STATEMENT OF DR ANDREW JAMES JOHNSON

I, Dr Andrew James Johnson, Executive Director of Medical Services of the Townsville Health Services District, of an address known to the Commission makes oath and states:

1. I have previously provided a statement to the Commission dated 13 July 2005. That statement details my employment history and current job responsibilities.

2. I commenced my current role in July 2000.

Vincent Berg

3. When I started at the Townsville Hospital, Vincent Berg was employed as a Registrar in the psychiatric unit. He was on a one year contract that was due to finish in January 2001.

4. I was not involved in the recruitment process for Vincent Berg but I understand that he had been registered by the Medical Board of Queensland and had also previously had a period of observership at the Gold Coast Hospital and had a favourable reference from a doctor at that Hospital.

5. Vincent Berg claimed that he had been a fully qualified psychiatrist in the former USSR, having a medical degree from the Voronezh State University. He also claimed to have completed a post-graduate specialty in psychiatry.

6. Vincent Berg claimed to have been ordained as a Deacon of the Russian orthodox church and claimed that he had been persecuted in the USSR

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because of his religious beliefs. He apparently claimed and I understand received refugee status. He also claimed that due to the fact that the KGB had persecuted him, there was some difficulty in verifying his work history in the USSR. Annexed to my statement and marked with the letters "AJJ-1" is a copy of Vincent Berg's resume from his personnel file.

7. Dr John Allan, the Director of the Mental Health Unit had some concerns about the performance of Vincent Berg and he raised those concerns with me as the Executive Director of Medical Services. Dr Allan related to me that Vincent Berg had interpersonal difficulties within the Mental Health Unit. He had ideas about psychiatry that were at variance with mainstream thinking about psychiatry. He refused to take direction and supervision from consultants within the Unit. He had a habit of changing medication prescribed by the consultant without permission. There was also a concern regarding attendance hours "on-call" and at an outpatient clinic at Charters Towers.

8. I spoke with Dr Allan about how to approach these matters. At that time I believed that the situation was that there was a properly registered doctor with bona fide qualifications whose performance was sub standard. I conducted a number of interviews with Vincent Berg in conjunction with Dr Allan, in an attempt to manage his performance. In conjunction with Dr Allan I also put in place a monitoring program.

9. At that time there was a division within the psychiatry ranks regarding Vincent Berg and at least 2 consultants supported him. In August 2000 a formal show cause notice was issued to Dr Berg, following which he went on extended sick leave and made a work cover claim. I recall that the claim alleged that he had been bullied and that Dr Allan and I had been applying undue pressure on him. That matter was investigated and the allegations proved to be baseless. However, it had become clear to me that it was not appropriate to reemploy Vincent Berg following the end of his contract due to his performance.

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10. I recall that when Vincent Berg learned that the Hospital was not renewing his contract he became quite angry and I recall he began writing to the local member of parliament and the then Director-General about these issues in an attempt to put pressure on the Hospital to re-employ him. However, I chose to hold my position and the Hospital did not re-employ him.

11. After Vincent Berg left the Hospital in early 2001 I had no further contact or involvement with him and he effectively disappeared from my view. In late 2002, I had a conversation with Dr Allan who relayed a story that he had been told by a colleague from the Royal Australian and New Zealand College of Psychiatrists. The story was to the effect that there had been a Doctor practicing in psychiatry in Townsville was not a doctor. Apparently, what had happened was that Vincent Berg had applied to the Australian Medical Council for specialist accreditation and the AMC had referred the matter to the College.

12. The College investigated his qualifications and found out that Vincent Berg's qualifications were forgeries. Dr Allan also informed me that the College had contacted the Medical Board of Queensland about this and relayed that information to the Medical Board in early 2002, some nine months earlier.

13. I was shocked and upset about this and I telephoned the College to confirm this information. On 28 November 2002 I wrote directly to the College seeking confirmation of these issues. Annexed to my statement and marked with the letters "AJJ-2" is a copy of my letter to the College.

14. The College replied on 2 December 2002 and also forwarded to me a copy of its letter to the Queensland Medical Board dated 23 January 2002 when it advised of the fact that the College had concerns about the veracity of Vincent Berg's qualifications and documentations and would not permit him to under go specialist assessment. The college also forwarded to me a copy of its letter to the Medical Board of Queensland regarding these issues.

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Annexed to my statement and marked with the letters "AJJ-3" is a copy of those letters.

15. Also at this time I sent an email to Steve Buckland the General Manager - Health Services summarizing the issues. Annexed to my Statement and marked with the letters "AJJ-4" is a copy of that email.

16. At this time I also began to have significant concerns about the impact this situation might have on patients. There were serious issues regarding patient safety particularly as Vincent Berg had practiced independently and had actively ignored attempts to supervise him. I had discussions with Dr John Allan and he commenced doing a chart audit of all of the patients who had been treated by Vincent Berg.

17. At that time I also had concerns about my personal safety and Dr Allan had similar concerns. It should be pointed out that this was not long after a doctor had been shot and killed by a former patient in Adelaide. Mr Ken Whelan, the District Manager, contacted the local Police Officer Christopher Reeves about these issues. He was also seeking some advice concerning whether there was a need to report Vincent Berg to the Police Service or the CMC.

18. On 6 December 2002 I spoke with Christopher Reeves about this situation and then sent an email to Ken Whelan with a copy to Steve Buckland. Annexed to my statement and marked with the letters "AJJ-6" is a copy of that email.

19. Ken Whelan was away for a short period of time in January and I was the acting District Manager. I was involved in speaking with the Police during this time.

20. I was seeking some information on the whereabouts of Vincent Berg.

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21. Dr Allan completed his Audit on 7 January 2003. He had identified 60 patients that he considered at high risk who needed to be contacted and reassessed.

22. On 13 January 2003 in conjunction with Dr Allan I prepared a briefing note to the then Minister Wendy Edmond. Within Queensland Health, Ministerial briefing notes go first to the Zonal Manager, then to the General Manager Health Services and then to the Director-General's Office. I forwarded that briefing note on 13 January 2003.

23. Attached to that Briefing note was a copy of Dr Allan's audit report and also a Communications Plan that Dr Allan and I proposed. The object of that communications plan was to contact all of the patients and to communicate the issue to the Media. That plan proposed that the media be contacted and the information released to them. Then all patients be contacted and asked to come into the Hospital for a review. I prepared a Draft media release and Dr Allan prepared a "script" to be used when contacting patients. Annexed to my statement and marked with the letters "AJJ-5" is a copy of that ministerial briefing note and annexures.

24. I proposed a "front foot" media strategy as I felt that Queensland Health and the Townsville Hospital had done nothing wrong in this situation. Vincent Berg's clinical problems had been recognized and he had been managed appropriately. He was registered with the Medical Board and the Hospital had no reason to suggest that his qualifications were forgeries. I also felt that by being open and transparent about these issues Queensland Health would be doing the best thing for its patients. Media exposure would also ensure that any patients who had not been identified in the audit might also come forward and be reviewed. Dr Allan and I went to enormous lengths to develop that communications plan and we felt that it was comprehensive and appropriate.

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25. Upon his return from leave, Ken Whelan then asked for some advice about whether or not there had been a fraud committed and what action could be taken to have Vincent Berg charged. He also had some communications with the Police about whether there was official misconduct and whether that ought to be referred to the Crime and Misconduct Commission ("the CMC").

26. I also am aware that Ken Whelan had some email correspondence with Terry Mehan the Zonal Manager and Steve Buckland the General Manager Health Services. I was not privy to that correspondence at the time but I was told that the Hospital had been directed not to refer the matter to the CMC and that the media were not to be contacted. This also meant that the patients could not be informed about Vincent Berg not being a doctor as that would inevitably lead to media coverage.

27. It was clear to me that the direction must have come from the General Manager of Health Services or perhaps higher within Queensland Health.

28. I was very uncomfortable about this direction. I am aware of my obligations under the *Crime and Misconduct Act* to refer suspected official misconduct to the CMC however I had briefed my superiors on the issue. I felt uncomfortable with the direction not to refer the matter to the CMC and was deeply distressed at the time. I also felt that as the direction had come from Steve Buckland I was unwilling to challenge that direction.

29. I was also satisfied that the clinical risk that had been identified could be addressed appropriately without the matter being released to the media. The critical matters had been dealt with and the other patients would be reviewed over time. Nothing further happened about the situation for some time.

30. On 10 June 2003 I received an email from Wayne Pennell a Detective Sergeant at the Townsville CIB enquiring whether I wished to make a formal complaint about Vincent Berg. I replied on 10 June 2003 advising that the Hospital did not wish to proceed with any action against Vincent Berg.

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Annexed to my statement and marked with the letters "AJJ-7" is a copy of those emails.

31. I have recently seen an email from Steve Buckland to Terry Mehan a copy of which was placed on Vincent Berg's file. That email deals with two issues, the direction not to refer the matter to the CMC, and the issue of myself and unidentified others not being able to brief properly. I take that comment to refer to the Ministerial Briefing note that I prepared which Dr Buckland would have seen at that point.

32. It was a very difficult decision for me not to report this matter to the CMC and the Queensland Police Service. However I was not prepared to go out on a limb about this as I felt that there would be retribution if I chose to do so.

33. I recall that at that time there had been a District Manager summarily dismissed by the General Manager of Health Services. I felt that if I spoke up then my job might be at risk. Certainly at that time bringing bad news was never a good thing. I felt that there was a push to ensure that Queensland Health was "kept off the front page".

Dr Don Myers

34. I was not heavily involved in the recruitment of Dr Don Myers until the end of the recruitment process when the position needed to be approved. Under the management structure of this Hospital the Clinical Directors of the various Institutes have a level of autonomy in the recruitment and selection of medical staff. I am involved in the selection process for Directors. For Senior Medical Officers and Staff Specialists the Clinical Directors have a much greater role. I supported those changes and believed that it reflected an appropriate devolution of authority and responsibility

35. I get involved when it comes to Area of Need and the granting of interim clinical privileges.

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36. As a result I may not be aware of any particular candidates for a position until the process is completed.

37. Dr Myers was one of the first doctors recruited through this process. By the time I was involved his recruitment was well under way. From his CV he appeared to be a very good candidate and the Hospital was very interested in him as a permanent appointment. He visited the Hospital in January 2005 but due to circumstances I was unable to meet with him. He was offered the position of Staff Specialist however he was unable to take up the duties.

38. It had been the intention at the time that if he was to come as a permanent appointment then an application for specialist accreditation or Deemed Specialist status would be made through the Royal Australasian College of Surgeons.

39. It takes 8 weeks for deemed specialist recognition or 12 weeks for full specialist accreditation to be determined by the College. That is a review on the papers where the College examines credentials and experience to determine if an Overseas Trained Doctor has had a level of training equivalent to an Australian specialist in the same field.

40. Dr Myers was unwilling to take up a permanent appointment at that time and a locum arrangement was negotiated. It was felt that a locum position might give the Hospital a chance to win him over and convince him to stay on a more permanent basis. It must be recognized that at that time the Hospital had been actively seeking the services of a third neurosurgeon for some time and was soon to face a period of extended leave for one neurosurgeon.

41. Given that Dr Myers was coming on a three month locum arrangement a decision was taken to employ him as a Senior Medical Officer (SMO) rather than as a Staff Specialist. I signed off on the Area of Need application

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however I don't recall specifically noticing the fact that it was for a SMO position.

42. For locum positions there has not been a practice of seeking deemed specialist status as often the time it takes to receive that accreditation is longer than the period of the locum. Therefore there is little point in applying for that status.

43. Dr Myers had excellent training and had worked in good medical departments in the USA, He was certified by the American Board of Neurological Surgery. Dr Rossato had interviewed him. Dr Rossato had given me assurances that, despite the fact that Dr Myers had been in the Virgin Islands and out of a large Hospital for some time, his skills were still up to date. I then asked Dr Rossato to make a recommendation to me for interim clinical privileges for Dr Myers. I asked Dr Rossato to specifically consider currency in emergency neurosurgery such as clipping cerebral aneurysms, as this was an issue Dr Guazzo raised with me as a potential concern. At that stage I had not met Dr Myers.

44. Dr Rossato sent me a recommendation seeking interim clinical privileges for Dr Myers. I have not granted Dr Myers any clinical privileges at the Hospital. He continues to practice under the supervision of Dr Guazzo and Dr Rossato.

45. I was always under the impression that Dr Myers was to be supervised at least until his level of competence could be confirmed. However I then learnt that Dr Rossato was going to be away for the first 3 weeks that Dr Myers was here, that left Dr Myers without any supervision. I then contacted Dr Guazzo to discuss whether he might be willing to supervise Dr Myers. Following that conversation I wrote an email dated 3 June 2005 summarizing my discussions with Dr Guazzo. Annexed to my statement and marked with the letters "AJJ-8" is a copy of that email. Dr Guazzo was not willing to formally supervise Dr Myers and Dr Guazzo had not been formally involved in the recruitment process.

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46. On 10 June 2005 I received a letter from Dr Guazzo confirming his position with respect to Dr Myers. Annexed to my statement and marked with the letters "AJJ-9" is a copy of that letter.

47. At this time I had also had contact from the Chief Health Officer, Dr Gerry Fitzgerald who also sits on the Medical Board of Queensland. Dr Fitzgerald raised concerns about the supervision of Dr Myers as an SMO. It transpired that the Medical Board had changed the policy requirements for supervision of doctors generally. The new system required that SMO's have a similar level of supervision to a Registrar. That is, the consultant must be satisfied that an SMO is competent to perform a particular procedure before the SMO is permitted to practice independently. In my view, this policy may create recruitment difficulties in the future for reasons that I discuss below.

48. As Dr Rossato was to be on leave for the first three weeks that Dr Myers was at the Hospital, I contacted Wavelength Consulting and asked if they might be able to assist in expediting Dr Myers deemed specialist accreditation. I was hopeful that college accreditation might be expedited to enable Dr Myers to be granted deemed specialist status.

49. I also contacted Dr Rossato who is a senior member of the Royal College of Surgeons and asked if he might be able to pull some strings to have the accreditation process sped up. I was not attempting to circumvent the college process I just felt that a an assessment "on the papers" might be able to be finalized quicker than the ordinary 8 week turnaround. However in the meantime Dr Myers was employed as an SMO.

50. I then recall having some contact with Dr Stitz who was taking over as the president of the College of Surgeons. He made some comments about a neurosurgeon practicing at Townsville that had not been through the college process. That created a degree of publicity about the recruitment of Dr

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Myers. I felt that the publicity was unnecessary as I had taken steps to address concerns about Dr Myers by implementing a system of supervision.

51. When I met with Dr Myers I asked him several questions about the practice that he had been recently engaged in. I specifically asked him about his recent experience in clipping cerebral aneurysms. Dr Myers volunteered that he was somewhat rusty and had not done one for a while.

52. The following comments are not a criticism of Dr Myers, I was very impressed with his personal insight with respect to his recent experience and the fact that he recognized that he had not had access to the latest equipment in the Virgin Islands. He appreciated that he would need to be familiarized with the procedures and equipment in the Townsville Hospital. However, I had concerns that Dr Rossato had given me assurances that Dr Myers was current with this procedure. On 24 June 2005 I wrote to Ken Whelan setting out my concerns. Annexed to my statement and marked with the letters "AJJ-10" is a copy of that correspondence.

53. The end result of this process is that the Townsville Hospital had employed Dr Myers as a locum neurosurgeon however the Hospital was not able to confidently proceed with permitting Dr Myers to operate independently. Not through any concerns about his ability or qualifications but rather as a result of the potential criticism, warranted or not, that it might attract.

54. I have had very good reports about Dr Myers ability and skills. He has previously had a very wide ranging practice in the USA, and freely admits that when in the Virgin Islands he did not have access to the technology available at the Townsville Hospital. I am also impressed that upon arrival he had the personal insight to recognize that he had not used some of his skills for a period. In my experience the mark of a good surgeon is the ability to recognize his or her limitations and work within them. I am also aware that to be an effective surgeon a doctor needs to have a high degree of self

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confidence and assuredness. Dr Myers has impressed me as an insightful and caring doctor who would be an asset to the Hospital if he chose to stay.

55. The consequences of all of this publicity is that the Townsville Hospital may very well have lost the long term services of a practitioner who might otherwise have been an outstanding addition to the Hospital.

56. The Townsville Hospital has been actively seeking the services of a third neurosurgeon for some time and has had considerable difficulty in attracting a senior practitioner to set up practice in Townsville either as a VMO or as a Staff Specialist.

57. The locum arrangement has been an excellent opportunity for the Hospital to review Dr Myers and make an assessment of his skills and fit within the neurosurgery team. In my view, it is an appropriate means to introduce and Overseas Trained Doctor into the Queensland Health System.

Supervision of Overseas Trained Doctors

58. For highly trained and experienced specialists from equivalent jurisdictions such as the USA, the UK and Canada, the prospect of being subject to an extensive period of supervision upon joining Queensland Health may be a deterrent to recruitment.

59. In the Northern Zone, we have introduced a system where Overseas Trained Doctors from equivalent jurisdictions work at the Townsville Hospital for a period of time before taking up duties in other regional Hospitals. The Townsville has a tertiary referral centre has the facilities and staff to enable Overseas Trained Doctors to be assessed and familiarized with the Queensland health care system. This is a period where their peers give Overseas Trained Doctors support and feedback. It also allows the District to assess their level of competence and support requirements.

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60. However, to suggest to an experienced overseas trained specialist that he or she will be subject to the level of supervision given to a Registrar may very well offend some highly qualified specialists. Many overseas trained specialists would welcome an opportunity to have peer support for a period of time before embarking on independent practice. However, there must be a degree of flexibility in any arrangement to take into account the variations in skills and experience of Overseas Trained Doctors.

61. An example of how this system works in the Northern Zone is that when an Overseas Trained Doctor starts with the Hospital I will arrange for a peer to attend the first few clinics or surgical lists with the new doctor as a support person. Most doctors welcome this arrangement.

62. There have been occasions where this arrangement has revealed serious shortcoming with some practitioners and the Hospital then attempts to either manage those issues or not proceed with the appointment.

63. Another arrangement in the Northern Zone is for doctors in remote and regional hospitals to rotate through the Townsville Hospital for a period of time on an annual basis. This is done for several reasons. Firstly, it is a means of peer support and prevents doctors in regional and rural areas from becoming isolated from their professional colleagues. Secondly, it also allows skills to be refreshed by working in a tertiary teaching Hospital.

64. This system was introduced following a report that I prepared into the death of a patient at the Charters Towers Hospital. That report is already an exhibit before the Commission. That report was briefed to the Zonal Manager who I am sure briefed it up the chain of command. As far as I am aware it has not been introduced in other zones.

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65. Dr Guazzo resigned from his position as a VMO last year for a number of reasons that I note he has discussed in his Statement to the Commission.

66. At that time I went to some lengths to have him reconsider his decision as I did not want to lose his services as they are essential to the Hospital and the population of North Queensland.

67. I believe that the public and private sector need to work closely together particularly in rural and regional areas. In North Queensland there is not a sufficient population base to support a large number of specialists particularly in the subspecialties such as neurosurgery. By having a VMO who has both a public and private practice allows the population of North Queensland to have access to neurosurgery services that may not otherwise be available.

68. I had detailed discussion with Dr Guazzo to have him return as a VMO. Dr Guazzo has since returned as a VMO and there have been changes made to accommodate his requirements.

VMOs and the polarization of the Medical Workforce

69. In conjunction with a colleague I have recently written a discussion paper that addresses the issue of the polarization of the medical workforce. That is my personal opinion and it does not reflect the view of Queensland Health. In my experience there has been a change in the medical profession with many doctors now choosing to practice either in the private sector or the public sector but not both. This has been particularly evident in North Queensland.

70. My paper discusses the way in which these matters can be addressed. It also discusses the fact that the private sector of the medical profession is heavily subsidized through Medicare and therefore from an economic view is

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not really a product of market forces. Annexed to my statement and marked with the letters "AJJ-11" is a copy of that paper.

Charters Towers

71. On behalf of Queensland Health I investigated the conduct of Dr Izak Maree at the Charters Towers Hospital. I prepared a report as a result of that investigation and that report is an exhibit before the Commission.

72. As a result of that report I developed the system described above relating to the introduction of Overseas Trained Doctors to the Queensland Health Care system.

Privileging and Credentialing

73. I chair the Townsville Credentialing Committee which covers Townsville and Mount Isa Districts for SMO and VMO assessments. There is also a Rural Credentialing Committee in North Queensland. As part of that process rural GP's that are going to practice in particular specialties are brought to the Townsville Hospital on a regular basis for peer support and review.

74. Many rural GPs also practice as VMO's in anaesthetics and obstetrics. In order to ensure that their skills are kept up to date those practitioners are rotated through major centers. This ensures that the doctor does not become isolated from colleagues by virtue of rural practice.

Patient Safety Framework

75. I am also heavily involved in the Patient Safety Program in the Hospital. I introduced the current patient safety framework that exists within the Hospital which is a system based on Root Cause Analysis (RCA).

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76. When I joined the Hospital in 2000 I came from a background in aviation medicine with the RAAF. I was struck by the difference between systems safety in the aviation industry and within Queensland Health. The aviation industry has been focused on systems safety for many years.

77. When I joined the Townsville Hospital it had numerous committees that dealt with patient safety issues but there was no overall framework in which patient safety operated. There was not linkage between the committees. The Hospital was restructured into its current framework and as a part of that I developed the Clinical Governance Council that oversees safety and quality issues and has now evolved into the Patient Safety Committee.

78. The purpose of the clinical governance council was to engage clinicians in the clinical oversight of the organization and engage the clinicians with the Executive.

79. The Clinical Governance Council brings together active clinicians from the 12 Clinical Services Units within the Health Services District. This process gradually built up a level of engagement between the clinical staff and the Executive Management.

80. As part of that restructure there was also devolution of authority and accountability to the heads of the clinical units and a restructure of the Clinical Service Units to create five Clinical Institutes.

81. I then started seeking ways in which patient safety issues could be identified. I learned of a RCA process that was used within the US Department of Veterans Affairs Hospitals in the USA. In 2002 I arranged to go on a training course in the USA to examine that process. I brought that program back to the Townsville Hospital and implemented it within the Hospital. The Veterans Affairs model is, in my opinion, one of the best patient safety models available and it is rapidly being adopted by Hospitals across Australia. To my knowledge it has been implemented in NSW and SA.

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82. The purpose of RCA is to provide a safe way to identify and address patient safety issues. It is not about populating a database full of statistics. The purpose is to identify vulnerabilities with systems and then put in place ways to address the weakness of those systems.

83. It is also not about apportioning blame rather it is about a "just culture" with a clear understanding of systems, impact on safety and what constitutes an individual "blameworthy" act.

84. The RCA process is only one part of the picture for patient safety. It is also necessary to have other systems in place such as on-going surgical audits, morbidity and mortality meetings and an open culture within the Hospital. Annexed to my statement and marked with the letters "AJJ-12" is a copy of the patient safety framework that we developed for the Townsville Hospital.

Clinical Governance

85. Having followed the Commission of Inquiry for some time I would like to draw the attention of the Commission to what I perceive as potential problems with alternative structures that have been put forward for discussion.

86. There have been several comments about the relative merits of a board structure for managing Hospitals and having an active clinician as the Director of Medical Services.

87. That was the structure in place in the Townsville Hospital when the events at ward 10B occurred. Annexed to my statement and marked with the letters "AJJ-13" is a copy of the summary of findings from the Commission of Inquiry into ward 10B.

88. I am a firm supporter of the concept that clinicians must be involved in the clinical governance of a Hospital. However, I see a distinction between

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89. clinical governance and the management of the Hospital. In the Townsville Hospital we have gone to great lengths to involved clinicians in the clinical governance of the Hospital. The Institute model of management allows clinicians' direct responsibility and accountability for the operation of their particular Institutes. They have financial accountability for their budgets but also have the authority of spend money within their allocated resources to meet clinical needs.

90. However, there is a need for active management of the Hospital as a means of supporting clinicians to do their jobs effectively. The management of people is a different skill set than that required by a clinician. The management of a Hospital must balance competing considerations and issues across a range of health service needs.

91. I also perceive a role for a local board structure in engaging the community, however there is still a need for a Hospital Executive to manage the resources of the Hospital in the long term.

All the facts and circumstances above stated are within my own knowledge and belief, save such as are from information only and my means of knowledge and sources of information appear on the face of this my Statement.

SWORN on day of 2005 at Townsville in the presence of:

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