Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF BARRY STEPHEN O'LOUGHLIN

Barry Stephen O'Loughlin makes oath and says as follows:

1. I have previously provided a statement ("the first statement"), which I swore on 11 July 2005, to the Commission. I make the following additional comments below.

2. I have seen approximately 42 former patients of Dr Jayant Patel pursuant to arrangements between those patients and Queensland Health. One or two of those patients were operated on by surgeons other than Dr Patel. It is my understanding that Queensland Health sent out letters to former patients of Dr Patel in early 2005 advising that Queensland Health will arrange for other doctors to provide second opinions and treatment to those patients. I was one of those Doctors.

3. It is my understanding that patients who responded to the said letters from Queensland Health were screened by the Bundaberg Base Hospital ("the Base") patient liaison officers and the then Acting Director of Medical Services at the Base. It is my understanding that the screening process involved an assessment of which patients needed to be seen by surgeons and which could be seen by general practitioners.

4. I am aware of two other surgeons from the Royal Brisbane Hospital ("the RBH") who saw former patients of Dr Patel at the Base, namely Dr Michael Rudd and Dr George Hopkins. Between them I think they saw about 25-30 patients. I am also aware that some of my other colleagues in Brisbane saw a number of former patients of Dr Patel.

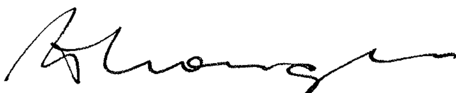
5. Of the 42 patients that I saw almost all were unhappy with the treatment that they had received. Of the 42 I felt that 7 patients needed remedial

surgery. Of the patients that I saw I consider that their outcomes ranged from satisfactory to disastrous. ~~The majority~~ Some of the patients had complaints that were of concern to them but not outside the realm of what you'd expect in respect of a competent surgeon. For example, complaints in relation to wound pain and scars. In my view a smaller proportion of patients that I saw received sub-optimal care from Dr Patel. I have not seen enough patients to determine whether that number is unusually high or acceptable.

6. I would describe the medical records I have perused as a "mixed bag". In some situations the records are very brief or non-existent. On some occasions the records were quite thorough.

7. I note from my observation of the records that Dr Patel did not appear to make use of cholangiograms during laparoscopic cholecystectomies. I perform cholangiograms during such procedures generally as a matter of course and I believe that generally they should be performed. There is a substantial body of opinion supporting the use of cholangiograms as a matter of routine during such procedures. However, there is also a reasonable body of opinion that suggests that routine cholangiograms may not be necessary. A failure by a surgeon to employ routine cholangiograms during laparoscopic cholecystectomies would not affect my assessment of that surgeon's clinical competence.

8. Based on the patients that I have seen and the views of people that I have spoken to at the Base, it seems to me that Dr Patel may have had a tendency to not always examine patients and to not be thorough in terms of assessment and consideration of options for treatment. Certainly, I have seen and heard little evidence that he sought advice from other specialists. That is consistent with what I have observed from the records. That is also consistent with my experience as Director of Surgery at the RBH. I did not have any contact with Dr Patel during the two years that he was Director of Surgery at the Base. That is unusual. I had regular contact with previous directors of surgery such as Drs



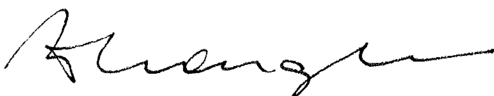
Anderson and Nankivell on a range of issues including clinical matters. I get the impression that Dr Patel conducted his practice in isolation.

9. I can also say that there did seem to be a pattern of wound problems, such as dehiscence and incisional hernias, in the patients that I have seen. An incisional hernia is a hernia that develops at the site of a surgical incision. However, I did not see enough patients to determine whether or not the incidence of those problems was unusually high.

10. In general terms, some of the problems I have observed in relation to Dr Patel's treatment include problems of judgement, knowledge and technical abilities. I have the impression that Dr Patel's surgical intervention was fairly aggressive. It does seem he was quick to operate. The patient whose treatment exemplifies those problems is Ian Vowles, referred to in the first statement. I would say that the treatment provided to Mr Vowles and Mr Vowles' outcome falls into the disastrous and tragic category. I would also say that Mr Vowles' treatment raises questions of Dr Patel's professional integrity. Those questions arise from the fact that at no stage did Dr Patel advise Mr Vowles that the biopsied specimen, referred to at paragraph 7 of the first statement, was not cancerous.

11. I would also like to say, in general, that surgery is not a benign undertaking. All practising surgeons have complications. Good surgical practice involves seeking to minimise the risks thereof and dealing with them in the best possible way. There are all sorts of techniques available to achieve this purpose, including keeping up to date, proper training, and enlisting the support of people who might be more competent and have more experience than oneself.

12. I set out below examples of patients whose care by Dr Patel I would consider to be less than the standard to be expected of a reasonably competent surgeon. My observations and conclusions are based on my



examinations of those patients and my observations and conclusions drawn from my perusal of the medical records.

Nelson Cox

13. I saw this patient at the Base on 29 April 2005. Mr Cox was essentially concerned by a painful incisional hernia he had developed as a result of surgery by Dr Patel.

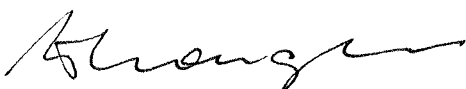
14. Mr Cox's original complaint was a painful gallstone condition. He was referred to surgical outpatients at the Base where Dr Patel saw him. Dr Patel advised during the consultation that the gall bladder would be removed by a laparoscopic cholecystectomy. Mr Cox consented to that operation. The operation went ahead on 25 October 2004.

15. According to the notes some difficulties arose during the operation. There is a note made of difficulty in entering the abdominal cavity. There is a query in the notes in relation to an "accessory bile duct" being clipped and divided. I am not sure what that means. The notes also indicate that the gall bladder was inadvertently opened during the surgery causing spillage of gall stones and bile. The operation was completed and Mr Cox was returned to the ward.

16. The following day Mr Cox was not well, suffering from abdominal tenderness and distension. Dr Patel advised a return to the operating theatre. In the surgical report for that second operation on 26 October 2005 a note is made that there was an evacuation of an abdominal wall haematoma. A haematoma is a collection of blood. This was at one of the sites where an instrument was inserted during the procedure.

17. The next day Mr Cox continued to be unwell.

18. On 29 October 2004 Mr Cox had continuing pain in the upper abdomen and again had signs of peritonitis. He had an ultra-sound scan which showed a collection of fluid under his liver. Dr Patel then diagnosed a



bile leak and recommended a further operation, an exploratory laparotomy. An exploratory laparotomy involves the making of an incision through the abdominal wall.

19. On 29 October 2004 an incision was made on the right hand side of Mr Cox below the rib margin to allow direct access to the operative field. Such an approach may be distinguished from a laparoscopic approach. During this approach Dr Patel found evidence of internal bleeding but was unable to locate the bleeding point. He then evacuated the blood and washed out (irrigated) the abdomen cavity. He also placed a drain in the area. He then sewed up the incision.

20. On 1 November 2004 it is noted that Mr Cox's general condition had improved, however the drain was draining bile stone fluid in volumes of several hundred millilitres per day. I would consider that to be of concern. On 8 November 2004 it is recorded that the drain was still draining bile. Eventually this ceased on 13 November 2004. The drain was removed on 14 November 2004. Mr Cox was discharged on 15 November 2004.

21. Mr Cox subsequently developed a painful incisional hernia. Dr Patel saw him on 23 March 2005 in follow-up clinic. Repair of that hernia was booked at that time.

22. I saw Mr Cox on 29 April 2005 and I observed that he had a large incisional hernia. I advised that there should be repair of that hernia. I performed that repair using prosthetic mesh.

23. In summary, the issues I observed in relation to Mr Cox are these:
    (a) He was a patient with gall stone problems who had four operations to sort out his problems. Normally the procedure is relatively straightforward, being key hole surgery. In most cases patients are in hospital not more than 24 hours. Recovery is quite rapid.

(b) It seems to me the second operation only partly dealt with Mr Cox's post-operative complications, and suggests the assessment of what was required may not have been sufficient.

(c) The bile leak that continued after the third operation was of concern and should have been investigated. There is no mention in the notes of the third operation of bile duct structures and clips placed. I would have been concerned that such things had been displaced or a duct had been opened where there had been such bile leakage.

(d) The development of the hernia in that sort of wound is unusual. It raises questions about how the wound was repaired. There is a suggestion that the wound was closed in an inadequate fashion.

(e) The number of operations was unusual.

(f) Occasionally complications arise from this sort of procedure and accordingly it is difficult to draw conclusions.

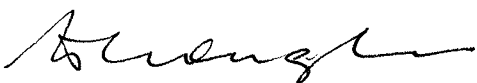
(g) I am not convinced that problems were dealt with adequately when they arose.

(h) I consider there was less than expert assessment and management of post-operative complications. I consider that the assessment and management of same was less than you'd expect from a surgeon experienced in that area.

Lynnette Van Vliet

24. Ms Vliet had a problem with painful gall stones. A laparoscopic cholecystectomy was recommended by Dr Patel and/or his team. The procedure was performed on 19 April 2004 at the Base by Dr Patel and his Registrar.

25. The operative notes record that a particular approach was taken to access the abdominal cavity (open umbilical approach). It seems this approach was taken in view of the fact the patient had previously had a number of abdominal operations. A prior history of same can lead to the formation of adhesions which involves adherence of the bowel to the



abdominal wall. It seems the technique used in this case was to protect against this happening.

26. According to the operative notes the procedure went ahead thereafter without event. Unfortunately, the following day, 20 April 2004, the patient was unwell with signs of concern (pain and tenderness). She was returned to the operating theatre for an exploratory laparotomy. During that procedure, performed by Dr Patel, it was noted that the small bowel had been inadvertently opened at the time of the first procedure. This resulted in a leak of small bowel content. This laceration was repaired. A note was made that a further inadvertent laceration was made at a different part of the bowel during the second operation. This was also repaired.

27. Following the second operation the patient developed a breakdown of the abdominal wound (wound infection and dehiscence). This required packing for some months until the wound had healed. She was left with a residual incisional hernia which indicated that there had been a complete dehiscence at some stage.

28. The said incisional hernia needed repair. I saw the patient on 29 April 2005 and advised accordingly. The repair was performed in Bundaberg by Dr Pitre Anderson in June of this year.

29. In summary the main issues in respect of this patient are these:
    (a) The patient had had multiple prior abdominal procedures. Clearly the technique to access the abdominal cavity was deficient. I feel that the placement of the first incision was ill-advised. Normally the incision should be placed well away from any previous incisions. This is the sort of mistake that happens occasionally and can be made by a reasonably competent surgeon. However if it happened on an unusually high number of occasions I would have concern about the competence of the surgeon.

(b) It seems to me that the placement of the incision involved less than adequate technical competence and clinical competence.

30. The above two cases, those of Mr Cox and Ms Vliet, cause me to wonder about Dr Patel's proficiency in laparoscopic surgery. It causes me to wonder whether he had been trained in laparoscopic surgery, and about his level of experience in same.

Una Connors

31. I saw this patient at the Base outpatients on 4 May 2005. She had been referred to the Base and saw one of its gastroenterologists, Mark Appleyard, up there. She had symptoms referrable to her bowel but she also had gynaecological symptoms. She was examined by the gastroenterologist who found she had an abdominal mass. In a letter to Ms Connors' GP the gastroenterologist indicated that he had advised there should be a colonoscopy (a visual examination of the large bowel), and also indicated that she should be referred to a consultant gynaecologist for assessment.

32. Subsequently a colonoscopy was performed by Dr Graham Radford-Smith and a mass was noted in the sigmoid colon. Biopsies were taken. They revealed normal colonic tissue with no evidence of malignancy. However, it was considered that the most likely diagnosis was bowel cancer and Ms Connors was referred to Dr Patel. It was a reasonable possibility at that time that despite the biopsy Ms Connors was suffering from cancer. In my view the reasonable course to take at that stage would be further investigation.

33. Mrs Connors was seen by Dr Patel on 18 March 2004. He advised that there should be a CT-Scan and tentatively arranged for surgery 2 weeks thereafter. He did not indicate in the notes what kind of surgery was recommended. I can see no evidence that Mrs Connors was physically examined on that occasion.

34. I recall the CT-Scan confirmed that Mrs Connors had a pelvic mass. The radiologist was circumspect in the report as to whether it arose from the bowel or the pelvic organs. I recall the comment in the report that the mass was in contact with the uterus and the exact origin of the mass was not clear. I don't recall whether the CT-Scans were reviewed at this stage by Dr Patel.

35. Mrs Connor went on to have surgery by Dr Patel on 2 March 2004. In the operation report it was recorded a large mass involving her sigmoid colon and left fallopian tube was noted. It was also noted there was a mass in the left ovary. The operation that was performed was a sigmoid colectomy, which involves the removal of the sigmoid colon. In addition the left ovary was removed separately. The bowel was rejoined and the abdomen was closed.

36. About 8-9 days post-operation there was a complete dehiscence of the abdominal wound. This necessitated a return to the operating theatre. That was performed on 8 April 2004 by another surgeon, Dr Gaffield.

37. Mrs Connors also suffered a myocardial infarction (heart attack) post-operatively. Her post-operative course was stormy and prolonged. When the pathology was returned it was revealed that she had a carcinoma arising from her ovary and infiltrating her bowel. She did not have bowel cancer, it was ovarian. The tumour had also spread to the lymph nodes.

38. Eventually, Mrs Connors was referred to a gynaecological oncologist at the RBH. Normally, optimal treatment for ovarian cancer involves extensive surgical clearance of gynaecological organs followed by chemotherapy. In view of Mrs Connors condition by the time she reached the RBH, particularly in light of her recent cardiac problems, the advice was that she was not fit enough for a second operation. The advice was that she should receive chemotherapy at the Base.

39. In summary the issues I observed in relation to Mrs Connors were these:

(a) Mrs Connors was inadequately assessed.

(b) There is no evidence that she was seen by a gynaecologist pre-operatively. This should be completed in the context of the gastroenterologist's advice to her GP that that should have happened.

(c) The CT-Scan suggested that the problem was not straightforward sigmoid cancer, especially given the colonoscopic biopsies were inconclusive. There were a number of signs pointing to ovarian rather than bowel cancer.

(d) The post-operative dehiscence raises questions in respect of Dr Patel's wound closure technique.

(e) The treatment that Mrs Connors received was sub-optimal.

(f) Mrs Connors heart attack rendered her unfit for optimal treatment for ovarian cancer. This effectively denied her best chance of treatment. Had Mrs Connors received optimal treatment in the first place, even if she had a heart attack post-operatively, at least she would have had optimal treatment for the ovarian cancer.

Eric Eisel

40. I saw this patient on 29 April 2005 at the Base. His ongoing problem was that he had had an operation performed by Dr Patel in August 2004. The wound from that operation had not healed when I saw him. The original operation was in respect of a fistula in the perianal region. Basically, that is a tunnel between the bowel and the skin. Usually it is a result of infection or abscess in that area.

41. The patient's other complaint was that he was unhappy with his bowel control. Specifically, he did not have complete control. He was getting some unconscious soiling.

42. The patient was seen on 3 July 2004 by one of the junior surgical staff. A diagnosis of a perianal fistula was made at that stage. The patient had a significant and worrying cardiac history, unrelated to the fistula. That

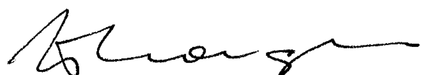
history was known to the Prince Charles Hospital. He had seen cardiologists and received treatment there. He had been booked to have a pacemaker there. In view of that history the patient was a significant operative risk.

43. The patient was referred to the anaesthetic (preadmission) clinic at the Base. It was considered by Dr Carter at that stage that it was reasonable for the surgery to go ahead followed by admission to intensive care. The surgery was performed by Dr Patel on 23 August 2004. I cannot find any evidence that he reviewed the patient pre-operatively. With the sort of risk factors associated with surgery on this patient I would reasonably expect that a surgeon would review the patient pre-operatively.

44. In the operation the fistula was excised and the area was laid open. The idea is that by laying the wound open it is given an opportunity to heal. This particular procedure requires judgement. If the fistula passes across muscle (which it sometimes does) in dividing the tissue it is possible that the anal sphincter might be divided in part or completely. When I saw Mr Eisel it seemed to me, based on his history and examination of him, that a good part of his anal sphincter had been divided. This is not the kind of mistake that an experienced surgeon should make.

45. Upon examining the patient I referred him to a colorectal surgeon for further examination. By that stage the wound had not healed 8 months post-operation. He probably needed further surgery to facilitate healing of his wound. He certainly required more expert assessment.

46. In summary the issues in respect of this patient are these:
   (a) There is no evidence of weighing up of relevant issues pre-operatively.
   (b) There is little detail in the notes of the operation in relation to the extent of the fistula and its relationship to the sphincter.
   (c) There are safer techniques than opening up the fistula. An experienced surgeon would have used those techniques and

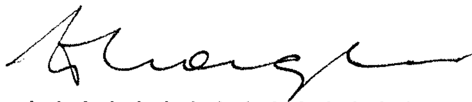


then referred the patient on to a specialist colorectal surgeon. Fistulas are often quite complex and those are better dealt with by specialists who regularly deal with them.

(d) Given the patient's significant cardiac history, it would have probably been better to refer him to a tertiary hospital. This was not an emergency situation.

All the facts and circumstances above deposed to are within my own knowledge and belief, save such as are deposed to from information only and my means of and sources of information appear on the fact of this my statement.

Affidavit ~~sworn~~ witnessed on 10 August 2005
at Brisbane in the presence of:



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Deponent

Solicitor/Justice of the Peace