Dr Jayant Patel – Director of Surgery

Incidents during tenure

Chair of TMG

Soon after arrival DM insisted that Dr Patel take up position as Chair of TMG/Accountable Officer ES. Thereafter Dr Patel took up such role and charged by DM to implement the recommendations from OT Reviews.

ICU

Strong wish to manage surgical patients in ICU including use of Surg PHO after-hours for surgical patients. Conducts ward rounds at 0730 (or earlier) and has offered to do such with anaesthetic/ICU staff. There is limited team work input to care of such patients.

Oesophagectomies

1st patient - poor patient selection – CRF/Dialysis, combined with concerns about interpretation of physiological data at end of operation vs what was told to family. After discussion with NUM ICU and DONS, NUM ICU was to arrange meeting with Dr Patel to discuss his voiced concerns with level of care in ICU and her concerns about his management options in ICU.

2nd patient – prolonged stay in ICU (on and off ventilator) with complications. Refused to transfer patient to Brisbane on basis of supposedly getting better, min workload and wish to continue care after surgery. Dr Joiner made appointment on 17 Jun 03 to express concerns about this operation being done here, partly at behest of nursing staff. His concerns related to major operation being performed with high risk of complications for which adequate level of backup was unavailable. He was also concerned about reluctance of Dr Patel to transfer patient to Brisbane. Dr Younis was asked to assess patient with agreement that patient remain for 24-48 hrs unless deteriorates or ICU becomes over full. Finally transferred to Mater Private. Dir of ICU Mater Private rang to express concern about such an operation being done at BBH without adequate backup.

Discussions held at that time (17 Jun 03) with Dr Patel about capability and capacity of ICU. Explained that Level 1 ICU that operated at Level 2 for short periods of time. Ventilation only for 48-72hrs unless reasonable chance of coming off ventilator. He acknowledged such but also pointed out that all such cases had been elective bookings, discussed with Dir of Anaesthetics & ICU, who had agreed that such operations could be done at BBH. He also identified that elective repair of patients with AAA were performed regularly at BBH.

4th patient – died post-operatively due to major bleed from aorta - ? cause of bleed. Discussion with Dr Patel led to assurance that no further oesophagectomies would be performed at BBH. Drs Carter and Berens expressed concern about this case in that it was an unexpected outcome of the operation and should have been reported to the Coroner. Their concerns were raised some 36-48 hours after the event (on day of patient's funeral). Assurance provided that no further cases will be done.

F/U
UR 034546 – Operation 19/5/03, Died 21/5/03
UR 130224 – Operation 6/6/03, Died 8/1/04
UR 009028 – Operation 1/12/03, Alive as at 1/9/04

Informal Report of Sexual Harassment

Report from ICU nursing staff member via HRM. Dr Patel denied such actions and explained that he was offering advice to staff member about places of interest in NY, where she was intending to travel. He had offered to share a meal with nurse and passed on his phone number to arrange such. There was no further contact made. Dr Patel was concerned about such allegations and noted that his religion, upbringing and past experience made him very aware of the appropriate standard of behaviour in the workplace.

Counselling and copy of relevant policy provided.

Complaint from Dr Dawid Smalberger – Jul 03

Dr Smalberger bought to my notice an incident in ICU when Dr Patel had publicly reprimanded him over his management of a patient with multiple comorbidities (medical and surgical). He had shouted and complained loudly in front of staff, patients and relatives and was unwilling to go elsewhere to discuss concerns. He felt belittled and humiliated and was requesting advice on a course of action.

I suggested that in first instance he approach Dr Patel to request he discuss the matter of care of the patient and to make Dr Patel aware of his concerns about how he had been treated. Should this be unsuccessful, I was willing to arrange a meeting between the two SMOs to discuss the matter. Finally Dr Smalberger could write an official letter of complaint to me which would require investigation and reply. Dr Smalberger accepted this information and no further action resulted.

Complaints from PHOs – Drs Kate Gray & Nadine Low

At the end of their term at BBH, they stated they were very unhappy with how Dr Patel treated them. They believed they weren't treated with respect appropriate to level of experience and present appointment (as Surg PHOs). They believed that Dr Patel micromanaged their actions in relation to care of patients and didn't allow them to use initiative.

This complaint was made following Dr Patel bringing to notice a number of occasions where routine and/or simple treatment principles/step for patients hadn't been done by these PHOs, as would be expected at such a level of seniority. These instances had occurred despite feedback about expectations. Dr Gray had received regular informal and formal feedback about her overall performance during the term, particularly in relation to attention to detail, attendance and availability.

The PHOs were counselled about complaints and I stated that I supported Dr Patel in this instance as he was the responsible treating clinician and their appointed supervisor plus there were specific cases which showed a lack of attention to detail, which potentially affected patient outcomes.

Thereafter most other PHOs and JHOs have enjoyed working in Surgery. Dr Patel outlines his expectations to residents at the start of term. He will provide feedback and constructive criticism to resident staff, which some staff don't enjoy.

Renal Unit

Concerns were raised about Dr Patel's personal infection control measures in relation to the insertion and/or manipulation of central venous lines in patients requiring emergency access for dialysis. Both ICN and NUM Renal Unit spoke to me about concerns (i.e wires inserted without use of gloves and/or no change of gloves between patients). I discussed these concerns with Dr Patel, who denied such and took some personal affront at such suggestions. Thereafter he stopped all involvement with the Renal Unit.

Thereafter some poor quality data was provided by Dr Miach (Director of Medicine) in support of his concerns about Dr Patel's surgical expertise in the insertion of Tenckhoff catheters and emergency vascular access for dialysis.

A copy of a letter from Dr Jenkins (Vasc Surgeon RBWH) regarding the management of Ms Daisy's leg amputation was received 8 Nov 04. This patient's follow-up in Surg OPD wasn't successfully coordinated between the Medical and Surgical teams (due to a major difference of opinion between Drs Miach and Patel about who was the managing clinician of this patient).

Dehiscience Rate

Initial concern raised by ICN. She investigated cases, discussed with Dr Patel and produced report. (See attached). Four cases related to technique primarily related to PHOs closing. Dr Patel was aware of such and agreed to supervise PHOs.

Further concern raised at ASPIC about possible increased rate of wound dehiscience in surgical patients. Audit conducted by Dr Patel and Kaye Ferrar of DQDSU (while Iwas away on leave). Rate less than previous year, although total numbers increased. Report attached.

Wound Infection Rate

As a follow-on to above, indirect reports were received about concern over wound infection rates. Using readmission date (within 28 days of original discharge) since 1999, there has been increase in surgical patient readmission rate since Jul -Dec 02 period, with majority of cases due to wound infection. See attached report. In last ½ of 03, Dr Patel had 46.4% of unplanned surgical readmissions, while in first ½ of 04 he had 39% of unplanned surgical readmissions. In the latter period, Dr Gaffield had a higher percentage of unplanned surgical readmissions.

Bramich Incident

Concerns related to delay in transfer, management of patient in ICU, interpersonal behaviour and comments/actions made to relatives.

Review of chart, records and statements from treating clinicians plus external specialist advice suggested that patient died from hypotension secondary to severe haemorrhage into thorax secondary to multiple intercostal artery damage (see PM results). Alternative management was available which may have made transfer possible, although potentially patient would have died despite such attempts. Result of case review not released due to receipt of letter of complaint and decision to seek external review. Coroner's case – has requested statements from all staff involved in management.

Interpersonal behaviour – relates to shouting, screaming and possible abuse of staff with apparent disregard for patient dignity (despite patient being very unwell). Copy of complaint provided to Dr Patel. He denies such behaviour and wished to deal with clinical management issues, for which he provided a written reply. Mediation was to be arranged, however formal complaint received from NUM ICU about Dr Patel.

DM and DMS undertook initial inquiries via interviews with Drs Berens, Strahan and Risson, after being named by NUM ICU in her complaint. (See separate notes). It was agreed that DMS seek advice from EDMS TGH about suitable nomination for external review of management in this situation. He suggested Dr Sam Baker or Dr Hamish Foster with possible advice from Audit Branch re: whistleblower status. DM decided Dr Baker inappropriate due to past employment at BBH. DMS suggested DM seek advice from Dr Mattiussi, DM Logan HSD about suitable alternative. Dr Alex Mahony from Redcliffe-Caboolture HSD nominated. DM to follow up arrangements. After further consideration and discussion with Dr John Scott, matter was referred to Dr Gerry Fitzgerald.

Thoracic cases

One operation performed on a patient with haemothorax post MVA. Patient had spent prolonged period in ICU (not under care of Dr Patel ?) and was failing to recover. Thoracotomy to remove blood in thorax performed with successful outcome for patient.

The second case was a wedge dissection of a lung nodule, where the patient didn't require any care in ICU. Nodule was non-malignant.

P26 Case

Concern raised by CCC & PRS about delay in transfer of this patient with consequential complications. See attached report prepared for ZM CZ. See attached report.

Patient received life saving and potentially limb saving surgery at BBH and should have been transferred when stable. New policy to reflect such change.

Tilt Train Disaster

Dr Patel was the surgeon on-call during the Tilt Train disaster. His performance during this period was outstanding. He arrived early, took charge and showed consistent, strong leadership throughout the management of all patients who presented to DEM. He ensured that teams and responsibilities were allocated, extra stores ordered and extra medical staff called in as required. His skills in triage were excellent and ensured that all patients were rapidly assessed and moved through DEM for further review and imaging assessment.

He was calm, realistic and able to direct a multitude of activities during a very busy time period. Dr Patel set an excellent role model for junior medical staff in DEM and on the wards during this stressful period. Thereafter he continued his normal workload, making arrangements for cover that night. His assessments were very accurate with the majority of patients discharged within his suggested timeframe.

Dr Patel received a BHSD Outstanding Achievement Award for his efforts at this time.

Consistent concerns

At times, Dr Patel overextends himself performing a limited number of certain major sub-speciality operations – oesophagectomies, thoracic cases and emergency vascular cases, when appropriate level of intensive clinical support isn't available for prolonged periods.
Dr Patel delays transfer of seriously ill patients to Brisbane.
Dr Patel's manner is perceived by many staff at all levels as very arrogant, abrasive, rude and potentially abusive.
Dr Patel has multiple responsibilities – clinical, administrative, educational and supervisory with resultant potential for fatigue and errors in judgement.
Throughout this period, Dr Patel has consistently covered while Dr Gaffield has been on leave, despite offers of locums for these periods.

Summary

Dr Patel is a very knowledgeable surgeon with many years experience of general surgery who was probably very good to excellent technically in his career in USA. He is now good to very good surgeon technically, who has not maintained currency in some major thoracic and abdominal procedures or all aspects of care of critically ill patients. This situation has been exacerbated by a lack of professionalism amongst staff in supporting Dr Patel in the care of critically ill patients. He has a very positive attitude to work, which combined with cumulative work stress and fatigue plus multiple responsibilities contribute to a specialist surgeon who has more potential to make errors of judgement in clinical care, particularly in relation to seriously ill patients.

These situations combined with interpersonal behaviour as noted by many staff leads to a situation where Dr Patel is unpopular and potentially without the support of many clinical staff, possibly affecting patient outcomes. I am uncertain that Dr Patel will be able or would be willing to change and/or modify his behaviour to reduce the associated tension that has developed over the period of his employment at BBH. Nevertheless I find the lack of professionalism (particularly bringing forward concerns at very late notice or when the specialist is on leave) and overt emotion displayed by many senior staff as regards Dr Patel very concerning. I believe there is a large number of staff actively undermining the continuing efforts of Dr Patel to provide a general surgical service to the people of Bundaberg.

As per conversation with DM of 4 Jan 05, I informed him of these thoughts about Dr Patel. I suggested the best option was to recruit a new Director of Surgery ASAP. In the interim, further boundaries in relation to Dr Patel's surgical practice will be developed, locums will be sourced for leave greater than one week and Dr Gaffield's leave be closely scrutinised.

Reinforced above advice to DM on 10 Jan 05, further expanding on my views. Suggested to DM that he take more proactive approach in dealing with complaints from NUM ICU and nursing staff from OT in order to engender staff confidence in process. He will consider.

Larger Issues

Lack of RACS representative for C&P Committee despite repeated requests to RACS.
Lack of peer review/ M&M meetings by surgeons/all clinicians at BBH.
Limited time to audit and review cases due to multiple administrative responsibilities of DMS.

Limited development of patient safety culture, policy, processes (inc RCA) due to lack of resources – personnel, time, training.

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Require 3rd staff surgeon position – internal relief/weekday AH roster/share RCS load.

Require dedicated Complaints Officer.

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