISSIONER: And if anyone who has already cross-examined wishes to ask more questions of Ms Edmond, they will have that opportunity to do so, although I also want to be totally fair to Ms Edmond and make the point that I don't at this stage see the slightest reason to doubt the voracity of her evidence, and if she honestly can't recall the exact format of documents whereby when they were received and what they were contained, I would have thought that was totally consistent with what you would expect from a busy Minister administering probably the State's largest and most complex department of government. So-----

MS DALTON: I'm not at all concerned to attack Ms Edmond in any way.

COMMISSIONER: No.

MS DALTON: But I'm concerned to gain from her some specific descriptions of the documents that I'm told exist, and, you know, it's screamingly obvious in Exhibit 306 which contains all the patients' waiting lists, outpatient by clinical type grouping for four years was produced by people in Queensland Health for the purpose of the Inquiry, it was produced from some source documents.

COMMISSIONER: Exactly.

MS DALTON: Where are those source documents and-----

COMMISSIONER: Yes.

MS DALTON: -----Commissioner, they ought to be produced.

COMMISSIONER: Indeed, and Ms Edmond's not going to be able to answer that.

MS DALTON: No, but she will be able to assist us in telling

us what type of documents they are.

COMMISSIONER: Yes. Now, does that course of action suit everyone? We take - Yes, Mr Couper?

MR COUPER: Commissioner, I had one suggestion.

COMMISSIONER: Yes.

MR COUPER: I had a couple of questions about Bundaberg flying from yesterday's evidence. If I might be permitted to do that before the break rather than afterwards?

COMMISSIONER: Look, I was going to ask whether anyone else - because there were a couple of people who haven't cross-examined, Mr Allen? Mr Diehm? Do you-----

MR DIEHM: I have a few that don't relate to the waiting list issue.

COMMISSIONER: And Mr Ashton, is-----

MS FEENEY: No, thank you, Commissioner, I have nothing.

COMMISSIONER: All right. Well, Mr Couper, you can certainly go ahead with your questions, and Mr Allen, I'll let you make your own call as to whether you proceed now or later. Likewise, Mr Diehm.

MR DIEHM: Thank you.

MR DOUGLAS: Ms McMillan might have some questions.

COMMISSIONER: I'm sorry, Ms McMillan, I keep forgetting you in the back row.

MS McMILLAN: I'm easy to miss, Commissioner. No, I don't have any at this stage.

COMMISSIONER: Thanks. Thank you Mr Couper.

MR COUPER: Thank you Mr Commissioner.

CROSS-EXAMINATION:

MR COUPER: Ms Edmond, you were asked some questions by my learned friend Mr Tait about events concerning Bundaberg Hospital in November of 2001, a communication from Dr Glasson at the Community Cabinet Meeting; can I ask you some things as to whether this refreshes your memory as to some of the events which occurred? Can I suggest to you that on the 3rd of December 2001, Dr Stable attended at the Bundaberg Hospital and spoke to the medical staff at the hospital in response to what was described as a very difficult situation?-- I don't

recall the date but I do recall that while we were up there at the Community Cabinet, he did that.

And do you recall that as an upshot of that meeting, he immediately caused the allocation of funds for two VMO surgical sessions and two VMO paediatric sessions a week plus an additional operating theatre staff member full-time?-- I don't recall the details but I do recall that he addressed a number of their concerns.

All right. And can I ask where you recall where in the budget for the following year, Queensland Health allocated an additional $1 million for VMOs, obstetrics and an Accident & Emergency SMO?-- For Bundaberg?

Yes?-- Yes.

Thank you.

COMMISSIONER: Thank you Mr Couper. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Ms Edmond, John Allen for the Queensland Nurses Union?-- Mmm-hmm.

If I could just take up something that you said to Mr Tait this afternoon, and I believe you were also dealing with in response to my learned friend Mr Couper yesterday evening. Your recollection is that the government expenditure upon public hospitals in Queensland was significantly less than other States at the start of your term as Minister but that you felt that it had approached the national average by the time you finished?-- That's my understanding.

Okay. And what sort of documents could we go to to ascertain those sort of figures?-- Oh, I think there's productivity Commission reports, but it's very difficult because the other area you'd have to go to is the documents developed for the AHCA agreement, the Health - the Australian Health Care Agreement.

The AIHW, that's the Australian Institute of Health and Welfare?-- Yes.

They collect and publish statistics in relation to that matter?-- I think they do, yes - in some areas, yes.

Okay. Now, look, the document that should be on the screen is figure 9.2 from a Commonwealth report on government services of 2005, and the figures are stated as being sourced from the AIHW?-- Mmm-hmm.

And also the Australian Bureau of Statistics. Now, reading from the document as it proceeded the chart, what it's meant to represent is the recurrent - real recurrent expenditure per person upon public hospitals and the various States from the period of '98 through to 2003?-- Yes, I can see that.

And the text of the 2005 report on government services indicates that in 2002/2003, government real recurrent expenditure on public hospitals in 2001/02 dollars was $895 per person for Australia. So the Australian average for the '02/'03 year was $895 per person and that those figures ranged from $1,165 per person in the Northern Territory, and that's indicated on the graph, you'll see that the highest figure for 2003-----?-- Mmm-hmm.

-----occurs in the Northern Territory?-- Yes.

So it ranged from $1,165 per person in the NT to $712 per person in Queensland in the same year, and therefore that figure for Queensland for 2003 which graphically appears a little bit over $700, was $712 per person. Now, have you got any reason to doubt those figures published from information sourced from the AIHW and ABS?-- I haven't, but can I say that different publications looked at different factors, what they were, you know, what they were looking at, some included different things. Without really sitting down and going through all the background data, I'm not sure if it was these figures on which I was basing that assumption.

Okay. Well, these figures appear to indicate that Queensland starts off really right towards the bottom of all of the States and Territories in 1998?-- Mmm-hmm.

And ends up right at the bottom in 2003?-- Yes, they appear to do that.

And in comparison to some other States, such as New South Wales, Victoria, Western Australia and South Australia, and indeed, the Australian average where there is a rise each year, the Queensland expenditure stays quite level?-- Yes, it does.

So that would appear to indicate firstly, that in Queensland, the Government expenditure upon public hospitals, that's both Federal and State, of course?-- Mmm-hmm.

As you'd pointed out, has been less than the other States and Territories, and unlike many of the other States, has not increased in any real way?-- Look, that's what it appears on these figures.

COMMISSIONER: Ms Edmond, just following up from that: I would have assumed, uninstructed, but Queensland should be needing to spend more money on health care than, say, New South Wales or Victoria or Tasmania because of all of the geographical and similar problems that people have identified to provide an equivalent service in Queensland should in theory cost more

dollars than in New South Wales or Victoria?-- Commissioner, I would need to spend a lot of time looking at the figures et cetera. In theory, that's right, if you're just talking about geographic events.

Yes?-- New South Wales have much higher salaries-----

Yes?-- -----for bureaucrats as well as doctors and nurses, and also their medical indemnity costs were much higher, as I'm sure Mr Tait would concur, you know, there's a whole range of issues that need to be taken into account. I can't at this stage recall what figures were in there, I have to say, I didn't come prepared for a budget or estimates hearing.

No?-- But I'm quite sure that I have seen figures which did show that Queensland had caught up, but it always looks at what - what you're including in that, those assumptions. Some figures for some States exclude the small hospitals, for example, under a certain size. Others, other States or other figures don't, they include everything. There's a whole range of different options of what you're looking at for data and I'd need to analyse that and seek some advice on where - on how it's been calculated to really advise you.

The other thing that strikes me as disturbing about these figures, if they're true?-- Mmm.

And if they're not explicable for the reasons you mention is that Queensland hospitals have traditionally and continue to provide more services than hospitals, public hospitals anywhere else in Australia with our outpatient clinics. Again, if these figures are accurate, it would imply that Queensland Health has been trying to provide a better service over a wider geographical area and a more remote geographical area than any other State or Territory with less money to do it?-- I think it's fair to comment that we have been trying to provide more services than is perhaps expected in other States over a wider geographic area in - under a tight budget, I think that's absolutely true.

And what that says to me is that if the taxpayers and the voters of Queensland want to maintain that level of service as Sir Llew - I don't normally divulge private discussions between the three Commissioners - but as Sir Llew said to me earlier today, "The great ALP dream of having free public care for everyone in the State" which we know goes back to Ned Hanlon and so on-----?-- Mmm-hmm.

-----50 years ago, if we're going to have to continue to having to do that, we're just going to have to spend more money?-- We're going to have to - look, I mean, I think that's a fair comment, that if you want to maintain the level of service that we've enjoyed, then you are going to have to be - the community is going to have to accept that there are costs involved, yes.

And you made the point very validly, that our doctors and indeed, as we've heard, our nurses are paid less than those in

other States of Australia, if we're going to continue to attract and retain the best people, we're going to have to match other States dollar for dollar in what we pay them?-- There are other factors in there and that is cost of living, of course.

Yes?-- I mean, that's relative too. Our cost of living in Queensland is - is lower than New South Wales and Victoria.

Yes?-- So that has to be factored in as well as with these figures. The high cost of in the Northern Territory, I think, is related more to a lot more of their health services I think are funded from the Commonwealth because they're Aboriginal health services.

Yes. And also it's an area with a very low density population?-- Yes.

For an area what, I think more than half the size of Queensland?-- Mmm-hmm.

There's only a couple of hundred thousand people, so naturally that makes it very expensive on a per capita basis, but it does seem realistic to compare Queensland perhaps not with the Northern Territory but with the States like South Australia, Western Australia and to some extent, New South Wales and Victoria as well, because they are all wealthy States, they are all States that have substantial populations and they're all States that have an expectation in their communities of getting good health service?-- Commissioner, may I sort of suggest that - I can opine on this-----

Yes?-- -----and try and remember the figures et cetera. There are probably other witnesses that you're going to have.

Yes?-- Who have a greater knowledge of those figures.

Yes?-- And the data, and they may be able to. If you would like me to at a later stage comment on them or explain or try and find research other figures, then I'm happy to do that, but I think you will probably have other witnesses before you who are much more across the number crunching than I am.

Well, can I ask you for some, in a formal sense, whether you would agree with a couple of motherhood statements, if I can put it that way: I'm sure you agree that there is no reason why Queenslanders shouldn't have - no reason why Queenslanders shouldn't have public health services that are at least as good as any other State in Australia?-- I believe Queenslanders have public health services which are better than most States currently. I hope they continue to do that.

There's no reason why Queensland doctors and nurses aren't entitled to the same financial rewards for their dedication as other doctors and nurses around Australia?-- I think all of those factors, Commissioner, with due respect, are taken into account, cost of living, all costs, all the rest of it, in the EB negotiations. I don't really want to join into EB

negotiations.

And there's no reason why our community can not afford to continue to provide a service which is, as always been - when I say "always", in our lifetimes at least - has always been better in the sense of being more comprehensive than any other State in Australia?-- I don't believe so.

Thank you.

D COMMISSIONER EDWARDS: May I ask?

COMMISSIONER: Yes.

D COMMISSIONER EDWARDS: Ms Edmond, I'm not quite so concerned about the level of expenditure, I think there are reasons we have a lower base because of traditional costs and so forth?-- Mmm.

What I'm more concerned about, that over this period, as this chart refers, growth has almost been nil which means that we're technically cutting out inflation and all those other matters, we are actually spending in real terms less money over that four year period each year. Have you a comment on that because I-----?-- Yes.

-----I think there is an explanation overall in the way the amount of expenditure is and I don't want to go into that at the moment, but I - what concerned me, and I've not seen such figures before, we are the only State that's had hardly any growth at all in expenditure on the current expenditure in health over the last four years - five years.

COMMISSIONER: Perhaps before you answer that, Ms Edmond, we haven't seen the context in which these documents - these figures were published. I thought, Mr Allen, you said that these were adjusted for inflation?

MR ALLEN: Yes, so that they're expressed as the graph states in 2001/2002 dollars.

COMMISSIONER: All right. So what is shown as stagnant is in a sense genuinely stagnant rather than a fall.

MR ALLEN: Yes.

COMMISSIONER: Because it's all in the same dollar figures. I'm not sure whether that changes the question?

D COMMISSIONER EDWARDS: No, it doesn't. It still concerns me that being stagnant is probably not good enough?-- I think during that period, if you recall, it was a fairly difficult budgetary situation for Queensland where we'd lost some taxes as a result of the incoming GST but we weren't yet receiving the benefit from that. My understanding is that has changed substantially since then and I only wish I'd been Health Minister when it happened.

COMMISSIONER: Yes?-- But I did have the benefit of being able to allocate a lot of those extra dollars in the lead-up to the 2004 election, so there was a substantial boost then.

Thank you.

MR ALLEN: Could I tender that table, Commissioner?

COMMISSIONER: Look, you're welcome to do so, Mr Allen, but I frankly think it would have been more useful to us if you could provide it in the context of the report of which it forms a part. For the purposes of cross-examination it makes your point very well, but for the purposes of our writing a report and making recommendations, I think we need to look at it more closely than simply one chart.

MR ALLEN: Yes, I'll arrange for the relevant report or at least the relevant part of the report-----

COMMISSIONER: Yes.

MR ALLEN: -----to be provided to the Commission.

COMMISSIONER: What is that called?

MR ALLEN: The actual table is taken from the report on Government Services 2005, but the information is sourced from certain AIHW and ABS studies.

COMMISSIONER: Yes, I saw that note at the foot, but you'll be tendering - well, I'll reserve at this stage Exhibit number 310 for the relevant extracts from the report on Government Services 2005.

MR ALLEN: Yes.

COMMISSIONER: Thank you.

MR ALLEN: What the statistics, of course, from those sort of agencies also show is that during that period when you were Minister, the public health system in Queensland was one of the most efficient out of all the States, and I think you mentioned that in your evidence yesterday?-- Yes, in terms of when you looked at the cost of providing services through case weighted separations, Queensland was often the most efficient or second to most efficient.

Okay. So Queensland seemed to be providing those services which were compared nationwide at a lesser cost than other States and Territories?-- Yes.

And one of the factors you mentioned in relation to such efficiency both yesterday and today is that Queensland Health paid its employees less than in other States?-- I said salaries were different across the States, yes.

Yes?-- Mmm-hmm.

And you've agreed with the Commissioner that doctors, nurses and administrators are paid less-----?-- Yes.

-----than in other States?-- Yes.

Now, the fact that a system might be the most efficient does not necessarily mean that it's the most clinically effective, that it produces the best outcomes for patients?-- No, you would look at clinical effectiveness with other measures than just dollar terms.

Because you may have a situation where it's the most efficient because for one reason the staff are being paid less, but that means essentially that the staff are propping the system up by working harder and earning less than their counterparts interstate?-- The ways of measuring other qualities in the system are numerous, they include unexpected returns to hospital, patient satisfaction surveys, a whole range of different areas that you can look at and can be measured, and my understanding is Queensland tended to perform very well in those other areas.

You see, over the last 50 days of these sittings, there have been quite a number of very experienced health professionals who've worked in the system for years who have described a situation where gross under-resourcing of the system means that staff are essentially reaching burnout stage?-- I think it's been recognised, and I've certainly recognised it, there's a shortage of staff in a number of areas.

And one of the causes, if not the root cause, is that the system is under-resourced?-- I don't accept that, Mr Allen. The main reason for - has been in many areas the lack of ability to recruit people, and if you have vacancies, obviously those salaries are not being spent, but if the hospital can recruit those salaries - recruit those specialists or nurses or whatever, then those salaries are expended and accommodation for that is made in their budget.

If the public system is one where staff are overworked and under-resourced, then staff will be lost to the private system; is that a matter of commonsense?-- You would think so, but my understanding is that the private sector has been equally short of staff, particularly in nursing staff.

You don't agree that the private sector is a more attractive employer for health professionals?-- Oh, not according to many of the people I've talked to, including many nurses. Many of them work there in short-term. They may even do that in addition to their Queensland Health duties, but I think if - I've visited people in the Wesley where they've had different staff every day of the week because an awful lot of them are short-term locum staff or sort of doing one session a week or one day a week so you have a rapid turnover. But it's a different - people go to the private sector for a whole lot of reasons. One can be philosophic, one can be because the hours suit them, they may only want to work particular hours. I moved from the public sector to the private sector for no

other reason than I was able to have more flexible working hours.

Do you agree that some people stay in the public system for philosophic reasons?-- Absolutely. I think there are a lot of wonderful, dedicated people out there in the public service doing - public sector doing a tremendous job, a tremendous job, and I don't think it is often appreciated by people.

And-----

COMMISSIONER: Ms Edmond, I can say, I am sure on behalf of all three of us, that we appreciate that very much. We just wonder whether the public health sector should be taking advantage of the good will of people who stay in the system when they could make more money outside it and could certainly make more money going interstate rather than paying people what they are worth?-- I am sure - I am sorry, I am not disagreeing with you.

MR ALLEN: See, we have had evidence, for example, that staff are incredibly overstretched in public hospital facilities, working double shifts, working 50 to 60 hour weeks, being unwilling to not work a double shift because they know it will let down other nursing staff, things like that. Are you saying that's all because there aren't enough nurses out there to employ?-- Mr Commissioner, with due respect, I think Mr Allen is trying to negotiate an EB here. I have been through that several times before. I am no longer the Minister and I really don't think it is appropriate that I am - that you are trying to get me into an EB debate.

COMMISSIONER: Mr Allen, I think you have made your point in any event, and you have made it, may I say, very well, but I am not sure exploring it any further is going to elucidate the issue any further.

MR ALLEN: I will move on. You weren't involved in EB to the extent that you were the minister responsible, though, were you?-- It depends which EB you mean. The first EB I think I was. The second EB we changed the system in cabinet, so that in all public sectors the minister for Industrial Relations became the minister responsible.

Okay. So rather than the minister responsible for health negotiating appropriate pay for their employees, it went to another minister?-- Any negotiations, of course, have to be signed off by cabinet.

And in relation to the cabinet process, you said that you are not sure if there has ever been any Health Minister on the CBRC. Certainly you were never on that committee?-- I was never on that committee. I can't recall before I was a cabinet minister, which is why I said I don't know if there ever had been.

Do you think, given the importance of the health portfolio, it would be appropriate that the Health Minister was included on such a committee?-- That's not a decision for me to make. That's a decision for machinery of government.

But you are here and entitled to express opinions. Do you think it would be appropriate?-- I thought I was here to assist the Commission of Inquiry into the Bundaberg Hospital and matters surrounding that. I didn't believe I was here in the role of cabinet minister on or not on the CBRC.

Well-----

COMMISSIONER: Can I simply ask this: do you have a view as to what would be better for Queensland, as a private citizen - albeit a private citizen with a lot of experience in government - do you have a view as to whether or not it would be better for health to be represented on that committee?-- With all due respect, Mr Commissioner, I think the Health Minister has enough on their plate-----

Yes?-- -----without taking on what is quite an extensive and onerous job of being on a CBRC where they have to review and go through all the documentation from every other department and their bids and decide, you know, where the funding is going to go. I really think the health portfolio is quite big enough.

Thank you.

MR ALLEN: Nothing further, thank you, Commissioner.

COMMISSIONER: Mr Diehm?

MR DIEHM: Yes, thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Ms Edmond I am Geoffrey Diehm. I represent Dr Keating, who was the Director of Medical Services at Bundaberg, also sometimes shop steward for those of us at the Bar table, but I won't buy into any further negotiations with working hours this afternoon. Ms Edmond, I only want to ask you about a very limited area of your evidence from yesterday afternoon and it concerns some questions that were asked of you by Deputy Commissioner Vider, and then Commissioner Morris concerning the placement or the opportunities for securing services of doctors typically in a VMO arrangement, though it may not necessarily be limited to strictly VMO arrangement, and some particular examples or a particular example was given to you about a situation at Bundaberg 2003 concerning a general surgeon there. And you gave some evidence that said that from your perspective or your experience, Queensland Health was very much amenable to those sorts of arrangements being put in place. You made reference in one of your answers to some examples - and perhaps it is just one example you meant - but you referred to Mackay or Rockhampton?-- Yes.

And you related something that thought it was cardiology,

though you weren't sure which particular specialty, and you related that, in effect, there was an approach from a private hospital because they had an opportunity to put this specialist on but didn't have the need for a full-time type arrangement and wanted to share the arrangement. My first question for you about this is in that particular example, why was it that you, as minister, were aware of that instance?-- I have to say, I am not sure. It may have just been mentioned to me in passing because we had been aware of, you know, the difficulty in recruiting to some of those areas. The other thing that happened was whenever I visited a facility, health facility, I would get a briefing paper about what was happening at that facility, including any problem areas, et cetera. So it may have been that on a visit to Mackay or Rockhampton - I can't even recall which one it was - that in a briefing note it mentioned that this had happened.

I had wondered, by way of example, whether the thing you were thinking of was something that your office had been particularly involved in; an initiative it had either sponsored or created?-- Not at all.

Okay.

COMMISSIONER: It wasn't something that would have needed to come to you for approval?-- If there had been a policy developed to say that we weren't going to put VMOs on or we were going to discourage VMOs or something, yes, I would have expected to be involved, and I am sure I would have been involved, but to my knowledge there was absolutely no such policy. It was a case of case by case depending on the need of the various - of particular facility and the opportunities that were there.

I ask that because from the evidence we've heard, I certainly have the impression - this may be wrong - but I certainly have the impression that, generally speaking, district managers and Directors of Medical Services don't have discretion or flexibility to make those sorts of arrangements with private hospitals, and I thought maybe it was therefore something that got referred up the line, perhaps to the Director-General, perhaps to you, to approve it before it went ahead?-- I think in those circumstances a phone call to the Director-General would have solicited advice and help if they needed it.

Right.

MR DIEHM: Thank you. The situation in practice, I suggest to you, was that where an opportunity and, indeed, a need may be identified by local management at a particular hospital, and where that wasn't otherwise catered for in their existing budget, they would have to put in to management up the line a case - a business case, as it might sometimes be described - to seek the necessary financial support for such arrangement?-- For new services, yes, on new initiatives they would.

Yes. And not just for new services or initiatives, but also

to extend existing services or initiatives beyond that budgeted for?-- Yes.

And to give that some practical content at Bundaberg, the Commissioner raised the example with you about a general surgeon coming to Bundaberg in 2003. There is some more context to that that I should raise with you. Shortly before that general surgeon's arrival in Bundaberg, there was an ear, nose and throat specialist who was coming to Bundaberg to work in private practice but who was making himself available to do some sessions at the Bundaberg Hospital for public patients as well and there was identified by the Director of Medical Services a need for that service because it was otherwise unfulfilled at Bundaberg, and a case was put in to management up the line for an appointment for that particular doctor at Bundaberg but that was declined?-- I am not aware of that.

You are not aware of that specific example, and I wouldn't expect you to necessarily be, but that such a thing would happen seems to be different to the perspective that you expressed in your evidence yesterday?-- Not quite. Can I say that I guess I was looking at where you had the situation where you had two known vacancies for surgeons, funding from those vacancies could be used more flexibly if they wished.

Yes, all right. So if there was room within their budget, then they could do it but if their budget - and, for instance, in that instance with the case of the ear, nose and throat surgeon, Bundaberg by that point in time had a full complement of general surgeons, it wasn't looking for new general surgeons specifically. It needed to go outside of its budget to appoint the ear, nose and throat surgeon. It is within your expectation, about the way things work at that time, that they would have to put a case in and that case may not ultimately be supported by management further up the line?-- It is - well, it is true there are a lot more bids put in for budget than there were available funds.

Yes. At the end of the day, for everybody concerned, it was a case about competing for the dollars?-- Yes.

And not all requests could be met?-- That's right.

And many, in fact, could not be met?-- Oh, I think probably it was about three or four times as many budget bids as there was accommodation.

Now, that's budget bids. That's at the time of budget that you are speaking about?-- Mmm.

These other things may come up in between budgets as well?-- Yes, and I would hope that they would be discussed with the relevant zonal manager to put in context because, of course, sometimes you can make arrangements between two adjacent towns, and things like that, when you look at the needs for both towns, and, you know, work in a cooperative way to get those services.

Yes, all right?-- So I would hope it was discussed with the zonal manager, that he would look and discuss it with other district managers, if that was the appropriate case, and a decision be made from there.

All right.

COMMISSIONER: Ms Edmond, just following up on Mr Diehm's questions and a remark you made earlier, you suggested - and I don't know whether you meant this as literally true - but you suggested someone could pick up the phone and speak to the Director-General and get something approved. The overwhelming evidence that we've heard to date is that that is just not how the system worked, that if you were suggesting anything out of the ordinary, even if it didn't cost more dollars, simply the fact that it wasn't something that was already approved, you had to have a business case, it had to go through the process, and we're told often six or seven layers of administration before you would get a decision, and often months of waiting till you would get a decision, and often no feedback as to why the decision was negative if that was so?-- Commissioner, I think that would depend whether it was going through the formal budget process, which is a long and lengthy one, or whether it was something that came up in between, an opportunistic chance to improve services, I would have thought, in my experience, was looked at seriously. Obviously it depended whether we had money or not.

Let me give you one example so that you know the sort of thing we're talking about. A doctor who is a renal specialist, a nephrologist, has told us that an opportunity came up to participate in the National Kidney Day in Bundaberg. He arranged with the local community sponsorship for that event. So it wasn't going to cost Queensland Health a cent. But he needed approval to run that event, so he had to put in his business case, it went to - I think it was Dr Keating - I may be wrong - from him to Mr Leck, from him up the line to the bureaucracy, and the event had come and gone - the day for this renal event had actually passed by the time he got any response to it and no-one ever told him why the response was negative?-- Commissioner, I can't respond to that, as I am sure you don't expect me to, but certainly around the State many hospitals had all sorts of wonderful events and apparently were able to get permission and support for that in appropriate timing to run those events. I don't know how it was different in this case and I wouldn't like to guess.

Isn't that the sort of thing that local management should have autonomy over? Isn't that the sort of thing that it is just ridiculous to have it come down to Charlotte Street to decide something as simple as that?-- With due respect, Commissioner, my understanding is that those things are handled - unless there was some particular issue that I am not aware of - and that's why I don't want to hazard a guess on it - I think maybe you should put that to the appropriate witnesses to find out, you know, was there something. Certainly in more recent years we have had the problem of public indemnity.

Yes?-- And that's raised questions about everything, from school fetes to, you know, merry-go-rounds, to anything. And some time in recent years, I believe it has become more complex if the hospital - if they are having a fete on their grounds if they have to get public liability insurance and how that works. So that - it may be that in recent times there has been an increase in the, I guess, formalisation of those, but I know hospitals that have markets on their grounds to raise funds for the auxiliary, I know a whole range of different things happening, and I really can't explain that one without knowing the particular circumstances and what the issue was with it.

I accept that entirely. May I try you with another example, and you may feel the same way about it. We have heard from numerous witnesses - not just one or two, but several - that as employed doctors they had contractual entitlements to attend conferences. That was part of their contract. However, to get approval to get on the plane and go to the conference, it had to go to the Minister's office. In a system where the local director has budget discretion up to a quarter of a million dollars, where he or she can go out and buy a piece of equipment for a quarter of a million dollars, it does seem a bit silly to have decisions over five or 10 or $15,000 being reserved to the minister?-- Yes, I am aware of the situation and, yes, I signed off on the advice usually from the department. I think this is across public service, it is not just at doctors. This is a cabinet decision from some years back where there was a level of criticism at government for the number of people who were off at conferences at any particular time, and it has been the case I think long before I became minister. So I don't really know the full background to it. But my understanding is that it was - and, again, this is not about doctors, it was about public servants across the board - my husband is an academic, he has to get approval, it goes through, too - and I think it was a measure to bring about some accountability into the cost of overseas travel. And you are quite right, I think health is the only area where there is gazetted arrangements for medical staff to get overseas - or get conference leave and overseas conference leave.

I think Judges might be the only other category of public servants, although one shouldn't call them public servants?-- And, Commissioner, you would be aware that at each and every time attracts some media attention.

Yes.

MR DIEHM: Thank you, Commissioner. Thank you, Ms Edmond.

COMMISSIONER: Mr Douglas, will we now take that break that was contemplated. How long do people expect they will need?

MR APPLEGARTH: Could I just say one other housekeeping matter which has a slight impact on the waiting list issue?

COMMISSIONER: Yes, Mr Applegarth.

MR APPLEGARTH: May it assist the Commission, may I tell you what the state of play is with my client's witness statement, its expected time for completion, and I hope it is some good news. I think counsel assisting thinks it is.

COMMISSIONER: Mr Applegarth, I would actually prefer not to know about those sort of things that go on behind the scenes, but if it has an impact, tell me about it.

MR APPLEGARTH: I think it has an impact on the other parties. I am happy to do it at a more convenient time if there is one.

COMMISSIONER: No, no.

MR APPLEGARTH: But it does have an impact, for reasons I will try to briefly develop. Our client's witness statement - that's just the statement, let alone the annexures - is growing every day and this new emerging issue on waiting lists threatens to make it bigger. So I have put forward a proposal to counsel assisting that my client's witness statement be split into two parts. We're working very hard on it. The first part deals with matters in relation to how Dr Buckland came to learn of matters concerning Dr Patel and what he did in response to those concerns. The second statement, which will come as soon as possible after that, will deal with broader issues, and we hope we will be able to deal with that as quickly as possible, but because the Commission identified earlier this week its interest in broader issues they were going to make certain recommendations, my client's been working solidly in the last week trying to address those issues, too.

And just by way of a preview, if I may, that statement ventures a proposal to try and reduce the political pointscoring by proposing that there be a bipartisan parliamentary committee on health which would hopefully overcome some of the problems that have vexed the Commission, and you heard from Dr McNeil earlier this week. So that's simply by way of preview, that he is hoping to address that issue, those sorts of policy issues, but he also has to address numerous questions that have been put by counsel assisting. We're doing our very best. My client's working literally day and night on it, as are all of us, but we don't want to delay providing the statement so that it might frustrate the progress of the Commission. So I just wanted to tell the other parties through the Commission that I have told counsel assisting that if he is happy with that course, but if that course affects some other party I am-----

COMMISSIONER: Well, Mr Applegarth, it really doesn't have much to do with me except in this sense: I think dates have been allocated for Dr Buckland to give his evidence. My only concern is that if Dr Buckland says anything controversial as regards another party, that party has notice of that through his statement in sufficient time to take instructions and prepare to cross-examine. It sounds to me, if I may say so,

that some of the things that are proposed to be covered in the evidence of Dr Buckland are really more in the nature of submissions rather than factual testimony. I don't criticise that. We're delightful to have help from any source, let alone from someone with as much experience in the system as Dr Buckland, but that's in a somewhat different category because if he is expressing opinions about what should happen in the future, that's unlikely to be something that's going to present the sort of natural justice issues.

MR APPLEGARTH: Yes, Commissioner. I perhaps have not expressed myself well enough. That's only a small part of the statement.

COMMISSIONER: Yes.

MR APPLEGARTH: If I could call it the second statement, the bulk of the second statement, which we're working on, which is factual, which is not going forward and making proposals, deals with a large number of rather detailed questions, and all I wish to identify is that we're doing our very best to assemble the documents - and the waiting list documents are but one example because we have been asked questions about waiting lists. So the difficulty the Commission has had with getting documents from the department is a difficulty which my client has as well.

So rather than wait to get all the documents about waiting lists and statements and have our statement as a whole delayed, that's why we propose to put forward two statements, and I thought I should mention that.

COMMISSIONER: I have no problem with that. We will now adjourn - shall we say till 4 o'clock? Will that give everyone efficient time and time for Ms Edmond to have a coffee?

WITNESS: Mr Commissioner, may I say something? I have an appointment tonight.

COMMISSIONER: Yes?-- I really don't want to miss it. I think the Broncos need me there. The way they have been going recently, I think it is essential I am there.

Particularly since they have lost some Queensland Health funding in the recent week?-- Could you give me an indication if I should make other arrangements?

No, definitely not. We will not go beyond 5 o'clock at the very latest. Is that - anyone disagree with that?

MS DALTON: All I was going to say, Commissioner, is that it is me that's raised the need for the adjournment and 15 minutes is all I need.

COMMISSIONER: Well, we will come back then at quarter to four.

THE COMMISSION ADJOURNED AT 3.25 P.M.

THE COMMISSION RESUMED AT 3.48 P.M.

WENDY MARJORIE EDMOND, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Ms Dalton.

MS DALTON: Thank you, Commissioner. Could Ms Edmond see Exhibit 306 again.

COMMISSIONER: Yes, Exhibit 306.

MS DALTON: You recall looking at that document yesterday, Ms Edmond, and saying that you had seen if not that particular document itself, something very much like it at various times through your ministry?-- Yes, I did. I think this is a summary from other documents that I've seen, I think.

And what are the type of documents that you would see? Would you see, for instance, compilations of data collected from each of these hospitals individually or would it be by zones or?-- No, if I can make it easier, the documents I saw were much more aligned with the ones learned counsel has in front of him, the waiting list reduction strategy, which includes this information plus other information alongside it.

All right. I wonder if the witness could also see this bundle of exhibits that we were provided.

COMMISSIONER: If she wishes to.

MR DOUGLAS: Yes, that can be done now?-- I haven't got one.

Would bear with me for a moment, please.

COMMISSIONER: It looks like Mr Scott has a set.

MR DOUGLAS: I've been at pains to ensure that everyone at the Bar table has a copy and now would you've ended up short, I'm sorry.

MS DALTON: Maybe just dealing with the top one first, which is the most recent of them, January 2003?-- Not on mine, it's the most ancient of them. Sorry, what were you after, January 2004?

January 2003. Have you got a 2004 one?-- No, no. Sorry. This is almost as much material as I used to get in a day in health to read. Thank you, I have that one.

You have January 2003?-- Yes.

First of all, I suppose let's look at the first page. The waiting list reduction strategy was the name of a particular policy in Queensland Health through all of this time, wasn't

it, that people were working?-- Yes, it was and it encompassed both surgery, emergency departments and outpatient appointments.

Yes. You'd encompass all the categories of waiting lists that are on Exhibit 306. That is surgical outpatient appointments but also medical, paediatric, psychiatric - all the waiting lists?-- Yes, I'm not sure about obstetrics. I don't ever remember discussing obstetrics and I think that was probably because it was fairly time related.

Yes. And if we - this is a report from the surgical access team and you will see most of it doesn't really deal with outpatients lists at all but with the surgical or official waiting list. Do you see all that-----?-- Yes, it does.

-----information on page 2 and page 3. They're all - that's the official waiting list information, isn't it?-- Yes.

For elective surgery, not for an outpatient appointment?-- No, that's elective surgery.

And the only part that deals with outpatient appointments is at page 6 at the top, I think?-- Yes.

And that's only surgical outpatients appointments, isn't it? It is not medical or paediatric or psychiatric?-- Yes, it also deals with emergency departments on page 5.

At point 1?-- Well, 1 and 3 benchmarking.

Oh, I see. All right. That gives - that actually gives the more useful information the Commissioner was talking about yesterday about wait times rather than just number of people waiting; is that right?-- This is purely related to emergency departments and the categories there.

Yes?-- Yes.

All right?-- And what percentage of them were waiting a long time and what category they were, whether they were GP type patients who were waiting for 10 hours or whether they were category 1 or 2 which were, you know, more urgent matters, and the time frames which are set by the Australian College of Emergency Medicine positions, you know, how they compared with that.

I understand that. And this type of information that is found at the top of page 6 of this document that we're looking at is obviously not the type of information you were talking about yesterday when you said you saw documents very similar to 306. It's presented quite differently and it's - relates only to the surgical, not to the other type of outpatient appointment?-- The other documents that we referred to yesterday were sort of summary documents which were similar to the ones that went in the waiting list documentation.

Similar to Exhibit 306?-- Oh, sorry, not - there was similar

documentation but for surgery in that format.

In the format of 306?-- Yes.

Elective surgery?-- For elective surgery.

And your similar information for outpatient appointments in - in a form similar to the 306?-- Most of the information I received was similar to this. But every so often you would-----

Similar to the graph?-- Similar to this one.

All right?-- Okay.

Yes?-- And with the information in it. And at various times, and I'm not sure how often, I think it was probably attached to not budget - cabinet submissions, there would be an accumulation of some of that data which would end up in a form similar to that.

That's right. And-----

MR DOUGLAS: It needs to be clarified. The-----?-- Sorry.

The last document referred to is Exhibit 306?-- 306, mmm.

And the document which was referred to previously as "this", is the report which is not yet been tendered for January 2003; is that correct, Ms Edmond?-- Yes, it is.

Thank you. I'm sorry to interrupt?-- Or, Mr Douglas, and all other reports. They're all - they may vary are little bit they're very similar-----

MS DALTON: Generally similar.

MR DOUGLAS: I just want the transcript to be recorded.

MS DALTON: Now, that's what I was going to ask you. From time to time you'd be called on as Minister to report to cabinet about the waiting list reduction strategy?-- Yes, I think it was on a quarterly or half-yearly basis.

All right. And when that happened, there'd be information prepared more in the format of Exhibit 306 for you to take to cabinet about the outpatients waiting lists, not just for surgery but for all types of appointments?-- Oh, I'm not sure if it was quite as detailed as that but a summary form of that. It may not be for every hospital but for the category - for hospital, yeah.

I take your point exactly, Ms Edmonds. It may not have broken down into such great detail hospital by hospital but it certainly would give at, if it's quarterly, quarterly intervals a total figure for people waiting for outpatient appointments?-- Yes.

Yes. So can you help me, I've described it as information submissions that you were taking to cabinet. Did they have a special name that might assist the people acting for Queensland Health to identify them?-- I think they would be an information submission.

That's its formal name, is it?-- Yes.

All right. Was it your understanding that those figures were collected until 2003, sort of quite by a laborious manual system but kept in a way that if you requested, "Look, I would like to know what that total is next week, please", the department could give it to you?-- I know it was initially recorded manually and I think I mentioned that yesterday.

You did, yes?-- It was quite difficult to get those figures and I think in the early reports I received, there were a lot of qualifications about those numbers. I'm not sure at what stage they had this on an electronic form.

About the middle of 2003 I'd suggest to you. Does that ring a bell?-- I'm sorry, I really don't recall when it changed over. I know that most - for a significant period of time they were working on trying to get this data in a form that was both reliable and useful.

Yes. And that was achieved at least by 2004 - at least by 2004, wasn't it?-- I'm fairly sure - yes, I'm quite sure it was achieved before I left office.

Now, I think you also said just a moment or two ago that there may have been information similar to that which we find in Exhibit 306 and I don't know but maybe, again, it might not be as detailed hospital by hospital but as to total numbers of patients waiting for outpatient appointments that were taken to cabinet not for the purpose of information as to how the waiting list reduction strategy was going but for the purpose of budgetary matters?-- I believe-----

That is the health budget?-- Yes, that submission actually covered - you know, it was a case of identifying budget issues as well. So it was a quarterly report into cabinet on how we were going on election commitments such as the waiting list strategy, et cetera, and also of budget considerations.

I see. So in terms of questions you were asked yesterday about if only there had been this kind of information to consider in the budgetary process, in fact there was that exact information to be considered in the budgetary process?-- It was certainly done fairly routinely through the - throughout the year. And it would have been part - certainly that information would have been in one way or another included in the budget submissions, maybe not as a lot of figures but certainly referred to in summary form I would expect.

Yes, in the way you thought would be most effective to present your case to get a bigger slice of the money available; is

that right?-- Yes, yes, it was. I'm trying to sort of suggest I think - I'm trying to help counsel here. We could go on with these questions for a long time. These were really working documents and if you go through them, you'll see that they often come up with things that were happening almost on a monthly basis or a quarterly basis in reaction to other events. So you might find, and I'd have to - on page 1 of my - the one I'm looking at, 2003.

Yes?-- It had "Funding and Incentives" and it would have comments there - and this is because of pressure being identified, and this is the purpose of these documents, Mr Commissioner.

COMMISSIONER: Yes?-- They weren't for publication. They were for working in-house. So what they do is they would have identified issues such as emergency department staffing, if you look at dot point 4 in "Funding and Incentives", at the Gold Coast, and extra funding has been made available and also at the Royal Children's health service districts. I can't remember what the - what was happening at that time to result in that extra funding but obviously pressures had been identified that needed to be addressed and those - you know, this was an ongoing happening whereby where there are problems identified, we would attempt to address them in a proper methodical way and that's what these documents are about. They're working documents to assist in the management of a very complex system in the best and fairest way possible, not by listening to who shouts the loudest but by looking at the data that you're getting, the number of throughputs, the pressure on the system and addressing that. You often get people who shout very loudly but when you actually look at the statistics, you may find that their workload is actually less than other districts that are managing very competently without making a lot of noise. I mean, it is not always a squeaky wheel that gets the oil in health.

MS DALTON: I understand. I understand that, partly, that's what you were saying yesterday about why often times these figures would not - the use of them was not so much to look at the total, although that may be in itself useful-----?-- Mmm-hmm.

-----but looking at the front page of 306 for instance, and this is a hypothetical factual basis, but it might be, say, of more concern to you to deny there are 12 patients waiting for a psychiatric outpatients appointment at Kingaroy than if there are 2,000 children waiting at the Mater Children's Hospital because there are a huge throughput of those?-- Yes absolutely.

And you could be pretty confident that they would be seen quickly whereas a psychiatrist might not go to Kingaroy for six months?-- Yes.

So the total numbers themselves might - it is not just a matter of looking at it-----?-- It can be meaningless.

Yes. They are a reflection of throughputs at the hospital?-- And services provided.

And hospital specialities provided at the hospitals?-- Yes. I'll give you an example of Mount Isa. They have very few resident specialists living in Mount Isa but if you go there, there is a white board or it used to be in the foyer of the hospital which had a whole - about 26 different categories of specialists who visit depending on the need. Some may visit weekly, some may visit three-monthly, depending on the need and the numbers involved. So if somebody is waiting to see a specialist in Mount Isa, the time they're waiting will depend on when the next - that specialist is coming to town. But in actual fact, they actually get a good round of specialists visiting there and I would suggest to learned counsel and the Commissioner, if you want to have your cataracts done, the shortest waiting times are not in Brisbane where all the specialists live, they're actually in Roma, Longreach, Weipa. You can get it done almost immediately there the next time Mark Loane or somebody is in Weipa, he'll do them.

Yes. So it's a matter of using this kind of information as to outpatient waiting numbers constructively to identify problem areas as well as looking at the total for budgetary purposes?-- Absolutely. I would look at - I would take this data and compare with previous data I'd received and try and see where there were outliers.

Okay?-- Not where there was just a steady increase but where there was sudden jump in the number of people waiting and I'd say, "Why?", or, "What are we going to do about it?"

Yes?-- Or sometimes there would be a big drop, and that's worth knowing too.

Yes. I understand. And in whatever form it was made available to you, when you needed to look either at specific problem areas, so perhaps focussing on a particular hospital region, district, or specific medical areas, say, paediatric or surgical, or whether you wanted to look at total numbers, that information was at all times collated by the department and all you had to do was ask for it and it would be provided; is that not right?-- That's right.

All right. Thanks for that?-- May I make a point?

Yes?-- And I make this in light of comments that were made in the media today. I said yesterday, Commissioner, that the figures you used of 100,000 plus waiting for specialists appointments when I left or now - I think now, I said that surprised me and I'd like to know how it was collated. Certainly the figures that are in these documents are very consistent with what I suggested and what I recall.

COMMISSIONER: Well, indeed, I was going-----?-- And significantly less than the 100,000.

I was going to point out to you in the document Ms Dalton had

just shown you, the January 2003 figures, if you go back to page 6, I can't guarantee that my arithmetic is right but based on the figures shown in that table, it looks like a total of about 33,800 at the 1st of January 2003 and 34,600 at the 1st of January '02. So, in any event, in the range of 33 or 34,000?-- Mmm-hmm.

Which would square away entirely with your evidence yesterday that going back to the figure of 36,000 in October 1998, your perception was that the figure reduced slightly but remained in the 30,000s?-- Yes. Even though the throughput had increased.

Yes?-- Yes.

MS DALTON: All right. What, obviously, these figures don't disclose were the people waiting for non-surgical outpatient appointments which is how we get to the much higher figure, and do you know whether you were given - I mean, the much higher figure we have got now for 30 June 2004?-- My understanding was there were roughly the same non-surgical as surgical. I have looked at the data provided after - in that summary form in 306 and I think I said it was about 50-50. It is not quite. It is slightly more surgical. But if you add together medical ops and gyno, paediatric, psychiatric, et cetera - I'm just looking at the one 2001 - there's the 32,000 surgical and 51,000 non------

COMMISSIONER: Non-surgical?-- No, 51 overall.

Overall, sorry?-- Including the surgical plus non-surgical. I think I said surgical and medical.

Yes?-- And I would like to correct that. It was probably meant to be surgical and non-surgical.

Yes, thank you.

MS DALTON: And, Ms Edmonds, that - in 306, that surgical, that's not waiting for elective surgery. That is waiting for the first appointment to see a surgeon as an outpaitent?-- Yes.

Or, I suppose, as an appointment after surgery to come back and check you're okay after surgery?-- It could be. That's what I was going to say. It could be a range of things. It could be for assessment. It could be after surgery.

Yes?-- Or it could be ongoing care that you're seeing at a clinic once a year because of a specific problem.

COMMISSIONER: Or it could be for an appointment for a scope or some other procedure that is not regarded as surgery in itself?-- Yes.

MS DALTON: In the surgical category?-- Well, it - sorry. Scopes - sorry, I'll just take that back, Commissioner.

COMMISSIONER: Yes?-- You've tricked me there. I must be getting tired.

It wasn't deliberate?-- It would normally - scopes would normally come under medical.

Right?-- Because, you see, they're often done by physicians.

Yes?-- Gastroenterologists rather than surgeons.

That's what I've-----?-- Or GPs.

I've tricked myself because the evidence we have heard is related to procedures in smaller districts such as Bundaberg where often it was the surgeon who undertook those procedures?-- In some places it is GPs, in some places doctors do it in their own rooms if they're accredited to do that.

Yes.

MS DALTON: Commissioner, you're alert to the point I think, I just want to make sure, because I was confused by what you just put - what you just put to Ms Edmond. That is, that the table on page 6 of the September 2003 matches up with the first column on Exhibit 306.

COMMISSIONER: Yes.

MS DALTON: It is people waiting for a surgical outpatient appointments. It is not the elective surgery waiting list; it is the outpatient surgery list and the figures-----

COMMISSIONER: That's why it's headed "Patients Waiting for a Surgical Outpatient Appointment".

MS DALTON: Yes. And the figures on page 6 match up pretty well - they're not exactly - with the first column in 306.

COMMISSIONER: Yes. Yes. I think where this all leads and see if I'm not mistaking it, is that after your press release in 1998, you had apparently ongoing figures about waiting lists - sorry, about what has sometimes been called unofficial waiting lists but lists of people waiting for appointments and this tends to confirm your recollection that those figures remained in the 30,000s. But at the same time there was often as many people again or up to as many people again waiting for appointments in the medical departments?-- Yes, and that the total waiting for specialists outpatient appointments was of a figure of 50,000 rather than 100,000 plus that's been mentioned. I'm not sure where that figure has come from.

Right?-- Can I say one other thing: in the early documents of these, they actually go through the strategy that was being set up and, of course, one of the first things they had to do in outpatients was to bring in, because there wasn't a nationally recognised criteria for prioritisation, to establish a way of prioritisation outpatient appointments. So

I think if you go through the early documents, you will see that there's work being done on refining how outpatients are handled, in the priority that they're going to be handled and then looking at how we can most efficiently use that time and reduce the number of don't-shows and all of that work that was being done.

MS DALTON: In 1998, your press release, the figures were about 36 waiting for elective surgery and about 36 waiting for an outpatients appointment and that included surgical and non-surgical outpatients appointments?-- No, I think that was surgical because it goes-----

Oh, it was only surgical outpatients?-- Because it goes on to say, "Of those, 20,000 were waiting for the big categories of ENT, orthopaedics."

MR MARTIN: Ophthalmology?-- Sorry, ophthalmology. I'm taking my learned counsel's advice.

MS DALTON: That would be cataract surgery, wouldn't it?-- It would be cataract surgery. That's the biggest area of ophthalmology surgery.

I see. So in '98 it was 36,000 waiting for elective surgery and 36 waiting for a surgical outpatient appointment?-- Yes, I'd have to look at the figures. About that figure.

COMMISSIONER: That's to the best of your recollection anyway?-- Yes:

MS DALTON: Commissioner, that's all I had on that topic and I just had one other question which arose out of something-----

COMMISSIONER: You're pushing your luck. Yes, go ahead, Ms Dalton.

MS DALTON: -----something you'd raised yesterday. That is, if the idea that the Commissioner floated with you yesterday, Ms Edmond, if Queensland Health were to announce to people on the waiting list that Queensland Health were to fund the gap and send them off to private specialists, the Commonwealth is likely to react immediately and angrily, isn't it, that that would be a breach of the health care agreement between the state and the Commonwealth, because it's fund shifting to the Commonwealth?-- It would be - yes. In the commitment going back some time, and perhaps Dr Stable would be able to fill you in better on that-----

Mmm?-- Because he was there before I became Minister and was involved in the previous AHCA negotiations, I don't know why they're called negotiations - the-----

COMMISSIONER: In fact, Ms Edmond, my question yesterday was whether there would be some obstacle to that and I think you've answered that with Ms Dalton's help. Yes.

MS DALTON: I think it might be illegal under the Health Insurance Commission Act, I'm not sure of the details of that, but anyway. Commissioner, that's all the questions I had, although I did want to speak to you obviously in the absence of the witness - I don't want to detain her further - about these categories of documents which she has identified which haven't been produced.

COMMISSIONER: All right. Is there anyone else who wishes to undertake further cross-examination before Mr Martin re-examines his client? No? Mr Martin?

MR MARTIN: And I have nothing, thank you, Commissioner.

COMMISSIONER: Well, Mr Martin, it did occur to me, and it's entirely at matter for you and Ms Edmond, but we've been, I think, extremely fortunate in these proceedings that the standard of journalism reporting the proceedings has been exceptionally high, but some of the reports last night and this morning relating to Ms Edmond's evidence I thought might have been regarded by her as being not an entirely accurate summary of what occurred, and if Ms Edmond wishes to have the opportunity to respond to that, I think it's only fair that she be given that opportunity. As I say, it's a matter for you and her.

MR MARTIN: Well, thank you. I had planned to say something myself about that.

COMMISSIONER: Yes.

MR MARTIN: And it is this: that whilst, of course, we're not concerned that you Commissioners would be infected by some of the journalism in respect of Ms Edmond's testimony, and in particular, the appallingly misleading banner headlines in respect of the articles in The Courier-Mail today. I do wish to particularly mention a passage in one of the articles, which carries the implication that Ms Edmond only gave certain evidence because of the Chairman's statement on Wednesday which in turn carries with it the further implication that Ms Edmond gave evidence adverse to herself.

Both of those implications are entirely unwarranted, and could I just inform the Commission that Ms Edmond's statement, which was tendered to the Commission, was complete before the Chairman's statement. Could I also inform the Commission that the media releases about which Ms Edmond was questioned the other day, at the request of counsel assisting, was provided by Ms Edmond through the solicitors to counsel assisting before any statement was made, and in entirety, every media

release that Ms Edmond had was provided and more through a great deal of work was provided to counsel assisting in the most user friendly manner possible, so that counsel assisting had the time to go through them for the purpose of Ms Edmond's evidence, and yes, with the greatest respect, we take the greatest umbrage at the media coverage dealt out to Ms Edmond, particularly in The Courier-Mail, some inaccuracy in The Australian, I haven't had the opportunity to hear the electronic media, but I do wish to place that before you.

COMMISSIONER: Thank you. I don't wish to say anything by way of either agreement or disagreement with what Mr Martin has said, what he said speaks for itself. I simply thought it was fair to give Ms Edmond the opportunity formally to respond to that since what was published purported to be an account of the proceedings at this Inquiry.

MR MARTIN: Thank you.

WITNESS: Mr Commissioner, I was always happy, and I think I indicated that, to come before this Commission of Inquiry, it didn't rely on your statement of comfort, I think it's called the other day, I've been more than prepared to help and do anything I can. I feel very passionately about your health service and maintaining it and I also feel for those health workers and - who are out there who, I think one of the things that they have said to me over and over again is it's so disappointing, they just don't know what they have to do to get recognition. You know, any negative is reported and stressed but all of the wonderful work that thousands and thousands of people are doing just gets ignored or distorted, and I think it's disappointing, and yes, I was very hurt and disappointed to see those comments. Firstly, they implied that I lied to this Commission, which I have not, I have done everything I can to answer as truthfully and honestly as I possibly can, given the passage of time that has been there since I was first originally dealing with these issues. I don't know what more I can say except to say that I was very hurt and disappointed and I would have hoped that there'd be some corrections made. I know that it's pointless for me to ask for those corrections.

COMMISSIONER: Well, I'm pleased to be able to give you a forum to do so, I'm not sure that it's either within my power or appropriate for me to do anything more than that, but I'm pleased to be able to give you that opportunity anyway?-- Thank you.

Thank you. Mr Douglas?

MR DOUGLAS: Yes, if it please the Commission, before Ms Edmond retires, it is appropriate at this point that I tender the bundle of documents which can conveniently be described as the Waiting List Reduction Strategy documents which are schedulised in the letter which is Exhibit 309 - I should say Exhibit for identification 309 in these - in the Commission proceeding.

COMMISSIONER: Oh, sorry, I thought 309 was the questionnaire for hospital doctors?

MR DOUGLAS: I'm sorry.

COMMISSIONER: 310 is the document which we're still waiting on from Mr Allen - I don't mean that critically.

MR DOUGLAS: I apologise for that, the exhibit for identification.

COMMISSIONER: I threatened to mark it for identification but I never got around to doing that, so we'll mark as Exhibit 311 the waiting list reduction strategy documents.

MR DOUGLAS: Yes, the witness has been examined on some of those documents and it's apposite that they be tendered at this point.

COMMISSIONER: But I think the covering letter should go with it.

MR DOUGLAS: Thank you.

COMMISSIONER: So that if there's a copy available of the covering letter.

MR DOUGLAS: Thank you.

COMMISSIONER: Just apropos to that covering letter, did you plan, Mr Douglas, to ask about the second sentence of the second dot point on the first page?

MR DOUGLAS: Yes. It's that particular sentence commencing, "In approximately January 2003" which was the cause of some concern, on the basis that it's properly characterised merely as an assertion at this point. That was the matter about which Mr Applegarth in particular had some concern, but he's not the only one.

COMMISSIONER: Yes.

MR APPLEGARTH: Mr Commissioner, my concern is this: that it's at a level of assertion, we don't mind that, but the difficulty that we have is that we asked a few days ago for - not through the Commission, I hasten to add, but through the correct channels which - from Queensland Health for all documents, and I don't have the letter here, my instructing solicitors don't have the letter inside the tribunal of the Commission for documents in relation to elective surgery lists and what's commonly called outpatient lists, because one of the questions which counsel assisting has asked us relates to waiting lists.

And so to help the Commission, we asked for these documents and the problem that we have is that we've been given many documents, but amongst them there's no instruction in January 2003, so we have the same problem I apprehend that the

Commission had last night and which seems to be an ongoing problem, that documents come through in dribs and drabs and that's - that was the only concern that I had, that this surely represents the instructions, and there's no reflection upon Crown law, none at all, but we can't prepare our statement and we're none the wiser until can we see the document, if any, that reflects that instruction and/or a statement, and that was why I rose earlier, we have that difficulty, we're trying to meet the questions that we've been asked, but we can only meet them properly if we have the documents and we just look forward to obtaining those matters because my client has had to, in the last seven days, go through many many documents on many many copies and he hasn't been able to give me the types of specific instructions that would enable me now to say whether that assertion is correct or not.

So Mr Commissioner, you understand the difficulty under which I operate in saying anything about that second sentence in the second dot point, that's why I raised the concern with counsel assisting. We just hope that in the next day or so, that there is a comprehensive disclosure, for want of a better word, of all documents that might assist my client and others who have been asked similar questions about waiting lists, because until we have all of the documents in relation to all of the matters that we've been asked about, we can't properly and comprehensively prepare the statement. I can't take it any further. You appreciate the concern.

COMMISSIONER: I do, Mr Applegarth. And may I say that your client isn't unique being in this position. It's the reality with all Commissions of Inquiry - I mean, you made the comment a couple of days ago, Mr Applegarth, that there's never been an inquiry like this one, but in fact, it's a feature common to all Commissions of Inquiry, that it is a movable feast, you don't know what the issues are, even from day-to-day. It's not like a civil trial where you've got the pleadings and evidence is called relevant to the issues clearly delineated in the pleadings and where disclosure takes place in advance and everyone knows what's going to happen.

The truth of this Inquiry, like every Inquiry, is that we chase down issues apparently of interest, sometimes they're resolved very expeditiously and very satisfactorily and they can be left alone, sometimes matters rear up that look as if they're adverse to a particular party and when that party has an opportunity to respond, that difficulty disappears.

It's commented - I happen to be reading it yesterday in Mr Fitzgerald's report how he encountered precisely the same problem in his seminal inquiry 20 years ago that tragically some people's reputations were injured on the way through because the exploration of the unknown inevitably leads to that happening. The remedy for that and the only possible remedy for that is to ensure that if something emerges at one stage of the proceedings which appears to be adverse to someone, they have the opportunity before the proceedings come to an end to answer it.

Now, there's a letter here from Crown law suggesting, and I, for the moment would expect suggesting based on the honest belief of those who gave the instructions when the letter was written, that the then General Manager, Health Services, gave a certain instruction to cease producing monthly reports. That may be true, but it may be explained because a different form of reporting took its place. It may be quite untrue.

As I said earlier, with the possible exception of events over the last 24 hours, the reporting of this Inquiry has been absolutely exemplary, largely because the major news organisations have assigned to it some of the State's most experienced and competent journalists and they have made very clear on occasions that evidence is untested or that that evidence is subject to conflicting evidence likely to be received at a later time, and I am quite confident that anyone following this Inquiry will understand that what is said in the Crown Law letter of the 26th of August 2005 is a matter which, Mr Applegarth, you haven't yet had the opportunity to challenge and which your client is not accepting until he's had a chance to review the documents and refresh his memory as to what occurred, and that applies to every other individual including those represented by Ms Dalton and Mr Couper and indeed by Mr Diehm and Mr Ashton, when he's here.

MR APPLEGARTH: Indeed Commissioner, and I appreciate what you've said, and I don't want to prolong this afternoon's proceedings, but - and we appreciate the tight timetable that has been set for the Commission, and the reason that I rose earlier this afternoon to identify the logistical problems that my client has were simply to not-----

COMMISSIONER: Well, you've done that, Mr Applegarth.

MR APPLEGARTH: -----leave the warning too late.

COMMISSIONER: Yes.

MR APPLEGARTH: Can I simply say that we're going to take up matters with counsel assisting in terms of the number of matters that we've been asked to address. That list may reduce down in the light of Mrs Edmond's evidence and the like, we'll try to reduce down, but if we have to deal with a lot of big topics, we thought with many many documents we'd like the documents as soon as possible, and on the topic of waiting lists, we'd like a statement from someone who can give if not the definitive account, but an account which we can all then rely upon. Without that, we're at a difficulty.

COMMISSIONER: Mr Applegarth, you know, Mr Boddice has already indicated that he will be furnishing a statement. That's right, furnishing a statement from a witness?

MR BODDICE: Certainly, and I take on board Mr Applegarth's concerns, we will provide a statement as soon as possible.

COMMISSIONER: We can't do better than that, and we all know,

everyone in this room knows and we rely on Mr Boddice that he's going to do what he's told us he's going to do.

MR APPLEGARTH: I don't want to anticipate problems where there may be none, but there are similar many big issues that we've been asked to address. We're doing our best to address them. We're calling for documents. We've had a degree of cooperation and assistance, but we see at least on the waiting list that we haven't been given all of the documents. That's the only point I wish to make. Thank you very much for extending me the opportunity to do so.

COMMISSIONER: Thank you Mr Applegarth.

MR DOUGLAS: Yes, your comments do cover the matter, Mr Commissioner.

COMMISSIONER: Thank you. Any further re-examination?

MR DOUGLAS: No, there isn't. May the witness be excused?

COMMISSIONER: Look, indeed. Ms Edmond, can I tell you really from the bottom of my heart how much we appreciate your coming out of political retirement to assist this Inquiry with your evidence. I have to be careful in what I say because I don't want anyone to think I've prejudged things, but my impression, I can say very confidently, is that the evidence you've been giving over the last two days has been accurate, honest and reliable to the best of your recollection. If there are some inconsistencies that come to light, I have no doubt that that's because you've put things out of your mind for obvious reasons?-- Mmm.

Your insights into the broader issues of the administration of Queensland Health have been extremely valuable and will be at the forefront of our consideration as we're pondering the matters before this Inquiry. We are very grateful to you and you're formally excused from further attendance?-- Thank you Commissioner.

Thank you.

WITNESS EXCUSED

MR COUPER: Commissioner.

COMMISSIONER: Mr Couper?

MR COUPER: On a slightly different vein to that raised by my learned friend, Mr Applegarth, I'm suppose asking a question with respect to that same paragraph of the letter dated August 2005 and it's this: in particular, given the evidence which has fallen from Ms Edmond, she had available to her at all times all of the information she requested about waiting lists

and waiting lists for outpatient services. What if anything is the issue which the Commission or counsel assisting perceives that my client ought to be addressing about the question whether a particular form of report ceased or not?

I say that because the only issue raised with us to-date by way of questioning in the statement was as a desirability of the public release of outpatient waiting list figures, and I say it also in the context that the letter goes on to say, "Collection of the specialist outpatient waiting lists data ceased soon after". That seems to be entirely inaccurate and given both Ms Edmond's evidence and the fact that there was produced Exhibit 306 which has figures as late as July 2003, broken down by hospital category from source documents we haven't seen-----

COMMISSIONER: It actually doesn't say it ceased, it says that the General Manager, Health Services, instructed the surgical access team to cease producing the monthly reports.

MR DOUGLAS: And collection of the specialist outpatient data ceased soon after, but it seems to be falsified by the evidence. So my inquiry is what impact has that said to have had on any issue to my client? He's got a lot on his plate and does he need to address it?

MR DOUGLAS: Yes, he does need to address it. The reality is if you've taken up, Mr Commissioner, the inquiry is necessarily a moving feast, the memorandum which was forwarded to Mr - detailed memorandum forwarded to Professor Stable's solicitors requesting treatment of a number of issues was anterior to the evidence given today and anterior to the documents that have been received but at by no means in so far as counsel assisting is concerned, obviates the need for treatment of those issues duly modified by the variations in the evidence which have occurred to-date and during which Mr Couper and his instructing solicitors have been present.

It hardly, with respect, constitutes a matter of such moment in terms of effort that it can't be dealt with. We will write to Mr Couper's solicitors, but Professor Stable should be on notice that there is an expectation that that issue will be - should ought be dealt with. So in so far as absolution is concerned with treatment of those issues, I can assure Mr Couper and his client that if it isn't dealt with in his statement, it will be the subject of inquiry and examination.

MR COUPER: I don't seek absolution, Commissioner, I seek to know what is the issue to which I'm supposed to address?

COMMISSIONER: Well, Mr Couper, I'm sorry, but that's not how it works, and you've been in enough Commissions of Inquiry to know how these things work. In an overall administrative sense, I guess that Mr Douglas is answerable to me, but he has complete autonomy in conducting investigations, preparing witness statements and calling evidence. If at some stage you feel that he is treating you unfairly, then you can raise that and I guess I will have to take steps to deal with it. But I

would have thought, frankly, that counsel of your experience and eminence and counsel of Mr Douglas's experience and eminence could sort this out amongst yourselves without expecting the three of us to sit here and listen to this unedifying debate as to the way in which things should be handled.

MR COUPER: Well, I was hoping it could have been quick. Obviously I'll await the correspondence.

MR DOUGLAS: And also if Professor Stable and those acting for him think in any way that I or any person on behalf of the Commission staff have been treating him unfairly in relation to this exposition of the issues, I'd also appreciate some correspondence about that.

COMMISSIONER: Yes.

MR APPLEGARTH: Mr Commissioner, I'm not going to engage in the discussion, we will correspond with counsel assisting. I take the force of what you just said about the importance of these things not being played out here. If we can sort them out with counsel assisting, we shall.

COMMISSIONER: Thank you for that. Ms Dalton, you also had something else?

MS DALTON: I did.

COMMISSIONER: Yes.

MS DALTON: And I'll preface it by saying that I am not criticising counsel assisting, Mr Douglas, in saying this because I understand he's as frustrated about this as I am, but if you look at the letter that went to Queensland Health asking for documents about waiting lists, it's specifically asking for briefing notes, submissions or a report to the Minister, Director-General or other staff and policy documents concerning the collection of waiting data, and we get back this letter of the 26th of August which doesn't say, "Look, here's everything we can find" or "We've made an attempt to respond in a complete way", it's just, "Here's some additional specialist outpatient waiting list data", and we get this bundle of monthly report.

MR BODDICE: Could I interrupt, Commissioner? With respect, I think the letters actually went the other way.

COMMISSIONER: Yes.

MR BODDICE: Our letter was in response to last night's question.

COMMISSIONER: Yes.

MR BODDICE: And subsequent to that a letter was sent today asking for further material which we haven't had the opportunity to respond to.

MR DOUGLAS: That is correct.

COMMISSIONER: And Ms Dalton's perfectly understandable when the letter's dated the 15th of April when in fact it went today.

MR BODDICE: Yes.

COMMISSIONER: But can I also say between your client, Ms Dalton, Mr Applegarth's client and Mr Couper's client, I suspect there is a large repository of knowledge of where documents are in Queensland Health than amongst any other three people living people in Queensland, so if your respective clients are able to identify particular documents or categories of documents which would be useful to them or useful to this Inquiry, I am confident Mr Douglas would appreciate your assistance.

MS DALTON: Well, the-----

COMMISSIONER: And I don't mean in open Court.

MS DALTON: No, no, but there is something I would like to place on the record and that - the Ex-Minister's evidence coincides with my instructions that there will be information in statements that went to Cabinet.

COMMISSIONER: Yes.

MS DALTON: With total figures for this outpatient list and also that went into the budgetary process. Now, the existence of those documents, let alone - just leave the contents aside for a minute - but the existence of those documents is important to my client and to Mr Applegarth's client, and again, to Mr Couper's client because of the comments that you made at transcript 4880 to 4882 yesterday evening about, "Well, the Minister seems to have done everything she could to get this unofficial waiting list going, but it was all just a bit too difficult for the senior bureaucrats to arrange it, it just wasn't there."

COMMISSIONER: Yes.

MS DALTON: And wouldn't it have been wonderful if we'd had it, because it could have gone off into the budgetary process and the funding - the funding might have been increased because of it. Now-----

MS DALTON: And that those documents were - that those figures were always available to her whenever she wanted them and that they did actually go into the budgetary process is obviously a pretty important response for our clients to those concerns, and that's why I'm interested in getting these from Queensland Health and the documents exactly that did go to Cabinet and did go into the budgetary process.

COMMISSIONER: And Ms Dalton, I accept entirely the force of

what you say. I appreciate that there are many people of whom Mr Sweetman in The Courier-Mail this morning is an example who criticised the fact that I've been proactive in these proceedings and raised matters of concern because that carries with it the inevitable risk, and it's been obvious from the outset, that if I react to evidence as it develops.

MS DALTON: Mmm.

COMMISSIONER: I make comments which are based on only part of the story.

MS DALTON: Mmm.

COMMISSIONER: However, we wouldn't have got to the stage we're at now unless we could develop the evidence and chase down those possibilities. Obviously, now we've had the - some of the documents produced and Ms Edmond has been assisted in her recollection by those documents.

MS DALTON: Mmm.

COMMISSIONER: It becomes perfectly apparent that for every month when she was Minister she had those figures and that they were presented in Cabinet submissions.

MS DALTON: Yes.

COMMISSIONER: But that's different from the situation as it appeared yesterday afternoon, and it may be different again at some other stage.

MS DALTON: It may be. The - I suppose the only concern is that you seem to have assumed that she didn't have them because of the fault of the senior bureaucracy when that wasn't what she was saying, which is a point I suppose I raised straight away with you this afternoon.

COMMISSIONER: Yes.

Look, the other point is that we've received some statements, including one from a Dr Cane, which is very critical of my client. Now, I am not privy to the arrangements that were made between those representing Dr Cane and the Commission. Do I understand that Dr Cane is coming to give evidence?

COMMISSIONER: I have no idea. That's the sort of thing in which I don't involve myself. If you want to take that up with counsel assisting and if you wish to - if there is no present arrangement for Dr Cane to give evidence and you want him made available, then take that up as well.

MS DALTON: All right, thanks.

COMMISSIONER: But that's counsel assisting's job.

MS DALTON: Thank you, Commissioner, and I will because obviously we need an opportunity to answer.

COMMISSIONER: Can I also say, Ms Dalton - I mean, I understand - I have been in your position many, many times. I know you are looking after your client's interests and doing so extremely well. But part of the forensic process, as I see it, is to ask questions that might appear to be Dorothy Dix's often are, to give witnesses the opportunity to say, "No, that's not the case, the bureaucrats really provided me with everything I wanted." You know, it is-----

MS DALTON: Commissioner, I-----

COMMISSIONER: It doesn't imply I have got some fixed view about things, it implies that that's - that's one conclusion which could be formed based on the evidence we've heard over many, many weeks and here is your opportunity to repudiate that so we know that isn't the position.

MS DALTON: I don't want to be overly tender about things but I think there is a lot of criticism made of senior bureaucrats. I act for somebody who's job was terminated on minimum notice for no reason. There are real people behind these broad descriptions of, you know, senior - you understand.

COMMISSIONER: I understand that entirely and, you know, having that sort of debate is unedifying, too. I am sure there are people who would say he had announced his retirement and he was just taking up on the announcement that he had made. I don't know.

MS DALTON: No, he wasn't, he was terminated with no reason, on 28 days' notice.

COMMISSIONER: Yes.

MS DALTON: Certainly hadn't announced his retirement.

COMMISSIONER: There you go.

MR ALLEN: Commissioner, Exhibit 310 was reserved for a document I referred to. Can I hand up a CD containing the full copy of the Productivity Commission's report on government services 2005, accompanied by a hardcopy of the forward and chapters 1, 2 and 9 of that report with the page containing the diagram referred to in evidence flagged.

COMMISSIONER: At this stage you can do whatever you like, Mr Allen. Yes, those documents will comprise Exhibit 310.

ADMITTED AND MARKED "EXHIBIT 310"

COMMISSIONER: Does anyone else have anything they wish to raise? All right. Well, so ends day 50. We will now adjourn until - I assume it is 10 a.m., is it, on Monday week?

MR DOUGLAS: Yes, Mr Commissioner.

COMMISSIONER: 10 a.m. on Monday week.

MR DOUGLAS: On that occasion it is proposed to call Professor Stable.

COMMISSIONER: Thank you. And it would make sense to clear anything out of this courtroom because I can't guarantee it won't be used for other purposes next week.

THE COMMISSION ADJOURNED AT 4.46 P.M. TILL 10 A.M. ON MONDAY, 5TH OF SEPTEMBER 2005