283

BUNDABERG HOSPITAL *COMMISSION OF INQUIRY*

STATEMENT OF DR PETER WOODRUFF

Peter William Harold Woodruff makes oath and states as follows:

Background

1. I am the Director of Vascular Surgery at the Princess Alexandra Hospital, Brisbane. I have held that position since 2004. Prior to my employment there, I practiced as a vascular surgeon. I commenced practice in 1974. From 1977 – 2003 (and while continuing my private practice), I was Visiting Medical Officer in Vascular Surgery at the Princess Alexandra Hospital.

2. I hold the qualifications of Bachelor of Medicine and Bachelor of Surgery (University of Adelaide) and a Masters of Surgery (Aberdeen University, Scotland). I have specialty qualifications in general surgery and vascular surgery.

3. I am registered in Queensland as a specialist in vascular surgery and general surgery. I am a Fellow of the Royal Australasian College of Surgeons, the Royal College of Surgeons of Edinburgh and a Fellow of the American College of Surgeons.

4. I was a member of the Council of the Royal Australasian College of Surgeons from 1997 – 2005. I served on the Executive of the Council for 5 years as Honorary Treasurer and Vice President.

5. I hold the position of President Elect of the Australian and New Zealand Society of Vascular Surgeons. I was the President of the Australian Association of Surgeons from 1997 to 1998.

6. I am a member of the Board of the Australian Council on Health Care Standards. The Council is the principal accrediting authority for health institutions in Australia. I have been a Board member for approximately 4 years.

7. I commenced my medical practice in Adelaide. I worked in Mt Isa for eighteen months, six of which were spent as a locum for the Royal Flying Doctor Service and Dr. Eric Milne, GP Surgeon. I worked in the National Health Service in the United Kingdom for four years between 1968 and 1974, and as a Harvard Surgical Fellow at the Boston City Hospital for eighteen months for some of that time. In 1974, when I returned from the United Kingdom, I took a position as Senior Lecturer in the Department of Surgery at the Royal Brisbane Hospital. I commenced private practice as a vascular surgeon in 1977 in Brisbane. In the course of my private practice I have operated in many private and public hospitals in South East Queensland.

8. I hold the rank of Wing Commander in the Royal Australian Air Force, Specialist Reserve. As a surgeon in the Air Force I have served as the sole surgeon in Bougainville and in Singapore.

9. I have had considerable experience in practicing surgery in isolated areas: in particular in Orkney, Shetland and Bougainville, in each instance as the sole surgeon.

10. Now produced and shown to me marked "PWHW1" is my curriculum vitae.

Review of Clinical Services Bundaberg Base Hospital: Confidential Review Report

11. I am one of the authors of the document entitled *Review of Clinical Services Bundaberg Base Hospital: Confidential Review Report* ("the Report"). My co-authors are Dr Mattiussi, Dr Wakefield and Associate Professor Hobbs. I was primarily responsible for Section 3.2 of the Report Clinical Case Review, which deals with clinical issues concerning Dr Patel's surgery.

12. Our investigations showed that Dr Patel was involved in the care of approximately 1,450 patients. I studied 221 patient files. In accordance with the Terms of Reference for our investigation, those files concerned patients who had died, been transferred to another institution or had an outcome the subject of a complaint.

13. I commenced the review on 18 April 2005. We included all patients in respect of whom complaints were made: to the Patient Liaison Officers; to the audit web site; or by direct mailing together with all patients the subject of incident reports and those brought to our attention during the course of interviews up to and including 30 May 2005. The report was provided on 30 June 2005.

14. My review consisted of an examination of the case chart of each patient. I read the files with the intention of identifying elements which appeared anomalous. This form of review is a sensible starting point for a review of Dr Patel's practices. A patient's medical chart ought properly to record a patient's condition, treatment and progress. A full investigation of the care of a particular patient might also involve, where possible, interviews with relevant members of the health care team and the patients concerned.

15. There may obviously have been patients in respect of whom there was an adverse outcome, but who fell outside the scope of the review.

16. The patient files comprised 47,500 pages. I have read through those. The files in respect of the 221 patients I considered are now held electronically on my computer, and I am able to have recourse to them quickly should the need arise during the course of my evidence. I have recorded notes of my conclusions in respect of my findings for each patient. I have also recorded what I hope to be instructive lists and sub-reports from that data. The patient files, my notes in respect of them, the various sub-lists, reports and other data

are all on my computer. I have downloaded the material from my investigations onto discs. Now produced and shown to me and marked "PWHW2" are discs containing the full results of my investigations and observations. I have extracted a number of lists from the electronic data, and attached them to this statement in hard copy. Now produced and shown to me and marked "PWHW3" are the lists, the contents of which are self explanatory.

17. Since my report, and as I have continued to review the material, my views about two patients have changed. Those patients are P36 and P98. They are reclassified from "Maybe" to "Yes" Two further patients, P2 and P216 have been added to the "Maybe" category. Annexed hereto and marked"PWHW4" is my reviewed opinion in respect of those four patients.

Findings on the Review

18. The report is now a matter of public record.

19. I continued to analyze the available material after providing the report.

20. The details for each patient are contained within the electronic record. The care and circumstances of each patient are, of course, different. There is obviously some difficulty in attempting to provide an overview. However, I think it instructive to make these observations:

    (a) Of the eighty-eight deaths, thirty-four occurred in the peri-operative phase, that is, within one month of surgery. The frequency of peri-operative deaths is an accepted surgical yardstick for measuring surgical outcomes. All peri-operative deaths justify investigation. (Table A)

    (b) Of these thirty-four patients, twenty-three were suffering a terminal condition. The relevance of this is that those patients were more likely

than an otherwise healthy patient to die within one month of the operation (e.g. ruptured abdominal aortic aneurysm, advanced malignancy, or extreme age). (Table B). Of the twenty-three patients suffering a terminal condition, thirteen were considered to be in extremis, that is, close to death. (There was one patient of the thirteen, P200, where Dr Patel possibly contributed to the adverse outcome). (Table B1).

(c) In respect of four of the twenty-three, other doctors were significant contributors to the outcome. (Table B2).

(d) In respect of the remaining six, in my opinion, Dr Patel significantly contributed to the adverse outcome of each of them: P224, P236, Kemps, Nagle, P98 and P215. (Table B3).

(e) Of the thirty-four peri-operative deaths, eleven were not terminal. (Table C). Three of these presented in extremis: P266, P276 and P291 (Table C1). Of the other eight, four died by reason of iatrogenic process by colleagues (Table C2). The remaining four died by reason of an adverse intervention by Dr Patel. (Table C3).

(f) From Table C, perioperative death in patients without terminal pathology, the care of Phillips, P28, P238, P276 and P291 were considered to involve very poor judgment on the part of Dr Patel. In Phillips, for example, the patient was inadequately prepared for an operation that should not have been done in Bundaberg; in P238., previous similar surgery in Brisbane 7 months earlier had almost caused her death, and hence a second similar operation carried extreme risk; in the case of P276 his symptoms were more likely caused by the onset of a heart attack than a significant bleed from the bowel; and in the case of P291 Dr Patel performed a bowel resection in the face of chronic renal failure. I am able to provide further details.

(g) One problem with a death audit such as this, particularly in a senior community, is that the large numbers of people dying of natural causes

has the effect of diluting the observed adverse outcomes of an iatrogenic nature. Of the fifty-four non peri-operative deaths. (Table D). There are forty deaths which are not related to Dr. Patels management or intervention. This group dying incidental to any intervention of Dr Patel has the effect of spuriously halving the statistical rate of his major adverse contributions of those whose demise he significantly contributed to. (Table D1). In eleven of the fifty-four Dr. Patel performed major surgery which was considered not to have had an adverse effect on the outcome (Table D2). In the remaining three Dr. Patels involvement contributed to an adverse outcome. (TableD3).

(h) In forty-eight patients Dr. Patel contributed to, or may have contributed to an adverse outcome. (Table E).

(i) The breakdown or distribution of patients with adverse outcomes is shown in (Table F).

(j) There are thirty-one surviving patients where Dr. Patel contributed to, or may have contributed to an adverse outcome. (Table G).

(k) Twenty-three of these patients suffered major technical complications; seven major wound dehiscence, twelve infection/haematomata and five leaking anastomoses, a very high incidence indeed.

More general observations on Dr Patel

21. It will be apparent from the above that Dr Patel fell short of a reasonable standard of care for his patients on a number of occasions. This took the form of operations inexpertly carried out and misjudgments as to the correct operation to perform, decisions to perform operations which were either unnecessary or on occasions destined to fail; and operating on the outskirts of or outside his expertise.

22. The Royal Australasian College of Surgeons identifies the following attributes for surgical competence:

(a) Medical expertise;

(b) Technical expertise;

(c) Judgment;

(d) Communication;

(e) Collaboration;

(f) Management and leadership;

(g) Health advocacy;

(h) Scholar and teacher;

(i) Professionalism.

(j)

23. In my opinion, Dr Patel was lacking a number of important characteristics. As will be apparent from my comments above, I believe he lacked judgment. He also lacked attributes relating to collaboration, management and leadership. On occasions he did not work well with other staff. Further, it is clear from the medical records that he did not always have the support of the nurses.

24. The impression I gained from perusing the records was that Dr Patel was very industrious, had reasonable medical knowledge, and was quick in surgery. I believe that he overstated what he knew. I suspect he was a fast learner. He tended to conduct operations himself rather than to seek or defer to other, perhaps more expert views. A pattern emerges of a reluctance to transfer patients when he should have done so.

25. I have been asked whether I consider that Dr Patel wrote medical records that were inaccurate. On the whole, my answer is "no". However, there were certainly entries in the records where they were patently non-sensical. The patient would be receiving adrenalin, for instance, and Dr Patel would be describing the patient as "haemodynamically stable". That does not make any

sense, but I suspect it is really illustrative of a pattern where Dr Patel reported optimistically on the status and progress of his patients. There are other anomalies (such as in the case of P236 where Dr Patel seems to have added to the Generic Consent Form) but I don't think that much can be extrapolated from that point.

26. On occasions Dr. Patel recorded a mishap that other surgeons might not have bothered to record. That tends to support his honesty in the context of his note keeping.

Issues arising from the Bundaberg Hospital events and recommendations

27. This inquiry has brought to the notice of the public events which not only reveal a series of misjudgments and incompetencies on the part of Dr. Patel, but also deep seated and endemic problems within the health care system. The level of public debate which the inquiry has generated presents our community with a unique opportunity to discuss and determine the future direction of our health care system.

28. Health care is becoming increasingly expensive for our community. This is the product of a number of factors. First, our community is aging. It is a fact that of the total health care expense that the average one of us generates during a lifetime, by far the most of it is spent as we approach and live through old age. As we get older, the cost of keeping us in an acceptable state, indeed alive, gets more and more. Secondly, our expectations of health care, and the health care system, are higher than they were before. This is reflected in increased litigation against hospitals and health carers. I make no judgment about that. However, the community must recognize that there is a real and significant cost in, for example, conducting an MRI on a patient to rule out the prospect of a 1 in 100 chance of a tumour. Thirdly, our advances in medical

science are often very expensive to implement. New and more expensive equipment and medicines are being administered to more and more people, often in the later stages of their lives.

29. The health system can always do with more money. There are a number of areas within the system where the quality of services and outcomes would be improved with better resources. Any debate must proceed from that premise. The issue for the public is how much it wishes our governments to spend on what standard of service. The biggest danger is to deny that there is a direct link between the amount the community pays for its system and the outcomes which the system provides. There needs to be open disclosure of the current outcomes so that the public can be involved in an informed debate.

30. On the other hand, and rightly, our governments are mindful of the level of taxes and the need to keep the health care system costs under control. Hospital administrators in particular are under pressure to keep costs to budgets. Pressure on funding is manifested in many ways: ward bed closures; restriction of intensive care bed numbers; and delays in obtaining outpatient appointments. The primary dysfunction and irony in the public system is that the less productive the hospital, the less expensive it is. Our community needs to understand that if it wishes to keep an A grade public health care system, it must permit its governments to spend the necessary funds to do so. There is no doubt too that the community's interests would be best served by a system which has single point responsibility and accountability, to prevent buck passing between different levels of government.

31. The events at Bundaberg bring into focus important issues concerning the provision of regional and remote health care. I will set out those issues, and my thoughts on how they might be addressed.

32. First, there has been a steady progression in the medical profession towards super specialization in both training and practice. This undoubtedly has led to an increased proficiency in those areas: better success rates, lower complication rates. However, this level of specialty is unsustainable in regional and remote areas. Consequently, it ought to be recognized that as matters presently stand a large range of operations are better performed in major centres.

Assuming a demand for the performance of surgical procedures in regional areas, there are two ways of lessening the problem identified.

The first is to develop a capacity within the system to cope with the urgent challenges presented in regional practice. This might be termed "hub and spoking". The regional doctor would be part of a team, which has wider expertise, and which is associated with one of the major hospitals. The doctor would be part of regular reviews and continuing professional development. The team would be responsible to relieve him when necessary, and when the doctor is confronted with a challenge he has immediate access to colleagues whom he knows and with whom he is familiar. This is the sort of network available to doctors in major hospitals. Modern technologies permit very effective communication of medical situations and solutions. For example, when I was practicing in Bougainville during the recent unrest there, I was based in a large tent. However, with access by satellite telephone to a wide range of specialist colleagues, I was able to be assisted in diagnosing and being guided through the management of a wide range of circumstances beyond my immediate area of expertise. Computer technology now could put a Brisbane specialist, for example, in the regional operating room.

In all of the pages of medical files that I read, there was not one letter written by Dr. Patel to any other medical practitioner. The average surgeon writes

letters all the time, writing reports on what he has done, or referring the patient to another specialist or hospital. This shows that Dr. Patel was poorly integrated into the surgical system in south-east Queensland. The prospect of this happening elsewhere is exacerbated by these remote positions being filled by overseas doctors with no connection, formal or informal, with the wider surgical system and community.

The second way to attack the problem is the development of a further specialty focused on emergency surgery over a wide range of circumstances. There is currently a specialty of Emergency Medicine practicing in accident and emergency teams, and retrieval teams, but that does not extend to surgery. A logical extension of the concept is a surgical specialty of training in a broad range of emergent circumstances. Such a specialist would be attached to as many regional hospitals as demand required. His primary task would be emergency surgery, with minimal responsibility for elective surgery.

33. Secondly, there was no effective audit of surgical outcomes. One of the striking features of the events at Bundaberg is the absence of documentation of the occurrences, and the fact that it went unaddressed for so long. There was no documented evidence of (for example) an effective morbidity and mortality meeting on a regular basis; no mortality audit; and no peer review. Such meetings ought to be conducted by all units within the hospital. Hence, in any given month, there might be a meeting of the vascular unit, a meeting of the intensive care unit, and so on. An effective system for surgical audit would include regular meetings of the whole health care team in each unit (doctors, nursing staff, and a senior administrator). Further, the Director of Medical Services or a clinician of similar rank should keep a list of all deaths in the hospital and should attend each morbidity and mortality meeting, that is, all of the meetings of all of the units. The Director is responsible for ensuring that all deaths in the hospital have been reviewed by the units. Where the

death involves a number of different units, the discussion concerning the deaths should happen at a joint meeting. In my view, the morbidity and mortality meetings should also be attended by a senior doctor from outside the unit. It need not be somebody from the hospital. It is preferable that it be a specialist from other than the specialty concerned: this encourages openness, and discourages the perpetration of rationalizations, "patient blaming" and heresies within specialties. Three characteristics of the meetings are particularly important: they must be "quarantined", that is, no other business should intrude upon the meetings; all the staff in the unit must participate; and the environment must be open and non-blaming, so that people can be free to speak candidly, ask questions and suggest other approaches to people presenting their cases. There is a legal issue as to protection of the contents of these discussions. Ideally, and from the perspective of the public interest, the contents of these meetings would not be available in legal proceedings. All the case notes presented at the meetings should be scanned onto a software package so that, if necessary, events can be addressed by searching the data. Contemporary recording of data and discussion is very advantageous: there are obvious difficulties in reconstructing data and events years after they have happened.

34. Thirdly, it is plain from an examination of the Bundaberg patient's files that communications between members of the clinical team frequently broke down. Written instructions have on occasions been repeated with increasing assertiveness because they have not been complied with. In an optimal situation, treatment regimes would be reached between senior nursing staff and the surgeon in a consultative way. On occasions that did not occur here. The importance of a team approach to the care of patients cannot be overstated.

When a ward round is carried out, it is best practice that the surgeon be accompanied by the ward sister, the physician and by the physiotherapist. That has the primary benefit of making sure that no information is lost between the various disciplines. It also ensures that the various people involved see themselves as participating in the care, rather than just following directions.

35. Fourthly, notwithstanding complaints about Dr. Patel, there were no effective procedures, or none implemented, quickly to deal with them. In my view, when concerns are raised about a particular doctor, the first response should be that an appropriate, very senior clinician carry out a review of the complaint. Effective audit procedures and recording of results of meetings means the clinician will have a data base to which to refer. The primary focus of the process is to identify the problem and to check and train the doctor. It would also involve, as would most often be the case, ensuring the doctor meets appropriate basic "fitness for purpose" testing. It would be something like the "line check" that is conducted for commercial pilots. The senior doctor would spend say a week with the practitioner, would interview other staff and would give the practitioner a score out of 5 over a range of topics. If there are scores below 3 on any topics, then the senior doctor would direct some remedial programme. The remedial programme might include attendance at the Skills Laboratory. Queensland Health has recently developed a very good facility on the campus of the Royal Brisbane Hospital. There, a doctor can simulate an operation, learn new technologies, and practice high risk procedures in no risk circumstances.

On some occasions preliminary review would suggest a serious problem. In those circumstances, it would be necessary to conduct a full review of all case notes. In the case of surgeons, reviewers would be particularly alert to three triggers: massive transfusions, peri-operative death, and unscheduled returns

to theatre. With the data available, it would be a relatively easy matter to ask appropriate questions to see if there is a basis for concern.

36. Fifthly, and in any event, surgeons and perhaps other doctors should be assessed periodically. The review should be carried out by a senior clinician or clinicians. Their status within the profession is important: it would be counter productive if it might be suggested the reviewers were competitors of the doctor being reviewed. The assessment could have three outcomes: there is no problem; there is a problem which can be addressed by further training; or the matter should be referred to the medical Board.

37. Sixthly, for Dr. Patel there was no system of continuing professional development. Current requirements for professional development are insufficient. The right to practice as a surgeon needs to be revalidated, or reaffirmed. The system for continuing professional development should include a check of clinical outcomes and reaffirmation of fitness for task. Surgeons should be required to demonstrate their competence at the Skills Laboratory, or like practical circumstances, from time to time. This, I know, will not be a popular idea amongst the profession, but in my view it is necessary. Pilots, for example, are regularly reviewed, and their competence regularly checked. The medical profession now has the capacity to do the same.

38. Seventhly, there is an issue which needs to be addressed concerning the standard of medical services which the community desires, and it's cost. Much has already been said of the modern focus of middle management on cost rather than the immediate interests of patients. This focus is not only deleterious to patient outcomes, but demoralizes clinicians, both nurses and doctors, and contributes to workforce shortages particularly in regional and remote areas. The strong emphasis on elective surgery targets, which is discussed within the Report, is an example of the current focus. There is

frustration amongst doctors that Queensland Health measures performance by financial indicators instead of patient outcomes.

39. Eighthly, our dependence on overseas doctors for regional and remote positions, indeed in the major cities, needs to be recognized and addressed. The fact is that Queensland's dependence on overseas doctors in Brisbane, in other cities and in remote and regional Queensland will get worse before it gets better. There are presently more than 1500 overseas doctors who have not yet been assessed by the Australian Medical Council employed in the public health system in Queensland. The demand for doctors caused by our quickly increasing population cannot be matched by the numbers of doctors presently graduating from our Universities and training programmes. Even the provision of more places at our universities will not provide more new young doctors before 2010, and new specialists before 2015. This predicament is the result of funding decisions for universities made in the 1980's. I commend the current rapid expansion of the medical schools. However, two further steps must be taken. First, the position of Visiting Medical Officer in public hospitals, that is, the engagement which allows a private practitioner to operate in the public system, must be made more attractive. In essence, that requires a change from corporate governance to clinical governance: if the doctor says the patient needs an operation, then permit the operation to take place, support the doctor and provide the resources to do it. The productivity for these doctors is noticeably higher in the private system than in the public system, and the drag can only be attributable to constraints imposed by budgets and bureaucratic intervention. Secondly, the number of specialist surgical training posts need to be increased, so that all doctors who have now completed their basic surgical training can progress to complete their advanced or specialist surgical training. There is presently a bottleneck in the production of specialist surgeons. The completion of the training of doctors with basic training depends upon the availability of operating theatres and of

supervisory surgeons. Hence, more Visiting Medical Officers need to be appointed to supervise the trainees, and more operating theatres need to be opened to permit the operations and training to take place.

I might add that the availability of Australian doctors to take positions in regional and remote areas is reduced by the fact that to do so runs counter to their prospects of obtaining positions in surgical training programmes. This problem would be solved to the benefit of Queensland if, when selecting surgical trainees through the national selection process, greater weight was placed upon surgical experience and outcomes. Many doctors while awaiting places on surgical training programmes write research papers, and greater importance is placed on such papers in the selection process than upon surgical experience in (for example) Bundaberg, Gympie or Charters Towers. It would be helpful were this changed. Further, doctors cannot become specialist surgeons nowadays until their late 30's. They have to do two degrees, and then their surgical training. Even then, it may be some years before they are ready to take on their own cases. By that time, they have families and HECS debts, and they are not nearly as ready to work in the public health system, particularly in regional and remote areas.

40. 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 knowledge and sources of information appear on the face of this my affidavit.

Dated 15 August 2005

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Deponent Solicitor/~~Justice of the Peace~~

Signed..... Taken by:.....

Deponent Solicitor/Justice of the Peace