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BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DR JAMES PETER BOYD

1. I, **DR JAMES PETER BOYD** Principal House Officer, c/- Princess Alexandra Hospital, Ipswich Road, Brisbane in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence of information held by the Commission of Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

3. I am currently employed at the Princess Alexandra Hospital as a Principal House Officer in Surgery. A Principal House Officer (PHO) is an unaccredited Registrar. I have been employed in this role since January 2005.

4. I was awarded Bachelor of Medicine and Surgery (MBBS) from the University of Papua New Guinea (PHG) in 1996. I then worked as a resident in surgery in PNG and 2 years as a Registrar in surgery also in PNG.

5. I moved to Australia in 2001 and commenced working at the Rockhampton Base Hospital in January of that year, initially as a Senior House Officer and then I was made a PHO after a period of 3 months.

6. I moved to Toowoomba Hospital in January 2002 and undertook the role of a PHO in surgery.

7. I then worked at the Matter Hospital from January 2003 as a PHO in surgery.

8. From 17 January 2004 I was employed at Bundaberg Base Hospital as a Principal House Officer in Surgery.

9. As the PHO at Bundaberg Base Hospital my role was to assist the consultant surgeons. The consultants were the Director of Surgery, Dr Patel, and other surgeons including Dr Jim Gaffield and Dr Anderson who did a session once a week. Dr Kingston also was a general surgeon who did some general surgical work. I would also undertake smaller procedures under the supervision of these surgeons.

10. For the first six months at Bundaberg I was mostly working with Dr Patel. This entailed assisting him in operations and being supervised by him for some procedures. It also involved seeing outpatients in clinics and emergency patients who came through the emergency department. I would also do ward rounds with Dr Patel and review inpatients.

11. I did not consider that there was anything wrong with Dr Patel as a surgeon. I thought that he was very competent. He did not appear to be any different to any other surgeons I had worked with in Australia. On a personal level Dr Patel was loud and came across as being arrogant and would tread on other peoples toes. That was the perception that others had of him. It did not bother me as much as I had worked with people like this before. I have seen other surgeons that are similar to Dr Patel. He was sometimes abrupt. I cannot say that he did not care about his patients. He would even come in to check on patients when he was not on call and on the weekends. He made himself available to be called upon.

12. There are not too many other Doctors that I have worked with that make themselves available when they are not on call. He even seemed somewhat obsessive about getting things right and would become annoyed if things were not done right. This annoyed people too but to me it was part of good patient care and meant that the patients got the best care.

13. Dr Patel was very good at teaching medical students and in fact I would say that he enjoyed teaching.

14. I have been shown the Patient Key that I am informed is being used by the Commission of Inquiry to identify patients and to maintain patient confidentiality. I have referred to the following patients in accordance with that Patient Key.

P 126

15. I have reviewed the patient chart in relation to this patient.

16. P126 was as a patient who had surgery on 19 May 2003 for diverticula disease and subsequently developed a wound infection. His wounds had healed by July 2003. He had recurrent symptoms of his disease in November 2003. I became involved on 20 January 2004 when he underwent an endoscopy and colonoscopy during which he was found to have a recurrence of his disease.

17. At this point P126 opted to be treated conservatively and there does not appear, from my reading of the chart notes, to be any further procedures after this time. I also cannot recall any further procedures after this time. I do not recall seeing this patient again after this time. I wrote a letter to his GP advising what was found in the procedures and advising that we would see him back in the outpatient's clinic if there were any problems. I had no further dealing with this patient after this time.

18. I can't recall Dr Patel's involvement with me in relation to this patient. I would have done a good part of the procedure, possibly under the supervision of Dr Patel. I cannot recall for sure.

19. I am not aware from reading the notes or otherwise that Dr Patel had any further involvement with this patient.

P22

20. I have reviewed the chart for this patient.

21. P22 was, at the time, a 94 year old man. I first saw him on 31 July 2004 in the emergency department as an emergency presentation. He presented with an acute distended abdomen. He was suffering from a bowel obstruction. He had dehydration and renal failure. Our plan at the time was to do an urgent decompression of his bowel as a matter of urgency to prevent perforation which was highly likely. This was discussed with his family (eldest son) in consultation with the anaesthetist and he was advised that there was a high risk of bowel perforation with or without the colonscopic decompression. The family were well aware of the risks and a collective decision between the family and the surgical team was made to proceed with procedure.

22. The decompression procedure was undertaken on the 31 July 2004. This relieved the problem but not definitively. He was reviewed the next day following the procedure by Dr Patel who also commented that there was a high risk of perforation and the patient would require surgery to rectify any such perforation in the event that it occurred.

23. The colonoscopy decompression was temporary procedure to help improve the patient for further surgery if required.

24. Surgery was performed on 2 August 2004 and P22 was found to have a huge twisted bowel that required removal. There was also faecal contamination during the procedure. This means that a perforation had occurred during the surgery. With a bowel dilated to this extent, the perforation would have occurred in any event. He also had a diverting ileostomy at the time. This means that a colostomy bag for drainage was performed. Dr Patel carried out this surgery and I assisted.

25. After the surgery P22 was transferred to ICU for monitoring and care.

26. P22 subsequently deteriorated and died on 18 August 2004, 16 days after the surgery.

27. I recall that Dr Sanjeeva Kariyawasam, Registrar, completed the death certificate for P22. He was Dr Patel's Registrar at the time. I was on call that day and that

was why I assisted with the surgery. The death certificate states the cause of death as "malnutrition and general deconditioning following emergency bowel surgery". It is often the case that the consultant and the registrar consult on the case of death. I was not involved in any discussions relating to the cause of death that was entered on the death certificate in relation to P22. It could be the case that Dr Kariyawasam completed the death certificate without any discussion or input from Dr Patel. I cannot say for sure as I did not complete nor was I involved in the completion of the death certificate.

28. I can say that it would be quiet consistent for someone who has survived bowel surgery for two weeks and after suffering a two week prolonged illness to die due to malnutrition and poor absorption and failure to thrive.

29. I did not attend upon this patient after the surgery.

P99

30. I have reviewed the chart for this patient.

31. P99 was a difficult case having had several operations on her abdomen for multiple gynaecological procedures. She had ongoing pain the cause of which was difficult to delineate. She had been investigated for the persistent pain around the site of the operation. After explaining to her that it would be difficult to find a definite cause, P99 decided to undergo exploration of the area to find any cause of the pain, in particular if there was a small hernia.

32. There was a reluctance by Dr Patel and myself to undertake the exploratory surgery the patient having had previous surgery. We proceeded as a result of the persistence by the patient even though it had been explained to that we would not likely find a cause of her pain.

33. This procedure was performed on 15 March 2004 by Dr Patel. I assisted and did part of the operation under his supervision. It was found that she had scaring but

no existence of any hernia. Following this, she developed a wound break down and required regular visits to the outpatient clinic for wound care.

34. Her last visit to outpatients was on 21 April and her wound had improved and she was to continue dressings at home and to return if there were any problems. I note she had poor pain tolerance and required more than usual pain killers for wound care management

35. I had no further involvement with this patient.

Signed at **Brisbane** on 17 June 2005.

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Dr James Peter Boyd
Principal House Officer/Surgery
Princes Alexandra Hospital