Submissions

Dr Stephen BUCKLAND

MinterEllison
LAWYERS

26 October 2005

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Attention: **Jarrod Cowley-Grimmond**

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Level 9
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Dear Sirs

Dr Buckland

Pursuant to the direction of Commissioner Davies, we **enclose** the submissions of Dr Buckland.

Yours faithfully
MINTER ELLISON

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enclosure

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS OF DR STEPHEN BUCKLAND

Introduction

1. These submissions concentrate on topics that were the subject of cross-examination of Dr Buckland. They will not repeat at length the evidence of Dr Buckland. For the purpose of these submissions, he relies by way of background on his witness statements, particularly his second statement,[1] which address the role of Director-General[2] ("DG"), the independent role of the Chief Health Officer ("CHO"), the structure of Queensland Health ("QH") and a number of systemic issues[3] which are relevant to the Commission's deliberations.

2. These submissions follow the same order as cross-examination topics. Finally, they shall briefly address the issue of budgets that the Commissioner raised on 17 October 2005.[4]

Dr Buckland's actions in response to Dr Patel and the Bundaberg Base Hospital

3. Dr Buckland acted reasonably in not suspending Dr Patel from duty, suspending him from providing surgical services or otherwise restricting his scope of practice on or after 24 March 2005 for three essential reasons:

   (a) He had received advice from the CHO on 22 March 2005 and again on 24 March 2005 that there was no evidence that Dr Patel's general surgical skills were inappropriate or incompetent and that there was insufficient evidence to take any action against Dr Patel;[5]

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1 Exhibit 336.

2 In particular, reference is made to paragraphs 34 to 45 of Exhibit 336 where Dr Buckland sets out the role of the DG is to *inter alia* deal with strategic issues whilst others were responsible for making decisions within hospitals and within zones. Also the DG was required to deal with large volumes of documents and a large number of issues on a daily basis.

3 Including under-funding of the public health system in a decentralised state (paras 60-100), the demands placed on the public hospital system (paras 165-176), medical workforce shortages (paras 101-105), the adverse consequences of a focus on fiscal management (para 35 and SMB15) and the entrenched economic philosophy that QH was "purchasing" services from hospitals, being a philosophy which focused on throughput and revenue rather than outcomes for the patient and the community (paras 48 and 303).

4 T.7098 ll.30-40.

5 Exhibit 391, page 2. This exhibit is a briefing by the CHO to the Minister dated 22 March 2005 and reflects the oral briefing received by Dr Buckland on that day and subsequently on 24 March 2005.

(b) The content of the CHO's audit report and the memorandum received by Dr Buckland on 24 March 2005, when read in conjunction with the oral briefings or even without them, did not provide sufficient evidence to warrant such action being taken by Dr Buckland; and

(c) By the evening of 24 March 2005, Dr Buckland was aware that Dr Patel was taking sick leave until 31 March 2005 and had indicated he would be resigning.[6]

Oral advice

4. Dr Buckland was first informed about Dr Patel and the fact that the CHO had been undertaking an investigation into general surgery services at the Bundaberg Base Hospital ("BBH") on 22 March 2005.[7]

5. Dr Buckland received an oral briefing from the CHO that day.[8] The CHO briefed the Minister in writing[9] and orally the same day.[10] The CHO acknowledges that the substance of his oral briefings to Dr Buckland and Mr Nuttall on 22 March 2005, and his subsequent oral briefing to Dr Buckland on 24 March 2005, were to the same effect.[11]

6. Dr FitzGerald was of the view at the time that there was "no evidence that [Dr Patel's] general surgical skills are inappropriate or incompetent".[12] In fact he reported comments that the "Director of Surgery has high standards and this has led to some degree of conflict with staff".[13]

7. The CHO did not advise that Dr Patel should be suspended, or, indeed, that there was sufficient evidence at the time to take any particular action against him.[14] Indeed, Dr FitzGerald advised that there was insufficient evidence to take any particular

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6 Exhibit 335, SMB4.
7 Exhibit 335 para 17.
8 Ibid para 20.
9 Exhibit 391.
10 Exhibit 225 para 78; T.6134.
11 T.6134.
12 Exhibit 391 page 2.
13 Exhibit 230 page 11.
14 This is stated in terms in dot point 4 on page 2 of Exhibit 391.

action against him.[15] Dr FitzGerald confirmed in his oral evidence that he did not advise Dr Buckland to suspend Dr Patel or to take any action against him.[16]

8. The CHO maintained this view and reiterated this advice to Dr Buckland at his subsequent oral briefing on the afternoon of 24 March 2005 when the CHO handed Dr Buckland his audit report and memorandum dated 24 March 2005.[17]

9. The oral briefings by the CHO on 22 and 24 March 2005, which were the obvious occasions for the CHO to recommend any immediate action with respect to Dr Patel, did not alert the then Minister or the then Director-General to matters which warranted any particular action being taken against Dr Patel, let alone that he be suspended forthwith. As a result of the CHO's briefings, Dr Buckland:

   (a) was not informed, and had no sense, that there was a major issue with Dr Patel's competence in undertaking general surgery;[18]

   (b) was satisfied that the matter was being adequately dealt with by referral to the MBQ based upon the information that the CHO had conveyed to him at that time;[19]

   (c) was satisfied that appropriate measures had been introduced to limit the scope of surgery being undertaken by Dr Patel;

   (d) anticipated that action would be taken to address the failure of systems noted in the last paragraph of the Memorandum of 24 March 2005.

Clinical Audit Report and Memorandum of 24 March 2005

10. Dr Buckland acted reasonably in not immediately suspending or taking other action against Dr Patel on the basis of the matters raised in the CHO's clinical audit report or memorandum of 24 March 2005.

11. The report highlighted two main concerns raised by staff, namely:[20]

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15 Exhibit 391 page 2.
16 T.6138.
17 T.6138 and T.6143.
18 Exhibit 335 paras 22 and 24. Page 11 of the Confidential Audit Report (Exhibit 230) also contained the assurance that Dr Patel had agreed to undertake only those procedures which were within the scope of the surgical service and relevant support service and had also agreed to transfer patients more readily to higher level facilities.
19 Exhibit 335 para 24.
20 Exhibit 230 page 11.

(a) General surgical procedures which had been undertaken outside the scope of BBH; and

(b) Lack of good working relationships between all staff in the general surgical service.

12. As previously noted, although the report indicated that Dr Patel had undertaken surgery beyond the capacity of the BBH and possibly his own skill and experience and had delayed the transfer of patients to tertiary hospitals, the CHO's report advised that these matters had been addressed.[21]

13. The CHO's report referred to rates of wound infection and wound dehiscence. Appendix 1 to the report in fact showed a wound infection rate of 2.7 at BBH compared to the peer group rate of 2.9. The CHO's view at the time in relation to rates of wound dehiscence was that the data showed that this rate was reducing.[22]

14. The Clinical Audit Report reported statistics about the rates of bile duct injury during laparoscopic cholecystectomy.[23] It was reasonable for Dr Buckland not to take action against Dr Patel on the basis of the bile duct injury statistics contained in the report on the basis of the following:

(a) the CHO's Report, his Memorandum and oral briefings did not highlight matters of particular concern in relation to bile duct injury;

(b) the CHO did not raise any concern about Dr Patel continuing to undertake general surgery after 24 March 2005 or undertaking laparoscopic cholecystectomies;

(c) Dr Buckland depended on the CHO and others to highlight matters of concern warranting suspension or other action;

(d) There could be a number of reasons for the statistical outlier in relation to bile duct injury reported at page 9 of the CHO's report, including patient characteristics and the severity of the conditions being suffered by the patient;[24]

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21 Report page 11 Exhibit 230. The CHO's advice to the Minister was to the same effect: Exhibit 391.

22 Exhibit 391 page 1, third-last dot point on the page.

23 Page 9 of the report. The Memorandum did not specifically refer to these, nor were they raised by the CHO in his oral briefings on 22 and 24 March 2005.

24 Exhibit 492 (Johnston) para 8.

(e) When a statistical outlier is identified, further investigation, for example a review of patient records, needs to be conducted to determine whether the statistical outlier is a cause of concern;[25]

(f) The ACHS indicators are a screening tool to identify clinical areas that may require further detailed review and are not a definitive measure of performance;[26]

(g) Dr Buckland and other persons who understood the appropriate use of ACHS indicators, namely that they identified matters that may require further detailed review, would not reasonably attribute to the statistics on page 9 of the CHO's report the same significance which others might. The evidence is that those statistics did not establish that bile duct injuries were the result of poor surgical practice on Dr Patel's part, despite the statistics' indication of bile duct injury for laparoscopic cholecystectomy procedures being many times the national average.[27] The extent of bile duct injuries, their causes, and any comparison between Dr Patel's performance and the standard to be expected of a surgeon undertaking the procedures that he undertook depended upon an investigation of the facts;

(h) Such an investigation has been undertaken by Dr Woodruff in relation to cases of bile duct injury.[28] His report appears to conclude that Dr Patel only caused one bile duct injury, which Dr Woodruff states was recognized by Dr Patel at the time and was repaired by Dr Patel at the time of injury.

(i) Dr Buckland was entitled to assume that the cases of reported bile duct injury would be investigated by the CHO as part of the audit process;

(j) The statistical outlier in relation to bile duct injury and the CHO's investigation into Dr Patel's clinical skills in connection with laparoscopic cholecystectomy or other procedures were not said by the CHO to be indicative of poor surgical skills or incompetence on the part of Dr Patel: on

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25 Ibid para 7.

26 Ibid paras 9 and 10.

27 The analysis of the tables at page 9 of the CHO's audit report does not necessarily support the proposition that Dr Patel's rate of bile duct injury was 25 times that of his peer group for a period of 18 months. Firstly, the comparison to arrive at the figure of 25 times appears to be a comparison between the June – December 2004 BBH rate with the 2003 ACHS rate, as opposed to a 2004 ACHS rate. Secondly, the figure of 25 times only relates to a comparison of six months of data and not for a period of 18 months.

28 Exhibit 498, in particular the third para of page 2.

the contrary, the CHO maintained that there was insufficient evidence that his surgical skills were inappropriate or incompetent[29];

(k) The statistical outlier in relation to bile duct injury did not, for the reasons noted above, provide a basis for Dr Buckland to independently conclude that Dr Patel had poor surgical skills, and that he should therefore be suspended or restricted from undertaking general surgery.

15. While the memorandum was written more specifically about Dr Patel and was worded more strongly than the clinical audit report, it too did not raise matters that made Dr Buckland's actions unreasonable.

16. The Memorandum of 24 March 2005 referred to a significantly higher surgical complication rate than the peer group rate and referred to Appendix 1 of the Report in that regard. One explanation for the higher complication rate was the reported fact that the Director of Surgery in the past had undertaken types of surgery which, in the CHO's view, were beyond the capability of BBH and possibly beyond Dr Patel's own skills and experience. Although the Clinical Audit Report did not state this in terms as the probable cause of a higher surgical complication rate than the peer group, the CHO's view at the time was that the complications related particularly to the more complex procedures that Dr Patel had previously performed that were beyond the capacity and facilities of BBH.[30] The view that the higher complication rate was due to the fact that Dr Patel in the past had undertaken types of surgery beyond the capability of BBH, and possibly beyond his own skills and experience, was consistent with the report and the CHO's oral briefings, and was supported by the CHO's view that there was no evidence that Dr Patel's surgical skills were inappropriate.

17. That Dr Patel had a significantly higher surgical complication rate than his peer group was a matter of concern, but in itself, was not a sufficient reason to immediately suspend him from duty or to restrict his scope of practice on 24 March 2004. A surgeon may have a higher surgical complication rate than a peer group because of the type of procedures that he or she undertakes. It was also consistent with Dr Patel having previously undertaken types of surgery which, in the CHO's view, were

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29 T.6138, 6143.

30 This is the view expressed by the CHO on 22 March 2005 on the final dot point on page 1 of Exhibit 391.

beyond the capability of BBH and possibly beyond his own skills and experience. The CHO advised that action had been taken to limit the scope of surgery performed by Dr Patel and to ensure that critically ill patients were appropriately referred to higher level hospitals.[31]

18. Although the Memorandum of 24 March 2005 commented in relation to Dr Patel's lack of judgment in undertaking these procedures and also delaying transfer:

(a) the practice of undertaking these procedures and delaying the transfer of patients had been addressed; and

(b) Dr Patel's alleged lack of judgment was to be examined by the MBQ.

In the circumstances, it was understandable, and it is submitted reasonable, for Dr Patel's lack of judgment to be addressed in this manner, rather than for him to be suspended forthwith or action taken to further restrict his scope of practice. Dr Buckland was not advised that any different action was called for.

19. Dr Buckland was advised in the Memorandum of 24 March 2005 that "the Credentials and Clinical Privileges Committee has not appropriately considered or credentialed" Dr Patel. The CHO's report[32] recommended the completion of the implementation of the process of credentialing and privileging.[33] The Memorandum of 24 March 2005 did not indicate that a Credentials and Clinical Privileges Committee had not been convened to consider Dr Patel. It stated that it had "not appropriately considered or credentialed" him. In any case, the CHO did not indicate that, had the Credentials and Clinical Privileges Committee appropriately considered the matter, that they would not have granted Dr Patel the credentials and privileges necessary to enable him to undertake the general surgery which he was practising as at 24 March 2005.

20. The CHO's report, and the Memorandum of 24 March 2005, reported a failure of systems at BBH to respond in a timely or effective manner to concerns raised by staff, some of which were raised over 12 months ago. This shortcoming was to be addressed by way of recommended system improvements and by a specific reminder to the hospital's management about the responsibility to ensure that they responded

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31 This point was made in Exhibit 391, fourth-last dot point on page 1, and also at page 11 of the Confidential Audit Report.

32 Pages 6 and 7 also referred to the need for the process of credentialing to be progressed.

33 Report page 12, strategic recommendation number 1.

appropriately to complaints.[34] This advice concerning a failure to respond in a timely or effective manner to complaints in the past, did not, on the basis of the advice and information available to Dr Buckland on 24 March 2005, make it reasonable for him to suspend Dr Patel from duty or to further restrict his scope of practice.

Dr Patel's cessation of duties

21. Dr Buckland acknowledges that because no action was taken on 24 March 2005 to suspend Dr Patel or to restrict him from continuing to perform procedures at the hospital, Dr Patel might have performed procedures over Easter, 24 March 2005 being Easter Thursday. On the basis of the information and advice that he had at the time, including the absence of any advice that Dr Patel was not fit to undertake general surgery cases, such as road trauma cases, it was understandable and reasonable that Dr Buckland, as Director-General, did not direct that Dr Patel be suspended. Such a course would have exposed road trauma victims and other persons requiring emergency surgery over the Easter period to the risk that BBH would not have the only general surgeon available over the Easter weekend[35] if BBH was not able to find someone to replace him at short notice.

22. By late on 24 March 2005 Dr Buckland understood that Dr Patel had resigned and intended to take sick leave until 31 March 2005.[36] It appears that Dr Patel ceased surgical duties around, if not before, Easter 2005.[37]

23. In summary, the decision not to suspend Dr Patel on 24 March 2005 was a reasonable one in the circumstances, based on the advice and information that Dr Buckland had at the time.

24. Others, with more information about Dr Patel than Dr Buckland had acquired about him between 22 and 24 March 2005, including the CHO, had been assessing and investigating his clinical work for a substantial period and had not taken action during

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34 See the last two sentences of the Memorandum of 24 March 2005; SMB3 to Exhibit 335.

35 Exhibits 474 and 475, the latter being an e-mail from Mr Leck to the Zonal Manager at 1.35pm on 24 March 2005 which reported "There are no general surgeons in Bundaberg (privately or publicly) as from 8.00 this morning (except Dr Patel)". See also attachment SMB4 to Exhibit 335. The advice late on 24 March 2005 was that PHO's would not be able to manage locally any major haemorrhagic event: Exhibit 335 SMB4.

36 Exhibit 335, SMB4.

that time to suspend him or restrict his scope of practice, or recommended such a course. Although Dr Buckland might have suspended Dr Patel on 22 or 24 March 2005 or restricted his scope of practice:

(a) the advice and information available to him did not justify such a course;

(b) such a course would have been at odds with the advice of the CHO who had investigated Dr Patel's clinical performance, who had taken no such steps during his investigations, and who did not support such a course as at 24 March 2005;

(c) no such advice was given by others with a more direct role in the management of BBH, or by the GMHS.

25. In general, and in circumstances where:

(a) the CHO did not recommend action to restrict Dr Patel's scope of practice, let alone recommend that he be suspended;

(b) reported higher surgical complication rates than the peer group were explicable by reference to Dr Patel's past conduct of undertaking types of surgery which were beyond the scope of BBH and possibly beyond his own skills and experience;

(c) Dr Buckland received the assurance that Dr Patel's past conduct in undertaking inappropriate complex procedures and in delaying the transfer of patients to high level facilities had been addressed;

(d) there was no advice that Dr Patel's general surgical skills were inappropriate or that any lack of competence existed that warranted his suspension or restriction on his scope of practice;

(e) the CHO's report and his Memorandum recommended a range of strategic and operational actions to address the failure of systems at the hospital, including failures that had led to a delay in the resolution of matters concerning Dr Patel;[38]

(f) the Memorandum of 24 March 2005 also recommended that the hospital management be specifically reminded of their responsibilities to put systems

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37 As matters transpired it appears that Dr Patel did not work at BBH on the Easter weekend and took sick leave until his contract expired on 31 March 2005. Exhibit 463 para 65, but the precise date upon which he last performed surgical duties is not entirely clear on the evidence.

38 Report page 12.

in place to ensure that they responded appropriately to reasonable clinical quality concerns; and

(g) Dr Patel was to be investigated by the MBQ in respect of his lack of judgment in undertaking procedures that were beyond the scope of BBH and possibly beyond his own skills and experience,[39]

it is submitted that the course of suspending Dr Patel on 24 March 2005, or restricting his scope of practice forthwith, was not supported by the advice and information that was then available to Dr Buckland.

26. At that stage Dr Buckland did not take any step to further investigate Dr Patel's conduct because it was his expectation that:

(a) as part of the usual audit process, the CHO would cross check the findings in his report against clinical files and test the facts upon which the report was based;[40]

(b) Dr Patel had been referred to the MBQ for further investigation.

27. The advice and information available to Dr Buckland as at 24 March 2005 indicated that appropriate steps had been and were being taken in relation to Dr Patel's conduct and in relation to the failure of systems at BBH, as disclosed in the CHO's investigation. The CHO's Report, his Memorandum of 24 March 2005 and his oral briefings on 22 and 24 March 2005 did not make Dr Buckland's failure to suspend Dr Patel from duty that day or to further restrict his scope of practice, or take steps to further investigate Dr Patel, unreasonable in the circumstances.

Advice to the Minister

28. Dr Buckland's briefings to the Minister in respect of Dr Patel over the period from 24 March 2005 to 7 April 2005 were reasonable in all of the circumstances.

29. The CHO reported directly to the Minister.[41] Precisely how and in what format his Confidential Audit Report was conveyed to the Minister's office is uncertain. But Dr Fitzgerald's evidence,[42] the fact that the CHO was asked to directly brief the

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39 The CHO formally referred the matter to the MBQ by letter dated 24 March 2005: Exhibit 225 - GF13.
40 Exhibit 335 para 25.
41 Exhibit 225 attachment GF2 para 5(a); Exhibit 337 para 5; T.6140.
42 T.6141-2.

Minister on this matter[43] and the fact that Minister was directly briefed by the CHO on 22 March 2005 makes it likely that his report was transmitted directly to the Minister's office or "walked in" to the Minister's office by a staff member. That the CHO reported directly to the Minister and would be expected to provide his report to the Minister's office is evidenced by the contents of Exhibit 391, in which the CHO stated that a copy of his draft report was enclosed. The draft report does not appear to have been enclosed with that email. But the direct reporting line to the Minister and the CHO's conduct in reporting directly to the Minister (rather than via the DG), in relation to the Confidential Audit Report makes it likely that the CHO or his staff would have provided a copy of his report to the Minister's office.

30. Mr Nuttall's evidence was that he asked the CHO to make sure that he completed his report as quickly as possible.[44] Mr Nuttall said that he was waiting on the report and "that's why I asked him to complete the report as quickly as he possibly could so I could get a handle on exactly what the situation was at the hospital".[45] The CHO indicated to Mr Nuttall that the report was very near completion and Mr Nuttall says that he asked the CHO to have it made available as soon as he possibly could.[46] Mr Nuttall's evidence was that he understood that the CHO would have given the report both to him and to the Director-General.[47]

31. The fact that Mr Nuttall may not have personally read the report does not mean that the report was not provided to his office prior to 7 April 2005.[48] Mr Nuttall's evidence tends to confirm the probability that a copy of the CHO's report was provided to the Minister's staff in late March or early April 2005. The fact that the Minister was not personally provided with a copy of the report when he attended the 7

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43 T.6140.
44 T.5312.
45 T.5312-5313.
46 T.5314.
47 T.5316, l.40.
48 For example, Mr Nuttall gave evidence that he did not read the material tabled by Mr Messenger MLA in Parliament before meeting with the CHO (T.5314), and the evidence is that Ministers, such as Mr Nuttall, depend upon staff to read the large volume of reports and other materials that are sent to the Minister's office.

April meeting[49] does not contradict the proposition that a copy of the CHO's report had been provided to the Minister's office before that date.[50]

32. The evidence makes it quite probable that a copy of the CHO's report was provided to the Minister's office at about the same time as it was provided to the DG on 24 March 2004, or soon afterwards.[51]

33. Dr Buckland was aware of the CHO's reporting relationship to the Minister and that the CHO had directly briefed the Minister in relation to Dr Patel and the BBH. There was nothing unusual in a senior departmental officer, such as the CHO, communicating directly with the Minister and/or the Minister's staff. Mrs Edmond gave evidence about the flow of communications between the Minister's office and senior members of the Department,[52] and Mr Nuttall gave evidence to like effect.[53] The uncontested evidence is that advice to the Minister was provided, inter alia, by direct access to senior executive and their staff, without being filtered by Dr Buckland.[54]

34. In the circumstances, it is likely that a copy of the CHO's report was provided to the Minister's staff in late March or early April 2005.

35. In the light of the evidence concerning the volume of material which flows into the Minister's office, one would not necessarily expect Mr Nuttall to personally have read the audit report given:

(a) the ordinary course of events;

(b) the fact that he had received written and oral briefings by the CHO on 22 March 2004;

(c) the Minister's staff would be expected to obtain a copy of the report, given that questions had been asked in the House about the CHO's investigation;

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49 T.5316.

50 If, however, this is not the case, then a copy of the report was easily obtainable by the Minister's staff from the CHO, and the DG's office was entitled to assume that the report either had been provided by the CHO to the Minister's office, or that, if it had not been, the Minister's office would have requested it from the CHO.

51 Easter intervened.

52 T.4936 l.10.

53 T.5334 ll.l-15.

54 Exhibit 336 para 37(a)(ii).

(d) the report was not materially different in substance to the CHO's earlier written or oral briefings to the Minister's office.

36. Prior to the visit to Bundaberg on 7 April 2005, Dr Buckland was entitled to assume that the Minister and his staff had been briefed by the CHO both orally and in writing about the CHO's investigation and that, the matter being in the public arena, the Minister's office had access to a copy of the report by the usual means of communication between the Minister's office and senior officers in the department such as the CHO. Dr Buckland had received the CHO's Memorandum of 24 May 2005, and followed that up with a further oral briefing from the CHO which, as previously noted, confirmed the substance of the advice which had been given to Dr Buckland and to the Minister on 22 March 2005. There is no evidence that the Memorandum dated 24 March 2005 was sent by the DG's office to the Minister's office. However, if it had been, and if the Minister's office had raised further questions about its contents either with Dr Buckland or with Dr FitzGerald, then the Minister would have been briefed in the same terms as Dr Buckland was briefed by the CHO on 24 March 2005, following receipt of the Memorandum. That briefing confirmed earlier advice. For the reasons outlined in paragraph 25(a) to (g), it did not recommend the suspension of Dr Patel or other action in relation to him, and indicated that system failures at BBH were being addressed.

37. Prior to the meeting of the hospital on 7 April 2005, Dr Buckland generally briefed the Minister about the matter. That briefing was based upon the information and advice which Dr Buckland had in turn received. There was no basis, at that stage, for Dr Buckland to reject the information, advice and recommendations which had been made to him by the CHO. Dr Buckland's briefing of the Minister was based upon the information and advice which was available to him at the time.

38. Some confusion exists about what was said to the Minister concerning completion of the audit report and completion of the audit process. The fact of the matter is that the audit report was effectively completed in at least a final draft form by 24 March 2005, but that Dr Patel's absence from Australia made it difficult to follow the usual process of consultation with someone who has been adversely named in such a report and it made it difficult to comply with the requirements of natural justice.

39. Prior to 7 April 2005, Dr Buckland anticipated that the audit process would be completed, including the usual audit process of confirmation of data. He expected action to be taken in accordance with the recommendations contained in the March 2005 Confidential Audit Report. He also anticipated the action contemplated by the 24 March 2005 Memorandum would occur, including referral of Dr Patel to the Medical Board. Accordingly, Dr Buckland did not take the view that issues in relation to Dr Patel's conduct at the hospital would not be pursued because of his absence from Australia.

The visit to Bundaberg on 7 April 2005

40. Dr Buckland did not advise the meeting of BBH staff on 7 April 2005 or the Minister that the CHO's audit report could not be completed because Dr Patel had left Australia or because the report contained confidential patient information. Dr Buckland admits that he may have caused confusion amongst staff and the Minister when discussing the completion of the audit process, but at no time did he mean to portray that the audit report could not be completed. There is no evidence that Dr Buckland advised staff or the Minister that the report contained confidential patient information.

41. Lacking a proper appreciation of the true situation at BBH and the underlying causes of staff concerns, the then Minister and the then Director-General visited the hospital and addressed staff on the afternoon of 7 April 2005. Dr Buckland readily acknowledged in his written statement that had he been better informed of issues in relation to Dr Patel before speaking to the staff that day, he would have consulted with the CHO and had a very different approach to the staff meeting.[55] It became clear from the mood of the meeting and the level of frustration and anger verbalised by some staff that there were more significant issues with Dr Patel than the Minister and the Director-General had been briefed.[56]

42. Two related, but distinct, matters need to be addressed:

(a) the Confidential Audit Report of Dr Fitzgerald and requests that its contents be generally communicated;

(b) ongoing processes to address failures identified in the audit report.

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55 Exhibit 335 para 39.

43. As to (a), the report was effectively completed.[57] It was critical of Dr Patel, who had yet to be given the opportunity to respond to adverse findings concerning him. The same issue of principle, namely the need to accord procedural fairness, would have arisen in respect of adverse findings against any other individual, such as a nurse. In attempting to articulate the proposition that no action could be taken against Dr Patel without first affording him an opportunity to respond to the report, Dr Buckland was not defending Dr Patel personally. The issue is one of procedural fairness. As Dr Buckland said in his evidence, "I support the right of anybody to natural justice, not just Dr Patel".[58]

44. Dr Buckland told the meeting of the problems that had been encountered in finalising the audit process because Dr Patel was in the United States and that he had to be accorded natural justice.[59] Dr Buckland did not advise that the report could not be completed because Dr Patel was overseas. There is no satisfactory evidence that Dr Buckland told the meeting or Mr Nuttall that the report could not be completed because it contained confidential patient information.[60]

45. As to (b), the expectation as at 7 April 2005 was that the review process would continue. Dr Keating's evidence is that Dr Buckland told the meeting that some recommendations from an organisational system perspective would be provided to the

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56 Ibid para 33, last sentence.

57 The precise state of the report and the appendix to it as at 7 April 2005 is not entirely clear: see Exhibit 392. Exhibit 495 para 15.

58 T.5567. See also paras 33-34 of Exhibit 335.

59 Exhibit 335 para 33.

60 This allegation was not put to Dr Buckland by Counsel Assisting 5503-5507. It was put to Dr Buckland by Counsel for the QNU and denied by him T.5556 l.50 – 5557 l.1. Mr Nuttall's statement indicates that it was the Minister's Media Advisor who told the media that the report would not be released publicly because, amongst other things, it contained confidential patient information: Exhibit 319, para 99. Mr Nuttall's statement paragraph 100 goes on to say that after speaking with the Director General he was of the opinion that the report should not be publicly released "for the above reasons". Those reasons include the fact that Dr Patel had left the country. Overall, the evidence does not support the conclusion that Dr Buckland cited confidential patient information as a reason why the report should not be released publicly. Mr Nuttall's witness statement para 100 might be interpreted as suggesting that Dr Buckland told Mr Nuttall that the report contained confidential patient information. If it was intended to convey that suggestion, it is in error. Mr Nuttall's oral evidence clarified the matter somewhat, namely that he referred at the meeting to the fact that it was standard practice that clinical audits were not released as a matter of course (T.5319). This was the case, and Mr Nuttall could not recall whether specifically what he was advised by Dr Buckland or Dr FitzGerald about these matters (T.5324, T.5326). The evidence of other persons who attended at the meeting on 7 April 2005 does not suggest that Dr Buckland cited confidential patient information as a basis as to why the report would not be completed or publicly released.

District Manager and the Executive to review and implement.[61] Also, the CHO was instructed by Dr Buckland to request the District Manager to report as to how the recommendations arising from the report were to be implemented.[62] As a result, the CHO requested the District Manager to provide a response and an implementation program for the recommendations arising from the report. The CHO indicated that he would be happy to assist in the preparation of that program.[63] It was Dr Buckland's expectation that this, and other parts of the usual audit process, could and would be undertaken, save that it would be difficult, if not impossible, to give Dr Patel the opportunity to respond to findings in the report in the manner that he would if he was an employee of QH and available to participate in the process.

46. In addressing two distinct issues, namely the general release of the CHO's Confidential Audit Report in circumstances in which Dr Patel had not been afforded an opportunity to respond to adverse findings in it concerning him, and the issue of what would be done to address the issues that the report raised, there was a potential for confusion. This potential was increased in circumstances where these issues were being addressed at a staff meeting, rather than in a more structured discussion. Dr Buckland readily conceded in his witness statement that, in hindsight, he can see that perhaps he caused confusion by the expressions he used at the meeting and by his failure to clearly articulate the difference between the finalisation of the audit report and the finalisation of the audit process.[64] Any confusion that he caused is very unfortunate. However, the contemporaneous documentation and Dr Keating's evidence indicates that the review process was not at an end, that Dr Patel's conduct was being referred to the MBQ and that the failure of systems identified in the audit report were to be addressed.

Events after the meeting on 7 April 2005

47. Upon leaving the staff meeting, Dr Buckland was asked to have a private conversation with Dr Keating. The conversation was brief due to the circumstances. In it

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61 T.6817 ll.40-42.

62 Attachment 13 to the Statement of Mr Bergin (Exhibit 383) which records the DG's request. The DG's request must have pre-dated 7 April 2005 which was the date of the CHO's letter to the District Manager. If, as appears to be the case, the CHO was still finalising his report in late March/early April 2005, this may explain why the letter dated 7 April 2005, which enclosed a copy of the report and requested a report from the District Manager, was not sent until that date.

63 This appears in the same letter to Mr Leck.

64 Exhibit 335 para 34.

Dr Keating disclosed that he had done a Google search on Dr Patel which had shown problems in relation to Dr Patel's registration in the United States.[65] Dr Buckland wanted to check the facts before briefing the Minister.[66] But on the return flight to Brisbane, he told the Minister "There is more to this guy (Patel) than we know, I'll have a look at it".[67] When Dr Buckland arrived home that night, he did a Google search.[68] He telephoned the CHO that same night, reported his findings and told the CHO that he should advise the MBQ as a matter of priority.[69] The next day Dr Buckland advised the Minister of Patel's restricted registration in two states.[70]

48. The revelation of Dr Patel's restricted registration in two American states and the level of frustration and anger displayed at the staff meeting on 7 April 2005 led Dr Buckland to believe that the problem was more extensive than previously thought. He decided that the seriousness of the matter required a comprehensive review of Dr Patel and the Bundaberg Health Service. He recommended the establishment of an investigative team and his recommendation was accepted.[71] The review team included a representative of the College of Surgeons and other individuals who were well-qualified to conduct such a review.

49. The Minister and Dr Buckland requested the CHO to travel to Bundaberg to provide feedback to the staff on the outcome of his investigations.[72] In addition, a large team of individuals from other locations within Queensland Health was despatched to Bundaberg to render assistance to patients of Dr Patel, the community and hospital staff.[73]

Summary – Dr Patel and BBH

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65 Exhibit 335 para 35. Dr Buckland's recollection of the details of the conversation appear at T.5507 ll.10-50. Differing recollections about the precise details disclosed during this brief conversation may not assume great importance, since Dr Buckland proceeded to undertake his own Google search that night.

66 Dr Buckland also recollects that Dr Keating said that he did not want to be identified as the source of the information; Exhibit 335 para 35; confirmed at T.5508 and T.5586-8.

67 Exhibit 335 para 36.

68 Ibid.

69 Ibid para 37.

70 Ibid para 38. Dr Buckland's evidence is that he mentioned the matter to the Minister again, including on an occasion on 12 April 2005 when they were driving in a car together: Exhibit 337 para 16. Although the former Minister may not recall these matters, no contrary version was put to Dr Buckland by the Minister's legal representatives.

71 Exhibit 335 paras 40 and 41.

72 Exhibit 335 para 48.

50. In summary, it is submitted that after 22 March 2005, when Dr Buckland first was informed of allegations in relation to Dr Patel, Dr Buckland acted reasonably on the basis of the information and advice that he received. The information and advice that Dr Buckland received at the time has subsequently been shown during the course of these proceedings to have been inaccurate or misleading. But that does not mean that Dr Buckland should not have acted on the basis of the information and advice that he received. Relevantly, he had not received any advice prior to 22 March 2005 from the CHO, other officers of QH or persons outside QH, such as representatives from the AMA, to suggest that Dr Patel was the subject of investigation, let alone that action should be taken to stop him from operating. On 24 March 2005, he still did not receive advice that action should be taken to stop Dr Patel from operating. It was reasonable for Dr Buckland to rely upon the information and advice provided by the CHO. That information and advice, both oral and in writing, did not recommend that Dr Patel be suspended or that other action be taken against him at that stage.

51. The Minister was briefed directly by the CHO and orally by Dr Buckland prior to the meeting with staff in Bundaberg on 7 April 2005. Dr Buckland's briefing of the Minister reflected the substance of the information and advice that Dr Buckland had received from the CHO.

52. Once Dr Buckland learned on 7 April 2005 that the situation in relation to Dr Patel and BBH was materially different, he took prompt action, namely to recommend the establishment of a well-qualified Review Team. After this time, there was also appropriate support from QH for staff and patients.

Lennox report

53. In August 2003, Dr Lennox wrote a report entitled "Management of International Medical Graduates – proposal for a State-Commonwealth collaboration to formalise and establish to a standard of excellence the management of all international medical graduates in Queensland", referred to in the Commission as the "Lennox report".[74] Dr Lennox wrote his report for the Joint OTD/TRD Committee which was comprised of the AMAQ, Queensland Health, Medical Board of Queensland, Commonwealth Department of Health and Aging and Commonwealth Department of Immigration,

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73 Exhibit 335 para 50.

Multicultural and Indigenous Affairs.[75] Dr Lennox says, "...although the document was written by a Queensland Health employee, the document was prepared for the Joint Committee of which Queensland Health was only one member".[76]

54. The Lennox report was given, by briefing dated 28 August 2003, to Dr Buckland as GMHS to "brief the GMHS on progress on proposal for integrated management of OTDs and to provide a draft invitation to the Medical Board of Queensland to commit to mandating the process".[77] Dr Buckland noted the briefing and signed the letter to the Medical Board of Queensland on 8 September 2003.[78]

55. The Lennox report was apparently considered by a committee of AMAQ and individuals representing various other groups impacted by the proposal in mid September 2003.[79] The AMAQ, by letter dated 12 September 2003, outlined its concerns with the Lennox report and made recommendations of further matters which needed to be incorporated into the report. It was also considered by a sub-committee of the MBQ. The MBQ also had concerns about the practical implications of the proposal.[80]

56. Dr Lennox asserts that it was evident from September 2003 that the proposed integrated management of IMG's was no longer receiving Queensland Health's management support.[81] However, Dr Lennox does not suggest that in or after September 2003 he made amendments to his proposal in response to the AMAQ's concerns, followed up MBQ as to their formal response or put any submission to the GMHS at Queensland Health requiring a decision about the proposal contained in the Lennox report.

57. The Lennox report was not an official Queensland Health document for four reasons: it was not produced for Queensland Health, it required the support of other

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74 Exhibit 55 attachments DRL9 and DRL12.
75 Exhibit 55 paras 24, 27 and 30.
76 Exhibit 55 para 30. T.894.
77 Exhibit 55 attachment DRL9.
78 Exhibit 55 attachments DRL9 and DRL10 and see T.5515. It was never put to Dr Buckland that he did not send the letter attached as DRL10.
79 The letter, which is DRL13 to Exhibit 55, states the meeting took place on 16 September but the letter itself is dated 12 September 2003. Presumably one of these dates is incorrect.
80 T.476-7.
81 Exhibit 55 para 20.

stakeholders but was not fully supported by them[82], it had not been costed by Treasury and it had not been submitted to the QH senior management for approval and therefore had not been approved.[83] The report would not be final, in the sense that it could be considered by the Director-General or Minister for approval, until full consultation with stakeholders had occurred and consensus had been reached and costings had been approved by Treasury and those matters were included in the report. Therefore, the report would certainly not be final until it had been amended as requested by the AMAQ in late September 2003 or, at the very least, amended to reflect the fact that the AMAQ had a number of qualifications to the report.[84]

58. Dr Buckland did not receive a request from Minister Edmond or Premier Beattie to follow up the completion of the Lennox report. It is not reasonable to suggest that a member of the QH executive, including Dr Buckland, should be required to monitor every media statement by the Premier or Minister for Health and take instructions as to action required by them via the media.[85]

59. It was reasonable for Dr Buckland to assume that Dr Lennox would follow through with his report and provide a submission to him which addressed the matters that must be contained in all submissions (as discussed in paragraph 57 above).[86] Given the many responsibilities of the GMHS, the large number of employees under his general management and the existence of other managers in the line of management between Dr Lennox and the GMHS and Dr Buckland's promotion to Acting Director-General on 1 November 2003, it is not reasonable to suggest that Dr Buckland was responsible for ensuring that Dr Lennox completed his report.

60. In circumstances in which the Lennox Report had not been finalised to address the concerns of the AMAQ and the MBQ, its proposals had not been costed and it had not been submitted for approval by QH, no occasion arose for Dr Buckland to approve any proposal that it be published to the general public. No recommendation appears

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82 As to AMAQ, see DRL13 to Exhibit 55, as to MBQ see para 11-13 of Exhibit 349. There is no evidence of the support of the proposal by Commonwealth Departments of Health and Aging or Immigration.

83 Exhibit 336 para 151; Exhibit 366 para 61-62, Edmond (T.4926 to T.4930), Exhibit 349 paras 11-14, Exhibit 55 para 30, DRL13.

84 T.4985.

85 T.5513-4.

86 As Mrs Edmond stated, it was reasonable to assume that all senior public servants, like Dr Lennox, knew that those matters should be addressed in reports: T.4931.

to have been made to Dr Buckland that the report in its then state be released to the general public.

61. The decision to adopt such a report and to publish such a report was one for the Minister of Health.[87]

62. Many of the safety and quality issues about OTD's raised in the Lennox report and earlier versions of the report by Dr Lennox were well known by Queensland Health.[88] In late 2002, Cabinet approved the development of a Skills Development Centre to promote safety and quality in general through the provision of a world class training centre. The board in charge of establishing the Skills Development Centre recognised in mid 2003 that the SDC could play an important role in the training and assessment of OTDs.[89] The Centre for Overseas Trained Doctors ("COTD") was incorporated into the Skills Development Centre in December 2003 and a project was approved for the SDC to establish improved recruitment, assessment and placement processes for OTD's in November 2004.[90] The issues of concern raised by Dr Lennox in the Lennox report were acted upon by QH.

63. Dr Stable and Dr Buckland, and Queensland Health as a whole, have always taken seriously the maintenance of the COTD.[91] Queensland Health did not during 2003 reduce its funding to the COTD or try and close it. The continued operation of the COTD was temporarily threatened in 2003 due to the withdrawal of funding by the Commonwealth government. Queensland Health gave a one-off additional payment to the COTD, on top of its recurrent annual payment, during 2003 to try and meet the shortfall created by the Commonwealth's withdrawal of funding. In November 2003, Queensland Health formally announced that the COTD would be operated by Queensland Health under the auspices of the Skills Development Centre which was to be opened the following year.[92]

Vincent Berg

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87 T.4926, T.5519, T.5725.
88 Exhibit 319 attachment 4. See also Mrs Edmond's evidence at T.4923-4.
89 Exhibit 336 para 143, attachment SMB42, SMB38; Exhibit 366 para 51.
90 Exhibit 336 152, 134; Exhibit 366 paras 51, 53.
91 Exhibit 336 paras 141-144 and 133-134, Exhibit 366 paras 48-53.
92 Attachment SMB43 to Exhibit 336.

64. Dr Buckland's evidence in relation to this matter appears in his second statement.[93] Dr Buckland was not involved in any aspect of Berg's registration or his employment by QH in Townsville as a registrar in psychiatry for the 2000 calendar year. During that time Dr Buckland was Zonal Manager in the Southern Zone. Dr Buckland first became aware of the issue of Berg's qualifications in December 2002, some two years after Berg had left his employment with QH. The issue that Dr Buckland was required to address at that time related to the process of identifying and contacting patients that Berg had seen as a psychiatric registrar.

65. Dr Buckland was called upon to make a difficult clinical and ethical decision which involved assessing competing risks, including the risk of harm to patients that would occur if Berg's lack of qualifications was communicated to vulnerable individuals, particularly through the media.[94] It is not the case that a decision was made not to contact patients. Instead, former patients were identified and contacted where considered appropriate by the local medical service. The ethical and clinical decision that Dr Buckland was asked to make was how the patients were to be contacted and what was to be communicated to them.

66. Dr Buckland describes the decision as perhaps one of the most difficult decisions he had to make as a medical practitioner and an administrator.[95] Dr Buckland readily acknowledged that other people, placed in his position, may have made a different decision when faced with the task of assessing risks and weighing alternative courses of action.[96]

67. In making his decision, Dr Buckland consulted with the then Director of Mental Health, Dr Brown. Dr Brown had been in Townsville in early December 2002 and had discussed the matter with Dr Johnson. She subsequently spoke with Dr Buckland and met with him for between 30 and 60 minutes. Dr Brown's view was that selected follow-up was preferable over public disclosure.[97]

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93 Exhibit 336 paras 207-231.

94 Exhibit 336 paras 224-228.

95 Ibid para 224. The view that the matter involved a difficult clinical and ethical decision was also expressed by the former Minister, Mrs Edmond, who gave evidence concerning her personal experience in dealing with individuals suffering from mental illness. T.4955-6 and T.4965 where Mrs Edmond stated that it was probably "one of the toughest decisions anyone would have to make...".

96 Exhibit 336 para 229.

97 Exhibit 376, Part C, paras 20-22.

68. Dr Buckland was asked under cross-examination about the absence of documentation in relation to this advice. Nothing turns upon the absence of documentation[98] since the evidence of Dr Buckland and the evidence of Dr Brown indicate the advice that he received and the reasons that informed that advice. However, there is no dispute concerning the substance of Dr Brown's opinion, and there is no suggestion that her opinion was other than the genuine and professional opinion of the Director of Mental Health.

69. Issues in relation to Berg were referred to QH Audit and Operational Branch to review and came to the attention of the Queensland Police Service.[99] The Audit Branch referred the matter to the CMC.[100] The MBQ was also seized of the matter.[101]

70. In summary, the decision that Dr Buckland was asked to make about the process to be adopted in December 2002/January 2003 in following up patients who had been seen by Vincent Berg as a psychiatric registrar some two years earlier posed difficult, ethical and clinical issues. The decision that was made by Dr Buckland was one that was open to him on the basis of the advice and information that he received at the time, including the advice of the Director of Mental Health. Although he acted on the basis of advice and discussions that he had with various people about the matter, Dr Buckland accepted in his evidence[102] that the decision rested with him, subject to it being countermanded by the Director General or the Minister. The decision that he made may not have been made by others, faced with the same difficult decision. But the decision was not unreasonable.

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98 Professor Stable (T.5733) stated he did not think a written report was necessary if Dr Buckland had satisfied himself by speaking to psychiatrists.

99 Exhibit 336 para 230.

100 Ibid.

101 Ibid para 231.

102 Exhibit 336 para 223.

Measured Quality

71. This issue emerged on the eve of Dr Buckland's oral evidence and, in the circumstances, could only be briefly addressed in his third statement which was given on the morning he came to give evidence.[103] Dr Buckland was also shown some documents during his oral evidence on 19 September 2005.

72. The history of the Measured Quality program is outlined and documented in statements given by Mr Collins[104] and it is unnecessary to repeat that detail. In short, the Measured Quality program commenced in about 2001 and submissions to the Director-General in relation to it pre-dated Dr Buckland's appointment as GMHS on 29 July 2002. In late 2002, a Cabinet Submission was prepared. A critical event was the Cabinet meeting of 11 November 200, followed by Mr Smith's email of 12 November 2002.[105] QH was required to act in accordance with decisions made by the Cabinet and by Cabinet Ministers concerning the dissemination of MQ reports.

73. Dr Buckland's own opinion concerning the merit of that decision appears to have been shared by other employees of QH. His opinion was that the hospital reports should be available to hospitals to give them feedback.[106] As he explained in his evidence, the issue at hand was to communicate matters to the organisation, namely the hospitals concerned, so that "we can get best value out of it".[107] Dr Buckland recalled discussions within the department following the political decisions made in November 2002 to the effect that QH staff were significantly disappointed because of the need to get benchmarking documents into circulation, the need to involve clinicians and to provide feedback.[108]

74. In March 2003, the Minister was briefed in a written brief prepared by Mr Collins, which was cleared by Dr Cuffe.[109] Dr Buckland was not involved with that briefing[110]

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103 Exhibit 337 paras 24-27.
104 Exhibits 377 and 378.
105 Exhibit 340, Exhibit 377, JEC11.
106 Exhibit 337 para 27.
107 T.5535 ll.1-10.
108 T.5529 ll.30-37.
109 Exhibit 377, JEC13.
110 There is no suggestion that the briefing was cleared by Dr Buckland and the document indicates that it was noted by the Minister after being cleared by Dr Cuffe.

or in the later 6 May 2003 presentation by Mr Collins to the Minister and the then Director-General.[111]

75. Dr Buckland became Acting Director-General on 1 November 2003 and in 2004 Dr Scott, as GMHS, issued new instructions in relation to the dissemination of MQ hospital reports for 2004.[112] These instructions attempted, within the constraints imposed by earlier government decisions, to make hard copies of the hospital reports more accessible to the hospitals.

76. In summary, Dr Buckland, like other QH employees, was obliged to implement Cabinet and Ministerial instructions concerning the dissemination of MQ hospital reports.

Waiting lists

77. The history of the Elective Surgery program and the Waiting List Reduction Strategy has been the subject of substantial evidence and it is unnecessary for the purposes of these submissions to canvass that history.[113] In short, the focus of government policy was to provide specific funding for additional elective surgery. Substantial funds were allocated, from time to time, to reduce elective surgery waiting lists. Considerable evidence has been given to the Commission concerning what have been described as the "anterior lists". It is convenient to briefly address these by way of submission in two respects:

(a) lists maintained locally; and

(b) statewide totals.

78. As to (a), for reasons explained by Dr Scott, Dr Buckland and others, the number of persons on a particular list awaiting an appointment to see a particular type of specialist at an outpatient clinic is relevant information that is accessible to local GPs. But, without more, this information will not inform the GP or the patient how long the person may have to wait for an appointment. This depends upon what Dr Buckland described as a capacity issue which he explained in his evidence.[114] Dr Scott's

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111 Exhibit 377 JEC14.

112 Ibid JEC16. Dr Buckland became Director-General on 29 April 2004.

113 Exhibits 327 and 462 (Zanco), Exhibit 328 (Walker), the oral evidence of Mrs Edmond (T.4873-T.4905, T.4964-5 and T.4972-3) and Dr Scott (T.5249- T.5257).

114 T.5588-9.

evidence was to similar effect.[115] This information is available to local GPs and others who wish to know how long a patient may have to wait for an appointment at a specialist outpatient clinic at a particular hospital for a particular specialty.

79. As to (b), the evidence of Mr Zanco and Mr Walker is that anterior lists were collected and, for a period, manually collated by the Surgical Access Team. However, for reasons explained by them, the data was unreliable.[116] The process of manual collation was a time-consuming exercise and because of the unreliability of the source data the collated information was unreliable.[117] As a result, the time-consuming and costly process of providing monthly summaries was discontinued upon the recommendation of the Surgical Access Team ("SAT"[118]). Dr Buckland gave evidence to the same effect.[119] Given its limited resources, the conclusion was reached that the project team was better spending its time and resources on developing a computerised system to collect reliable data, than on the time-consuming process of manual collation of unreliable data. The reporting of outpatient waiting list data by the hospitals to the SAT did not cease.[120]

80. The existence of anterior lists has been the subject of regular comment and inquiry by Members of Parliament and journalists.[121] The existence of specific outpatient waiting lists and issues in relation to their administration was known to Health Ministers under whom Dr Buckland served.[122] From time to time the total numbers of persons state wide on the anterior lists was included in submissions prepared for Cabinet.[123] For example, in an Information Submission prepared for Cabinet in July 2005, QH advised that approximately 84,000 patients were waiting to be seen by surgical

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115 T.5253-4.

116 Exhibit 326 (Zanco No 1) para 24; Walker evidence T.6203. In respect of initial problems with data, see Exhibit 328 para 55 and T.6180-1.

117 Mr Walker's evidence was that monthly reports could have been publicly disseminated but he would be most concerned about the quality of the data: T.6183.

118 For ease of reference the Surgical Access Team and the Surgical Access Service will each be referred to as SAT.

119 Exhibit 336 para 185.

120 Exhibit 328 para 74.

121 Exhibit 336 para 175, Exhibit 317 (Scott), JGS 17, Mr Nuttall's evidence T.5343-4.

122 Exhibit 336 para 176. The evidence of the relevant Ministers was not to the contrary. For example, Mr Nuttall (Exhibits 320 and 321, T.5343-5) and Mrs Edmond (T.4873-T.4905, T.4964-5 and T.4972-3).

123 Exhibit 328 para 69. See for example, GW22 to GW30 of Exhibit 328.

outpatient specialists of which approximately 60,000 were not booked for a specialist outpatient appointment.[124]

81. It was open, at any time, for the Minister or the Cabinet to request and publish these statewide figures. The department would have been required to collate the collected figures. The figures, so collated, may not have been very reliable for the reasons known to both the department and the Ministers.

82. Ultimately, the public release of reports and information is determined by the Government, not by the department.[125] The Government decided to publish elective surgery waiting figures rather than totals compiled from the anterior lists. This policy pre-dated Dr Buckland's appointment as GMHS and DG, and continued after he ceased to be DG.

Elective surgery and elective surgery targets

83. Dr Buckland was asked some questions about this topic during his oral evidence by Counsel Assisting. The questions touched upon a potentially enormous issue concerning elective surgery, its funding and the processes and rules that have governed these matters over the years. Dr Buckland addressed these matters generally in his second statement.[126] It is unnecessary to repeat the contents of his evidence which was not contested. In brief, the evidence shows a strong policy commitment by the Government to devote specific funding to reducing elective surgery waiting lists. However, the system of funding elective surgery gave rise to significant problems that have been identified by Dr Buckland, including the fact that the process was complicated and did not reflect the actual cost to the hospital of providing these services.[127] This was confirmed by Mr Walker in his evidence.[128] The elective surgery program became more and more rule-bound. The result was a constant tension between the SAT and the doctors in the hospitals. Hospitals were having to subsidise elective surgery from their ordinary funds.[129]

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124 Exhibit 323 page 2.
125 Exhibit 366 para 75; T 5720.
126 Exhibit 336 paras 189-196. A more comprehensive account of the funding and practices relating to elective surgery is given by Mr Zanco in his statement dated 4/10/05 being Exhibit 462.
127 Exhibit 336 para 191.
128 T.6199, T.6204-7.
129 Exhibit 336 para 192. The existence of tension between the SAT and the hospitals is reflected in other evidence: see Bergin T.6015, Exhibit 384, Cuffe T.6580, Exhibit 416 attachment DFM6, Exhibits

This footnote is continued on the next page.

84. After becoming GMHS, Dr Buckland found himself in the middle of an ongoing conflict between the SAT and hospitals over the funding and administration of elective surgery. The evidence shows that he resolved disputes over classification and reclassification processes by adopting new business rules in October 2003.

85. Based on this experience, he learned that clinicians and hospital management who were responsible for managing the delivery of elective surgery needed more input into the processes. The process by which funding to hospitals was turned on and off like a tap was harmful. The evidence is that it provided no certainty upon which services could be planned.[130]

86. After Dr Buckland became Director-General, the funding structure of elective surgery was changed so that elective surgery funding was distributed directly to hospitals as a one line item of recurrent base funding as opposed to a multiple funding program, which was given and taken at the control of the SAT.[131]

87. The old funding structure also created a distinction between surgical procedures and medical procedures. Dr Buckland regarded this as a "perverse driver" which led to poor clinical practice.[132]

88. The funding model which pre-existed Dr Buckland's appointment as GMHS and DG was based upon a purchaser provider model that had been introduced in the mid to late 1990's as part of a philosophy of economic rationalism that dominated health and other government services.[133] The practical consequences of such a model, which enabled the SAT to effectively purchase elective surgery services from hospitals at below cost, was the subject of examination during Mr Walker's evidence.[134]

395, 396, 419 (in particular, reference on page 2 of file note that Dr Margetts considered action by SAS as "bullying"), 429 (in particular, Memo from Fraser Coast HSD dated 3.09.03, email from Toowoomba HSD), Medical Superintendents' Advisory Committee Exhibit 346 Stable ("junior officers who are pushing their own barrow but didn't understand the broader picture...") T.5760.

130 See for example the evidence of Dr Mattiussi T.5876, T.5878-9.

131 Exhibit 336 para 194, SMB59.

132 Exhibit 336 para 195. He elaborated on the nature of this "perverse driver" in his oral evidence. T.5542 and T.5590-1.

133 Exhibit 336 para 48, para 303.

134 T.6204-7.

89. As Director-General, Dr Buckland and others within QH, were concerned at the consequences of hospitals being required to provide elective surgery services at below cost. In August 2004, this issue was highlighted in a Cabinet submission.[135]

90. The elective surgery program and its funding is a complex issue. Government policy specifically funded an elective surgery waiting list reduction strategy and QH developed programs to implement government policy. Through a series of decisions, the Government devoted substantial resources to reducing elective surgery waiting lists. But as Dr Scott's oral evidence explained, even with additional funding, QH did not have the capacity to make inroads into either the category 3 waiting times or the anterior waiting lists.[136] These concerns were stated in the Information Submission to Cabinet about Category 3 patients dated July 2005.[137]

91. Dr Buckland has attempted to address the general issue of waiting lists, including the fact that waiting lists for public hospitals are a result of:

(a) the demand for services in that system;

(b) the fact that the demand is partly the result of the failure of preventative health strategies in the past;

(c) the burden of disease in our communities, particularly amongst socially disadvantaged groups;

(d) under-funding;

(e) the sheer weight of numbers on a system that is not means tested in an era when an increasing number of "middle class" (for want of a better phrase) people turn to the public hospital system in Queensland for health care.[138]

92. Dr Buckland has also addressed specific issues in relation to waiting lists.[139]

93. The policies and practices in relation to waiting lists, elective surgery and its funding pre-dated Dr Buckland's appointment as GMHS and his appointment as DG. During the few years that he occupied those positions, he was required to implement government policy that placed a priority on the reduction of elective surgery waiting

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135 See pages 1 and 8 of GW31 which is attached to Exhibit 328.

136 T.5391-2.

137 Exhibit 323.

138 These matters are addressed at paragraphs 153 to 172 of his second statement, Exhibit 336.

lists. When he became Director-General, Dr Buckland authorised improvements to the system of funding of elective surgery and to remove the "perverse driver" which placed excessive emphasis on elective surgery to the detriment of elective procedures.

Dr Buckland's Involvement in Relation to the Giblin-North Report

94. Dr Giblin and Dr North were each appointed and each was granted an indemnity on 6 May 2004.[140] Each had an unconditional indemnity and the indemnity given upon their appointment was the indemnity that they relied upon in submitting their report in May 2005.

95. The Giblin-North Report recommended the significant step of ceasing all orthopaedic surgical health care activity in the public sector in the Fraser Coast Health Service District. Dr Buckland did not dismiss this as a possibility and, as he made clear in his evidence, he respected the qualifications of the authors of the report.[141] However, he sought to ascertain the currency and content of the evidence upon which such a recommendation was based.

96. Dr Buckland made the reasonable request to meet with Dr Giblin and Dr North to understand the basis for their recommendations and for access to the documents that were relied upon to prepare the report. Dr Buckland's request was reasonable for three reasons.

97. Firstly, the report said nothing about the fact that some 4 months earlier, Dr Kwon, who was an Australian trained orthopaedic surgeon from Sydney and a member of the AOA, had commenced work in the Hervey Bay Hospital as Director of Surgery.[142] It was unclear to Dr Buckland on the face of the report whether the investigators knew that Dr Kwon had replaced Dr Naidoo or had taken that fact into account when making their recommendation.

98. Secondly, the section of the report which contained the recommendation to cease all orthopaedic services, being the "Patient Care" section, was worded in such a way that

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139 Paragraphs 177 to 188 of Exhibit 336 and issues in relation to elective surgery and funding at paragraphs 189 to 196 of Exhibit 336.

140 Exhibit 316 (also is Attachment SMB65 to Exhibit 336).

141 Exhibit 336 para 243; T.5550-1.

142 This fact is acknowledged by Dr North: T.5175-6 and at T.5183-4 "We weren't asked to investigate in May 2005, we were asked to investigate in July 2004."

it was not clear to Dr Buckland whether the recommendation was based on clinical evidence, such as personal observation of operations and validation of allegations by reference to patient records, rather than concerns expressed during interviews.[143]

99. Thirdly, Dr Buckland had not been given any indication from the doctors or others prior to 6 May 2005 that the orthopaedic service at Fraser Coast was in such a state that it required immediate closure.[144] The recommendation did not come at the end of a long history known by Dr Buckland, but rather almost out of the blue.

100. It was reasonable for Dr Buckland to not immediately act on the recommendation to cease all orthopaedic services until such time as he had a better understanding of the currency and content of the evidence upon which the recommendation was made.

101. As Director-General, Dr Buckland was faced with competing advice. He did not have the advantage of the extensive forensic exploration undertaken by this Commission to ascertain the position as at May 2005.[145] He had the Giblin-North Report recommending that the service cease, a recommendation that appeared to be based on an assumption that the service was unchanged from July 2004.

102. The competing view, and the one articulated by the Chief Health Officer, was that the issues of concern raised by the investigators could be addressed in a different way and that the recommendation to shut down the service had "significant clinical, legal, industrial and community implications".[146]

103. Dr Buckland was advised by Dr Fitzgerald and Dr Scott respectively that the methodology adopted by Dr Giblin and Dr North was "an interview and focus group approach to identify issues of concern"[147] and "not on clinical material, either in terms of cases performed by the doctors under consideration or through personal

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143 The report itself did not make this clear, but parts of it indicated that it was based largely on allegations made during interviews. In addition the Report did not identify the persons who made such allegations, such that Dr Buckland was not aware whether the allegations were made by one person or many and whether they were made by persons with relevant experience and knowledge. See pages 27 and 28 of the report, Exhibit 38: "heard that", "stated that", "reported that", "noted".

144 Para 242(e) of Exhibit 336.

145 The state of the service as at May 2005 was not expressly addressed in the Giblin-North Report, which reported their investigations from an inspection in July 2004.

146 Exhibit 336 para 245, SMB 76.

147 Ibid.

observation of the operative procedures and capacity of the doctors involved".[148] He was also advised that they had "not sought or been in a position to validate any of the concerns and ordinarily such concerns would require a more formalised investigation in which evidence is collected and responded to".[149] The principal issues of concern were said to relate to the management and organization of orthopaedic services at Hervey Bay and the information collected in regard to clinical standards was "circumstantial and not validated at this time".[150] Dr Buckland was advised that it would "not be wise to take such dramatic action without first recourse to attempts to seek alternative solutions to the issues of concerns identified in the report. Indeed any such decision would be challengeable on the ground of failure to take due care to seek alternative solutions".[151]

104. Dr Buckland also received advice from Dr Kwon that:

(a) In the short space of time he had been running the Orthopaedics Department at Hervey Bay Hospital, he had done a large amount of work to address the issues apparently raised in the Giblin-North report;

(b) He was fully supervising Doctors Krishna and Sharma; and

(c) The services being provided were safe and patient safety was not at risk.[152]

105. It was also reasonable that action to cease all services wait until Dr Buckland had had the opportunity to understand the currency and content of the evidence on which the recommendation was based given the apparent lack of urgency demonstrated by the doctors themselves. Some ten months had passed since the doctors had visited the Fraser Coast Health Service District. If the circumstances existing at the Hervey Bay Hospital at July 2004 were such that it warranted Dr Buckland shutting down the service without further investigation or consideration, the doctors might have been expected, at the very least, to have advised QH of their views immediately after their inspection. Because this did not occur, it was therefore reasonable for Dr Buckland to assume that the circumstances were not so dire that he could not first enquire into the currency and content of the evidence behind the report.

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148 Exhibit 336, SMB75.
149 Exhibit 336, SMB76.
150 Ibid.
151 Ibid.
152 Exhibit 336 para 247.

106. Given the report's failure to make any comment about the presence of Dr Kwon and the fact that Dr Naidoo had left, and the advice that Dr Buckland had received from Dr Kwon about the state of the services as at May 2005, it was reasonable for Dr Buckland to question the currency of the Giblin-North findings that:[153]

(a) SMO's at the Hervey Bay Hospital were undertaking procedures that were beyond their competence;

(b) SMO's at the Hervey Bay Hospital were undertaking procedures unsupervised in circumstances where they ought reasonably have been supervised;

(c) the Director of Orthopaedics was difficult to contact when on call, had taken excessive leave and frequently cancelled surgery;

(d) the continued operation of the Hervey Bay orthopaedics unit posed a real risk to patients at that hospital.

107. Dr Buckland had reasonable grounds to suspect that those matters were no longer the case as at May 2005. It was therefore reasonable that Dr Buckland did not take immediate action to close the orthopaedic unit. It was also reasonable for Dr Buckland to assume that patients at the hospital were not at risk. It was also reasonable that Dr Buckland did not immediately restrict the scope of practice of the SMO's at Hervey Bay Hospital for two additional reasons. Firstly, it is not the role of the Director-General to determine the scope of services of individual doctors. Secondly, the report did not recommend that the SMO's in question cease doing particular types of surgery. It only recommended that they be supervised at all times in the operating theatre.[154] Dr Buckland had received advice from Dr Kwon that this was now occurring. Dr Buckland did take immediate steps to have the SMO's skills assessed by the Skills Development Centre.[155]

108. The orthopaedic procedures at Hervey Bay Hospital were immediately ceased on the resignation of Dr Kwon, who resigned on 15 May 2005.[156]

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153 Dr Buckland has never questioned the accuracy of what the doctors reported was said to them in July 2004, but rather whether that state of affairs still existed in May 2005: T.5550-1.

154 See pages 18 and 19 of Exhibit 38.

155 See his memorandum to Dr Scott dated 9 May 2005 (being the Monday following the Friday when Dr Buckland first saw the report): attachment SMB74 to Exhibit 336.

156 Attachment SMB84 to Exhibit 336.

109. The evidence upon which Dr Giblin and Dr North relied is a matter that has been explored at some length before the Commission. In May 2005 Dr Buckland sought to ascertain what that evidence was, since it apparently was based upon interviews and had not been validated by a formal investigation. This is not meant to be critical of Dr Giblin and Dr North. As Dr North's evidence indicated,[157] he expected further investigations[158] since his and Dr Giblin's investigations had been of a limited kind.

110. In the circumstances, Dr Buckland acted reasonably in May 2005 in determining whether to immediately act upon the recommendations of the Giblin-North Report to shut down the service. He was entitled to consider competing views from the CHO and request clarification of the evidence which Giblin-North relied upon in making such significant recommendations, including whether account was taken of changes in the service that had occurred in early 2005 upon the appointment of Dr Kwon.

Classification and reclassification of Emergency Presentations and the 30 July 2003 submission by the Surgical Access Team

111. For reasons to be outlined below, the following submissions are made:

The 30 July submission

(a) The SAT's submission dated 30 July 2003 was seriously flawed. It was the unbalanced and untested product of a desktop analysis. It did not disclose, even in a short summary form, the known hospitals' position that there were good practical reasons why hospitals needed to re-classify patients and that re-classification was permitted by the Business Rules.

(b) Contrary to a standing direction, the SAT failed to consult with zones and hospitals before making the submission, which sought approval for an amendment of the Business Rules on the strength of allegations that several hospitals had deliberately engaged in unauthorised reclassification.

(c) Despite these features of the 30 July submission, Dr Buckland treated the submission with interest, worked through its detail in a meeting with members of the SAT on 15 August 2003 and determined a plan of action based upon its contents.

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157 T.5178 and T.5199.

158 of the kind contemplated by the CHO's Memo to the DG. SMB76 to Exhibit 336 or GF32 to Exhibit 225.

Removal of Reference to the Submission from RecFind

(d) Ms Miller, who with Ms Brennan was responsible for the management of documents in the GMHS' office, had a number of concerns about the submission,[159] and was also concerned that registration of the document on RecFind might cause persons to believe that the information contained in it was authorised and validated.[160] As a result she believed that the document should be removed from RecFind until the information contained in it could be validated by the HSDs and zones.[161]

(e) She instructed Ms Brennan to do this.[162] She believes that Dr Buckland endorsed this instruction, but she has no specific recollection of him doing so.[163]

(f) Ms Miller's instruction, if carried out, did not constitute the disposal of a public record within the meaning of s.13 of the *Public Records Act*, 2002 ("the Act").

(g) There is an insufficient evidence to conclude that Dr Buckland breached s.13 of the Act in permitting Ms Miller to remove reference to the document from RecFind.

(h) Removing reference to the document from the RecFind indexing system would not avoid or defeat disclosure of the document under FOI legislation. The original submission was filed and accessible, and an electronic copy of it remained on the computer network.

The allegation that Dr Buckland directed that hard copies of the Submission held by the SAT be destroyed and that it be removed from the Network

(i) No direction was given by Dr Buckland that hard copies of the submission held by the SAT be destroyed and that the document be removed from the Network.

(j) This allegation depends on the evidence of Dr Cuffe concerning his recollection of a phone conversation with Ms Brennan in late August 2003, and also his recollection of a conversation with Dr Buckland in early 2004.

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159 Exhibit 416 para 15
160 Ibid para 18
161 Ibid
162 Ibid para 21
163 Ibid para 19

(k) The allegation is inconsistent with other evidence that commands acceptance.

(l) The suggestion that Dr Buckland directed the destruction of the 30 July 2003 submission is untenable, improbable in the extreme and unsupported by the weight of the evidence. This includes evidence that the document was kept and filed where it should have been kept and filed. It is also inconsistent with his conduct in August 2003 when he "went into bat" for the SAT on the strength of the submission in their follow up with hospitals, as a result of which further documents were generated by the hospitals in relation to allegations of unauthorised reclassification by them.

The dispute between certain members of the SAT and hospitals over classification and reclassification

112. The funding of Elective Surgery and issues in relation to classification and re-classification are addressed in a recent statement of Mr Zanco dated 4 October 2005.[164] Some of the points made by Mr Zanco are:

(a) It took hospitals quite a number of years after the commencement of the elective surgery program in 1995 to understand the complexity and difficulties associated with the program. They sought guidance and training from the SAT, and especially Mr Zanco, to improve their processes to ensure that they managed the waiting list effectively and were appropriately classifying and receiving funding for which they were entitled.[165]

(b) There are many good practical reasons why hospitals may need to re-classify patients originally admitted with an emergency status to an elective status:

(i) the definition of an elective admission for Commonwealth and QHAPDC reporting requirements does not preclude a patient from being classified as elective because they were admitted through the Emergency Department;

(ii) during the professional indemnity crisis in 2002 and 2003, many elective surgery lists were cancelled and cases that would normally have been performed as elective surgery were being performed as emergency surgery as a means of continuing to treat patients despite the industrial action;

164 Exhibit 462. Mr Zanco was a member of the SAT from July 1998 until January 2005. Before that he was the Manager of Admissions Transfers and Discharge at the RBH.

(iii) patients may be on waiting lists awaiting elective surgery but their condition deteriorates rapidly requiring an emergency admission;

(iv) many minor elective surgery procedures are performed in emergency facilities in regional centres but are not emergency cases;

(v) in hospitals with a high proportion of junior medical staff, the method of safe practice includes junior staff admitting the patients into emergency before review by senior staff and an assessment to schedule the patient for elective surgery;

(vi) if a patient is admitted for a condition unrelated to the reason they are on the elective surgery waiting list, they often have their elective surgery performed while they are in hospital. This may occur due to the inadequacy of support for them at their home, the distance they must travel or because the next available space in the elective surgery list allows them to be treated sooner rather than later;

(vii) in some districts, the Emergency Department acts as a transition lounge or admission portal for patients awaiting elective surgery admission outside normal working hours.[166]

(c) For a significant number of years, some in the SAT have expressed the belief that hospitals have been improperly changing the coding of patient records from emergency to elective surgery to increase their access to elective surgery funding. This belief had been challenged by others in the SAT and others on the ground (eg Medical Superintendents) and was not supported by an independent audit.[167]

(d) The competing view has always been that if hospitals are complying with the Commonwealth and QHAPDC elective surgery definitions, there is nothing improper if the coding for the patient has, at some stage, been re-classified.[168]

113. Mr Zanco also explains that the re-classification argument propounded by some members of the SAT was flawed because it relies on a number of doubtful assumptions, namely:

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165 Exhibit 462 para 22; T.6020.
166 Exhibit 462 para 26.
167 Ibid para 24.
168 Ibid para 25.

(a) that at the commencement of the elective surgery program in 1995/6, hospitals were accurately recording data without the support of better information systems that were introduced years later.[169] It also ignores the fact that hospitals took time to properly understand and apply relevant definitions and that over time SAT provided support and guidance to improve these processes;

(b) that the cost of elective surgery has remained the same since 1995/6;[170]

(c) that data entry errors at hospitals did not occur;[171]

(d) that where elective surgery activity increases, but total surgery does not, it can only be the result of re-classification.[172]

114. The re-classification argument relies upon the flawed assumption that every re-classification does not comply with relevant rules.[173]

115. The re-classification argument propounded by certain members of the SAT was not supported by an independent study undertaken by KPMG in 2002, which identified issues relating to the recording of appropriate admission codes for patients presenting through emergency departments. Unlike the SAT, KPMG reviewed actual clinical files across a sample of hospitals and services within hospitals. It identified a number of patients who were coded as emergency that should have been elective. Its audit highlighted the need for further training and auditing within hospitals. Its conclusion essentially was the opposite of the re-classification argument propounded by some members of the SAT and demonstrated that hospitals were in fact missing out on activity and funding they could claim against the program.[174]

116. As a result, the SAT conducted workshops. The changes in recording practices resulting from these workshops encouraged re-classification. In short, the SAT was encouraging re-classification.[175]

<u>The nature of the 30 July 2003 submission</u>

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169 Ibid para 27.
170 Ibid para 28.
171 Ibid para 29.
172 Ibid para 30. This does not take into account that the mix of services being offered can change in hospitals from year to year, depending on the specialist staff it can attract.
173 Ibid para 31.
174 Ibid para 33.
175 Ibid paras 32 and 34.

117. Viewed against this background, the 30 July 2003 submission prepared by Mr Roberts and cleared by Mr Walker can be said to be seriously flawed. It represented an inadequately researched and blinkered view about re-classification in general. It represented what Dr Cuffe described as an "ideological" point of view.[176] It omitted the position of Mr Zanco about the appropriateness of reclassification, as outlined above, despite stating that he had been consulted in relation to the submission. It also omitted to refer to the fact that the KPMG study was essentially to the opposite effect of the re-classification argument propounded in the submission.

118. It is difficult to accept that the author of the submission, Mr Roberts, or Mr Walker who cleared it, were not aware of the fact that the practice of reclassification by several hospitals, including major hospitals such as the Princess Alexandra Hospital, reflected the kinds of practices outlined by Mr Zanco above, was based upon reasonable interpretation of the then-current business rules[177] and, in the case of many hospitals, had been encouraged by advice to this effect by other members of the SAT. It is very unlikely that Messrs Roberts and Walker did not know the position of other members of the SAT such as Mr Zanco about the legitimacy and appropriateness of reclassification, being the position applied by the hospitals and which had been endorsed in the 2002 KPMG review. Despite this, the 30 July 2003 submission did not:

(a) disclose, even in a short summary form, the hospitals' position that there were good practical reasons why hospitals needed to re-classify patients and that re-classification was permitted by the Business Rules;

(b) consult with zones and hospitals before making the submission to the General Manager Health Services that these hospitals had deliberately engaged in unauthorised reclassification.

119. Although Mr Walker, Mr Roberts and Dr Cuffe sought to deflect these criticisms by stating that the submission was simply about obtaining authority to commence an audit process, and also by focussing upon Nambour Hospital as if it was the only hospital against which allegations of abuse were levelled, the document does not

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176 T.6571.

177 which did not preclude a person who had originally presented for admission at an Emergency Department and who subsequently underwent elective surgery being classified or reclassified as having undergone elective surgery.

support this claim. If the submission had been simply accepted by Dr Buckland and marked by him as "approved", it would have approved the various recommendations made in the submission which included amendment to the Elective Surgery Business Rules to specifically exclude presentations from emergency departments and the approval of financial adjustments to those hospitals shown to be actively re-classifying emergency presentations to elective surgery.[178]

120. The evidence is that there was a standing direction that submissions from the SAT to the GMHS office were to be the subject of consultation with the relevant districts and hospitals and the endorsement of Zonal Managers if the submissions related to funding associated with surgical activity targets and the Business Rules associated with the Elective Surgery Program.[179] The recommendations contained in the 30 July 2003 submission, if approved, would have authorised changes to the Business Rules and also affected the funding of hospitals which were "actively re-classifying". On either basis, the submission should have been the subject of prior consultation in accordance with the standing direction.

121. One possible view is that the authors of the submission did not wish it to be subjected to this process of consultation, preferring to advance their views about reclassification, to make allegations of abuse against several hospitals and, thereby, presumably, to enhance the prospects of having their recommendations approved forthwith by the GMHS. Another view is that the submission, whilst well-intentioned, was unbalanced and the untested product of a desktop analysis.[180] This was the view that Dr Buckland took at the time he received the submission.

Dr Buckland's response to the 30 July 2003 Submission

122. Rather than simply send the 30 July submission back to the SAT on the basis that it was unbalanced and untested and required further work, Dr Buckland met members of

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178 Cuffe (T.6564, T.6570, T.6582), Roberts (T.6438, T.6444-5), Walker (T.6217).

179 Exhibit 426 para 10, T.7108 l.30, 7110 ll.20-25.

180 Although an audit process in relation to certain hospitals, particularly in relation to Nambour Hospital, might have been justified and was, in fact, subsequently approved by Dr Buckland, this does not explain why the authors of the submission did not undertake some simple communications with the hospitals in question or zonal management to obtain at least a preliminary explanation from the hospitals concerning their practices and their justification for reclassification. Perhaps the authors did not do this because they already knew the answer. The alternative is that they abstained from doing so because they did not wish to know the answer. Either way, the submission was unbalanced in its

This footnote is continued on the next page.

the SAT on 15 August 2003. The evidence is that he treated the submission with interest, worked through the detail in relation to the table of hospitals, raised questions in relation to the submission and discussed a plan of action based upon it. Such an approach is inconsistent with someone wishing to bury the document and the issues to which it related.

The filing and retention of the 30 July 2003 submission

123. QH communicated to the Commission the allegation that a direction was received from Dr Buckland that hard copies of the document were to be destroyed and the electronic copy removed from the Queensland Health Network. This allegation, which became a matter of public record on 22 September 2005,[181] was apt to suggest that, if a direction had been given to destroy the document, then the original of the document would have been similarly destroyed. It is unfortunate, to say the least, that before QH conveyed this allegation to the Commission it did not make appropriate investigations concerning the matter. These appear to have post-dated 22 September 2005, whereupon it was established that the submission to the GMHS remained where it might have expected to be found, namely filed in the SAT file in the office of the GMHS.[182] It had not been destroyed. IT analysis also reported that the electronic copy had not been deleted from the Network.[183]

124. The allegation that Dr Buckland, or someone on his behalf, directed that the document be destroyed and that electronic copies of it be removed from the Queensland Health Network will be further addressed below. However, if Dr Buckland wanted the document destroyed, it is odd that he permitted the document to be retained and filed where one would expect it to be. His other conduct was inconsistent with wishing the issue to go away to the extent of directing that the submission be destroyed. He asked the SAT to take up the issue with hospitals. He put his name to letters which "went into bat" for the SAT in their follow up with hospitals.[184] As a result, further

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omission of any reference to the views held by other members of the SAT and the views of hospitals that reclassification was appropriate in certain cases and authorised by the current Business Rules.

181 T.5732.

182 Exhibit 416 para 9

183 See Exhibit 495 paras 21-22, a point acknowledged by Mr Walker when he came to give evidence at T.6197 and T.6222.

184 T.6565 and Exhibit 428.

documents were generated by the hospitals in relation to allegations of unauthorised reclassification by them.

Removal from RecFind

125. Ms Miller says that she recommended that the 30 July submission be removed from RecFind until such time as the information in it could be validated by the HSD's and the zones.[185] Her concern was that a document registered on RecFind is often viewed as authorised and validated.[186]

126. RecFind is an index. It is not a data storage system upon which a document itself is contained.[187] The removal of reference to a document from RecFind did not delete the document from the computer server upon which the document was stored, let alone destroy or dispose of hard or electronic copies of it. Ms Miller's instruction to remove reference to the document from RecFind, if carried out, did not involve destroying or damaging a public record, or part of it, or abandoning, transferring or otherwise disposing of a public record.[188] Ms Miller's instruction, if carried out, did not constitute the disposal of a public record within the meaning of s.13 of the Act.

127. Ms Miller's evidence about what, if anything, Dr Buckland said about removal from RecFind does not involve any recollection of such an instruction, but is based upon a belief about what would have happened.[189]

128. Further, and in the alternative, if Dr Buckland accepted Ms Miller's recommendation that reference to the document be removed from RecFind then it was reasonable for him to act upon her advice about whether the document should be on RecFind until

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185 Exhibit 416 para 18.

186 Ibid.

187 Cuffe (T.6548), Miller (T.6407).

188 See *Public Records Act*, 2002, s.13 and the definition of "disposal" in the Dictionary in Schedule 2 of the Act. Page 8 of the Explanatory Notes states: "For the purposes of this Bill the term 'disposal' refers to the **final** decision concerning the fate of records, including the retention of all or part of a public record, the destruction, deletion, migration or conversion of a public record or part of a public record; or abandoning, transferring, donating or selling a public record or part of a public record" (emphasis added). No final decision was made by Ms Miller, let alone by Dr Buckland, about whether reference to the 30 July 2003 submission would be reinstated on RecFind once there had been consultation with the HSDs and the Zones.

189 Exhibit 416 para 19. This evidence is insufficient to conclude that Dr Buckland gave such an instruction. The evidence is equally consistent with Ms Miller giving the written instruction to Ms Brennan in conformity with her views about whether the submission should be recorded on RecFind, and what she understood to be Dr Buckland's concern that the submission had not been validated by the HSDs and Zones.

such time as the information in it could be validated by HSDs and zones. Dr Buckland relied on others to attend to document management, and he was entitled to accept advice of the kind that Ms Miller says that she gave in relation to the document being registered on RecFind. The practice of removing documents from RecFind[190] was a practice that Dr Buckland was entitled to assume accorded with proper practice and he did not know that it was contrary to any guidelines. Given his limited knowledge at the time about RecFind and document management practices[191], he would have been justified in accepting Ms Miller's advice. In the circumstances, any decision to permit Ms Miller to have reference to the submission removed from RecFind until such time as the information in it could be validated by HSDs and zones, was justifiable on the basis of the advice and information known to him at the time, or should be excused.

129. In the circumstances, there was no contravention by Dr Buckland of s.13 of the Act and it would be inappropriate to refer any alleged conduct by him in permitting reference to the submission to be removed from Recfind for further investigation or prosecution.

130. Any instruction by Ms Miller to remove reference of the document from RecFind, and any permission which Dr Buckland gave to that course, was based upon legitimate and genuine concerns entertained by Ms Miller, rather than some improper motive, and, in all of the circumstances, it would be inappropriate to recommend referral of the matter for further investigation or possible prosecution.

131. Dr Buckland has no specific recollection of the discussions referred to in paragraphs 17 and 18 of Ms Miller's statement.[192] But if those discussions occurred, and if Ms Miller expressed her concern about the reliability of the submission, pending validation by the HSDs and zones, then it was reasonable, in the circumstances, for Dr Buckland to appreciate those concerns. If it be the case that Dr Buckland accepted Ms Miller's advice to have reference to the submission removed from

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190 Exhibit 416 para 20 (Miller); Exhibit 425 para 10 (Brennan)

191 T 7100- 7105. The onerous duties of the GMHS, the volume of material that he was required to process and his reliance on others to attend to document management explains why Dr Buckland was not familiar with practices and guidelines in relation to the use of RecFind.

192 Exhibit 459 para 1.

RecFind until such time as the information in it could be validated by HSDs and zones,[193] then that too was reasonable, given:

(a) the nature of the document and the risk articulated by Ms Miller that its allegations against several hospitals of deliberate abuse of the system by active reclassification might be viewed as authorised and validated;[194]

(b) Dr Buckland's then limited knowledge about RecFind and his reliance on others concerning document management practices.

132. Moreover, removing reference to the document from the RecFind indexing system would not avoid or defeat any application that might be made for it under FOI legislation or other processes for the legitimate disclosure of the document. The evidence is that a request for such a document would have been responded to by various searches and there is no reason to suggest that these searches would not have located the hard copies of the submission or the copies of it which were stored electronically.

133. In summary, the 30 July 2003 submission was at the very least unbalanced and untested, pending consultation with HSDs and zones that should have been undertaken prior to its submission. On one view, it was an attempt to directly lobby the GMHS to authorise changes to the Business Rules. This was apparently the view taken by a meeting of Zonal Managers and Health Services on 27 October 2003.[195] Any decision to remove reference to the document from RecFind pending such time as the information and allegations in it could be validated was based on legitimate concerns held by Ms Miller, and apparently articulated by her to Dr Buckland at the time. Any instruction to remove reference to the document from RecFind did not involve a contravention of s.13 of the Act. Further, if Dr Buckland permitted Ms Miller to give such an instruction, he did not breach the Act. Any such permission was based on advice which was reasonable for him to accept.

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193 As previously noted, Ms Miller's evidence (Exhibit 416 para 19) is to the effect that she believes that such a course was endorsed by Dr Buckland, although she does not have a specific recollection of this occurring. Nor does Dr Buckland, but he does not deny that Ms Miller's instruction may have been endorsed by him: Exhibit 459; T.7106.

194 Pending investigation and consultation with the zones and hospitals, and in circumstances in which the serious allegations against several hospitals had not been properly investigated by even perfunctory inquiries by the SAT into the hospitals' justification for their reclassification practices, it was a reasonable view that the submission's allegation of misconduct by several hospitals should not be given whatever authority might be associated with the submission's registration on RecFind.

The allegation that Dr Buckland directed that hard copies of the Submission be destroyed and that it be removed from the Network

134. This allegation in inherently improbable for the reasons canvassed above.

135. It is also unsupported by the weight of the evidence. The original document was kept, not destroyed.

136. This allegation depends on the evidence of Dr Cuffe concerning his recollection of a phone conversation with Ms Brennan in late August 2003, and also his recollection of a conversation with Dr Buckand in early 2004. For reasons to be developed, Dr Cuffe's recollection is unreliable, and should not be accepted since it is inconsistent with other evidence that commands acceptance.

137. Dr Cuffe does not allege that Dr Buckland gave him the alleged direction.

138. Mr Walker made it clear that Dr Buckland did not direct him to destroy or delete a document.[196] His evidence was hearsay, based upon what Dr Cuffe had told him. Likewise, Mr Roberts says that he has "never heard Steve tell me or mention in my presence that he ordered the removal of that document".[197]

139. Ms Miller's instruction to Ms Brennan, noted on the front of the submission, would have been understood by Ms Brennan to mean that the submission should be removed from RecFind, not that the document itself should be destroyed.[198]

140. Ms Brennan does not recall a direction being given for the document to be destroyed.[199]

141. The evidence is that an order to destroy a document is unprecedented.[200] If Ms Brennan had been asked to destroy all hard and electronic copies of any documents, then presumably she would remember such an exceptional request.

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195 Exhibit 416 para 50.
196 T.6230.
197 T.6434.
198 Exhibit 425 para 10. It is quite possible that Ms Miller's handwritten instruction to Ms Brennan was only written after the meeting on 15 August, 2003, and her statement (Exhibit 416 para 21) is not specific about the point.
199 Ibid para 15.
200 Walker (Exhibit 393 para 10); Cuffe (T.6555); Roberts (Exhibit 417 para 21 and T.6434).

142. Dr Cuffe's recollection of his conversation with Ms Brennan should not be accepted. In light of Ms Brennan's evidence[201], and the improbability that she would not recall such an instruction if one had been given, it seems that Dr Cuffe misunderstood something that was said to him by Ms Brennan.[202]

143. Further, the suggestion that Dr Buckland directed the destruction of the 30 July 2003 submission is untenable, improbable in the extreme and unsupported by the weight of the evidence. The document given to the GMHS was retained, filed in the GMHS office and was the subject of consideration and further action. Dr Buckland went into bat for SAT, based upon the allegations contained in it. Such conduct, which prompted the creation of further documents about the issue of reclassification, is inconsistent with an instruction being issued by Dr Buckland, or by someone on his behalf, that the document be destroyed. The apparent explanation for this misunderstanding is that a direction was given for it to be removed from RecFind. Strong evidence that there was no instruction from Dr Buckland to destroy the document is the fact that the document was kept and filed where it should have been kept and filed.

144. The fact that there was no such instruction by Dr Buckland is supported by the evidence of Ms Miller, and of Ms Brennan. Dr Buckland denied giving any such instruction, and there is no sound reason to reject his evidence.[203]

145. Some very limited support for the proposition that such a direction was given appeared in the witness statements of Mr Walker and Dr Cuffe. However, upon exploration of the issue with Mr Walker in his oral evidence, his position is that the word "destroyed" or "destruct" was not used in the conversation in question, which apparently occurred in early 2004.[204]

146. As to Dr Cuffe, his oral evidence initially was that he did not recall any later conversation with Dr Buckland[205] but later his recollection appeared to improve and

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201 which was received without any request that she be cross examined on her evidence (Exhibit 425 para 15) that she could not recall any such direction being given to her or communicating it to Dr Cuffe.

202 For example, reference by Ms Brennan to the fact that the document had been removed from RecFind may have been misinterpreted by him.

203 T.7112 l.45

204 T.6229-30.

205 T.6556.

he claimed to have a recollection that Dr Buckland stated that "the document that was asked to be destroyed had been seen on the officer's desk, which was the 30th of July submission".[206]

147. Dr Cuffe's evidence in this regard is at odds with the weight of the evidence. His recollection should not be accepted. Dr Cuffe's recollection may be a genuinely-held belief that this was said, but is one based upon reconstruction. The conversation with Dr Buckland apparently happened early in 2004. Several months earlier, hard copies of the 30 July 2003 submission held by the SAT apparently had been destroyed on Dr Cuffe's instructions. A brief conversation between Dr Buckland and Dr Cuffe early in 2004 about an earlier submission on reclassification must have brought to Dr Cuffe's mind the document, copies of which had been destroyed by the Surgical Access Team on Dr Cuffe's instruction. But Dr Buckland did not refer to the document having been destroyed.[207] It had not been, and Dr Buckland did not say that it had. He had no reason to suppose that it had been destroyed. He did not issue an instruction that it be destroyed. Ms Brennan did not receive such an instruction. The process of subconscious reconstruction of conversations long after the event is well-known to the law.[208] Dr Cuffe's recollection is the product of such a reconstruction.

148. Dr Cuffe may have issued a direction to the SAT to destroy their hard copies of the submission because he misunderstood something that was said to him by Ms Brennan. Reference by Ms Brennan to the fact that the document had been removed from RecFind may have been misinterpreted by him. Perhaps he took the view that the

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206 T.6557.

207 T 7113 – 7115; Exhibit 459 para 4.

208 For example McLelland CJ in Eq in *Watson v Foxman* (2000) 49 NSWLR 315 at 318-319 observed:

> "...human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions of self-interest as well as conscious consideration of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which plausible details are then, again often subconsciously, constructed. All this is a matter of ordinary human experience
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> Each element of the cause of action must be proved to the reasonable satisfaction of the court, which means that the court "must feel an actual persuasion of its occurrence or existence". Such satisfaction is "not ... attained or established independently of the nature and consequence of the fact or facts to be proved" including the "seriousness of an allegation made, the inherent unlikelihood of an

This footnote is continued on the next page.

document had been discredited, or at least rebutted by responses from the zones and several hospitals which addressed allegations levelled at them. Those responses provided compelling explanations for their practices in relation to reclassification. By early September 2003, Dr Cuffe must have appreciated that the 30 July submission levelled unbalanced, untested and, in most respects, false allegations of abuse against several hospitals and was based upon an interpretation of the Business Rules which the SAT was unable to defend.[209] It is hard to accept that by then, if not sooner, he was not embarrassed by the document.[210] Although Dr Cuffe denied being embarrassed by the document, when regard is had to the comprehensive responses provided by the hospitals and the zones[211] to allegations of unauthorised reclassification, he surely must have been embarrassed by the fact that he permitted such an unbalanced and untested document to be submitted to the GMHS. Therefore, if Dr Cuffe's evidence about not being embarrassed is not accepted, it is distinctly possible that embarrassment over its contents motivated him to direct staff in the SAS to delete hard copies of the document and to remove the document from the Network.[212]

149. In summary, Dr Cuffe's recollection of the detail of his conversation in early 2004 with Dr Buckland is unreliable. It appears to be the product of reconstruction which attributes to the office of GMHS a direction which was not actually given office. The probability is that Dr Cuffe misinterpreted something that was said to him by Ms Brennan. Perhaps something said about the document being deleted from the system (thereby meaning RecFind) was wrongly taken by him as indicating that he should arrange to have the document withdrawn from possible future circulation. A

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occurrence of a given description, or the gravity of the consequences flowing from a particular finding": *Helton v Allen* (1940) 63 CLR 691 at 712." [emphasis added]

209 Hence its lack of response to two specific written requests by Dr Buckland as to whether the Zones' interpretation of the Business Rules and source of referral codes were correct. Exhibits 384, 397.

210 The submission that by then Dr Cuffe must have been embarrassed by the submission is not inconsistent with the fact that Dr Buckland, at an earlier time, and before the hospitals' responses were available, regarded the submission as inadequately researched rather than embarrassing. T.7110 l.31 – T.7111 l.9.

211 The response from Dr Ashby and Dr Wakefield from the PAH (Exhibit 429 Tab A) is an example. The simple, but persuasive, briefing from the Central Zone Exhibit 384 which Messrs Walker and Roberts were unable to answer is another. See generally: Exhibit 429; Exhibit 416 attachment DFM6; Exhibit 396; Exhibit 419.

212 Notably, recent analysis by QH's IT section (Exhibit 495 paras 21 and 22) is that the electronic copy of the document was never removed from the Network.

further and alternative possibility is that he gave the direction because he was embarrassed by the document, and was keen to limit its further circulation.

150. The allegation that was made by Mr Walker, and which was conveyed to the Commission in September 2005 concerning an alleged direction by Dr Buckland concerning the destruction of hard copies of the 30 July submission and the removal of the document from the computer network, was based upon hearsay.[213] It has subsequently been scrutinised and, it is submitted, is unsupported by reliable evidence. It is at odds with evidence that commands acceptance.

151. The allegation should be rejected and no further action taken in relation to it, since the evidence does not support the conclusion that Dr Buckland issued the direction.[214] The evidence certainly does not support such a conclusion having regard to the degree of satisfaction that would need to be attained to be satisfied that such a serious allegation was made out, and the improbability that Dr Buckland would issue such an instruction.[215]

152. In conclusion, although reference to the 30 July submission apparently was removed from RecFind index upon the written instruction of Ms Miller to Ms Brennan, the submission was not destroyed or disposed of. It was retained and filed where it should have been filed. Electronic copies of it also remained on the Network.[216] The weight of the evidence is that neither Dr Buckland, Ms Miller nor Ms Brennan gave an instruction that hard copies of it held by SAT be destroyed and that electronic copies of it be removed from the Network. Hearsay evidence to the effect that such an instruction was given by Dr Buckland appears to have been based upon a misunderstanding. Dr Buckland's conduct in acting upon the submission, actually going in to bat for the SAT on the strength of it, encouraging communications within QH about the issues raised in it and retaining the submission in its proper place within

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213 namely what Mr Walker was told by Dr Cuffe about what he was supposedly told by Ms Brennan.

214 For completeness, it should be noted that no breach of the *Public Records Act*, 2002 occurred in relation to the submission which was retained and filed where it should have been filed, and an electronic copy of it remained on the QH computer network where it was stored. Any disposal by certain members of the SAT team of their own hard copies was not at Dr Buckland's instigation.

215 The observations quoted above of McClelland CJ concerning the satisfaction that must be attained in respect of a serious allegation which is based upon recollection of a conversation are apposite.

216 Exhibit 495 paras 21 and 22.

QH is inconsistent with the conduct of someone who would want the submission destroyed and discussion of the issues canvassed in it stifled.

Budgets and the focus on financial compliance

153. The Commissioner on 17 October 2005 stated[217] that, although not wanting to go into major systemic issues, he had to deal with the budgets imposed on QH by the government and by QH on the various hospitals, and that this should be borne in mind when making submissions.

154. Dr Buckland has addressed these issues in his second statement.

155. The evidence is that the public health system in Queensland has been substantially under-funded.[218] Decisions about the allocation of this inadequate funding are addressed in paragraphs 82-100 of Dr Buckland's second statement.

156. On any reasonable view the funds allocated to public hospitals by government have been inadequate to provide the services demanded of them, and to adequately remunerate staff.

157. The constraints placed on public hospitals and other sections of the public health system by budgets has been a cause of general disaffection amongst staff and pressure on persons responsible for compliance with budgets.

158. These pressures were compounded by an economic philosophy that QH was "purchasing" services from hospitals, being a philosophy which focused on throughput and revenue rather than outcomes for the patient and the community. QH did not initiate this philosophy, and Dr Buckland specifically criticised it when he applied for the position of Director-General on 29 March 2004. But it seems to have been a philosophy that was championed and entrenched by entities outside QH. As Dr Buckland stated:[219]

> "For QH, like many other organizations, the last decade has been one of financial compliance and the culture surrounding economic rationalism. In making that observation, I am not denying the

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217 T.7098 ll.30-40.

218 Dr Buckland in Exhibit 336 para 77 pointed to the Productivity Commission's Report on Government Services 2005. The matter has been addressed in the Interim and Final reports of Mr Forster's Review.

219 Exhibit 336 para 23.

> importance of financial compliance and the need for accountability in the use of public money. This is a requirement across all government departments and agencies as a matter of proper corporate governance and to meet the requirements of the *Financial Administration and Audit Act* 1977. But the focus on fiscal management has the potential to lead to lazy decision making at a local level. For example, if a doctor had a good idea it could be dismissed with a simple excuse 'There is no money in the budget for it'."

159. In the mid-late 1990's, Funder, Purchaser/Provider Models were introduced and the Performance Management Unit was established. This was part of the philosophy of economic rationalism that has dominated health and other government services during the last decade. Dr Buckland's evidence was that it has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community.[220]

160. Dr Buckland made no secret of his concern about the focus on throughput and budgets.[221] Based on his lengthy experience in running hospitals, and his relatively brief period as GMHS, Dr Buckland hoped to shift QH's focus on fiscal management. In his application to be Director-General, Dr Buckland wrote:[222]

> "Until recently, Queensland Health has focussed heavily on fiscal management. While this approach has been successful in securing the bottom line, it has suppressed the organisation's ability to respond appropriately to the emerging challenges facing the Queensland health system. This has also resulted in a disaffected workforce, a lack of innovative problem solving, strained relationships with other government agencies and a lack of public confidence in the system's capability."

161. The pressure on District Managers such as Mr Leck over the years to meet budgets has been the subject of evidence. Although the scope for even a Director-General of Health to reduce these pressures is limited, given the system of financial administration which QH is required to apply, during his relatively brief time as

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220 Exhibit 336 para 48.

221 This is not to deny the fact that as GMHS, and in accordance with government priorities to achieve targets for elective surgery funding, Dr Buckland urged that surgical throughput be maintained: Exhibits 398, 428 and 348 (the 2003/04 Business Rules, page 10).

222 Exhibit 336 para 35, SMB 15.

Director-General Dr Buckland supported initiatives that were intended to relieve the financial pressure on hospitals.

162. When he became Director-General, it was difficult for Dr Buckland to understand whether District budget overruns were due to growth pressures or management issues. Districts would carry their deficit into the following financial year. This had two significant effects. It reinforced the focus on budgets for District Management and it impeded the financial planning by QH in trying to understand the causes of budgetary difficulties.[223]

163. In the 2004/05 financial year he retired all District debt and funded the "growth in debt" that occurred during 03/04. This was to allow monitoring of District budgets to determine the cause of any pressures, to be able to address those issues in the 05/06 financial year and to better understand the true impact of growth pressures.[224] For example, if a district had a net debt of $5m at 30 June 2004 and that debt had increased from $3m from the previous financial year (that is, an increase of $2m in the 03/04 financial year), the district's debt of $5m was retired as at 30 June 2004 and the district was funded an additional $2m. This was to ensure that all districts would commence the financial year on an equal basis.[225]

164. As previously noted, hospitals were having to subsidise elective surgery from their ordinary funds. As Director-General Dr Buckland implemented changes to the elective surgery funding structure so that it:

(a) reflects today's costs of performing the surgery;[226]

(b) forms a one line item in base funding;

(c) is managed by districts and zones;[227] and

(d) includes medical procedures.[228]

165. The changes addressed the threat to the budget integrity of hospitals of having to provide elective surgery services at prices less than their actual cost. They reduced the complexities associated with the former system under which the SAT controlled

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223 Exhibit 336 para 75.
224 Ibid paras 76.
225 Ibid para 97.
226 Ibid para 191.
227 Ibid para 194.

funding of elective surgery, and overcame the harmful process by which funding to hospitals was turned on and off like a tap, being a process that provided no certainty upon which services could be planned.[229]

166. Dr Buckland's evidence was that attempts to shift the focus of QH away from fiscal management and on to the delivery of patient care encountered resistance.[230] Such organisational changes can be perceived by individuals and groups as being targeted at them, and devaluing the importance of the work they do.[231]

167. But the greater source of resistance is the entrenched culture of economic rationalism and the mind-set that government departments like Queensland Health are in the business of "purchasing" services. As Dr Buckland statement noted[232] this culture is not confined to health. As his application to be Director-General indicates, and as his evidence confirms, [233]it was a culture that he hoped to change with the support of the QH workforce.

168. Dr Buckland accepts that the Commission does not have Terms of Reference to recommend changes to address these broad systemic issues. However, it is impossible to address the circumstances of the QH workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:

(a) the budget constraints on QH in general and on public hospitals in particular; and

(b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.

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228 Ibid para 195.

229 Dr Buckland also worked with Strategic Policy and Finance to develop a 5 year financial forecast to give certainty of funding for new services and to fully cost in the subsequent years the escalating impact of any new initiatives: Exhibit 336 para 74.

230 Ibid para 302.

231 Ibid para 304.

232 Ibid para 303.

233 Ibid.

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28 October 2005

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Attention: Jarrod Cowley-Grimmond

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Level 9
Brisbane Magistrates Court Building
363 George Street
BRISBANE QLD 4000

Dear Sirs

Dr Buckland

We refer to our client's submissions, which were lodged with the Commission and provided to the other parties.

As you will have noted, our client's submissions address a number of topics, including matters that were not the subject of the Commission's notice of possible adverse findings dated 18 October 2005. The topics were addressed in the same order as topics of cross-examination, and also added a section in relation to the issue of budgets.

As an aid to you in identifying the parts of the submissions that respond to the six matters in respect of which our client was invited to make submissions in relation to possible adverse findings, we provide for your assistance the following references.

Topic 1

Addressed in paragraphs 3 to 27. The specific matters mentioned in subparagraphs (i) to (x) are specifically addressed in the following paragraphs:

(i)	paragraph 16
(ii) and (iii)	paragraphs 16, 17 & 18
(iv)	paragraph 18
(v)	paragraph 19
(vi)	paragraph 20
(vii)	paragraph 14
(viii)	paragraph 13
(ix)	not specifically addressed
(x)	paragraphs 21 to 25

Topic 2

These matter is addressed generally in paragraphs 28 to 39.

The matters addressed in subparagraphs (i) to (vi) are more specifically addressed in the following paragraphs:

(i)	paragraphs 28 to 36
(ii) and (iii)	paragraph 36
(iv)	paragraph 37
(v)	paragraph 38
(vi)	paragraph 39

Topic 3

These matters are addressed under in paragraphs 40 to 49.

Topic 4

These matters are addressed in paragraphs 94 to 110.

Topic 5

These matters are addressed generally in paragraphs 111 to 152. The specific matters raised in subparagraphs (i) to (iii) are addressed in the following paragraphs:

(i)	paragraphs 111, 123 to 124, 134 to 152
(ii)	paragraphs 111, 136, 145 to 152
(iii)	paragraphs 111, 125 to 133
(iv)	paragraphs 111 & 151

Topic 6

This topic is addressed in paragraphs 53 to 63.

We trust that this cross-referencing is of assistance to you.

Yours faithfully

Yours faithfully
MINTER ELLISON

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Dear Sirs

Dr Buckland

Pursuant to the direction of Commissioner Davies, we **enclose** further submissions of Dr Buckland.

Yours faithfully
MINTER ELLISON

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enclosure

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS OF DR STEPHEN BUCKLAND IN REPLY TO THE SUBMISSIONS ON BEHALF OF THE QCSA AND DR ARONEY

1. The submissions under reply were provided outside the time directed for submissions by the Commission.[1] This submission is limited to replying to their personal attacks on Dr Buckland and will not address the other matters contained in them.

2. The submissions of the QCSA and Dr Aroney make two accusations against Dr Buckland:

   (a) That Dr Buckland behaved aggressively with the effect of intimidating speakers at a meeting of the Cardiac Society on 15 February 2004;[2] and

   (b) That Dr Buckland had a cavalier disregard for accuracy and transparency in relation to cardiac services at Prince Charles Hospital and used dishonesty as a management tool of choice.[3]

3. Neither matter was put to Dr Buckland on the two occasions he gave evidence. In fact, there was no cross examination of Dr Buckland by any party about these matters or about cardiac services at Prince Charles Hospital.

4. If such serious accusations against Dr Buckland were to be made, then fairness dictated that the allegations and any evidence in support of them should have been put to Dr Buckland. They were not.

5. As to the meeting of the Cardiac Society in February 2004 , the evidence of Dr Scott,[4] as to the conduct of the meeting should be accepted. The evidence, including Dr Aroney's oral evidence, does not bear out the assertions made in his final submissions.

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1 Dated 27 October 2005 and received by Dr Buckland's legal representatives on the morning of Friday 28 October 2005. Despite their timing, they do not appear to be in response to any other submissions, such as the submissions of Dr Scott dated 7 October 2005 (circulated 21/10/05) or his submissions dated 26 October 2005 (circulated 26/10/05) .

2 Paragraphs 8 and 13.

3 Paragraphs 16 to 18. The allegation was made in relation to what *The Courier-Mail* reported Dr Buckland as saying in October 2004.

4 Exhibit 317 para 19.16 to 19.17.

6. As to Dr Buckland's conduct in relation to cardiac services at Prince Charles Hospital, there is no evidence that Dr Buckland acted on the basis of advice and information that he knew to be wrong. Whatever the merits of decisions that were made by QH in relation to cardiac services and their funding[5], there is no basis for the unfair submission that accuses Dr Buckland of dishonesty.[6] The preparedness of Dr Aroney to now accuse Dr Buckland of dishonesty in final submissions does him no credit at all.

7. Finally, other evidence in relation to Dr Buckland and Prince Charles Hospital should be mentioned. Dr McNeil gave evidence about a meeting that Dr Buckland attended at Prince Charles Hospital in 2004. Dr McNeil chaired its Medical Advisory Committee. Its members included Dr Darren Walters., a cardiologist at Prince Charles[7]. Dr McNeil's evidence is that Dr Buckland asked at the meeting what Prince Charles needed in terms of cardiac services. The evidence is that additional funding was given.[8] Dr McNeil gave evidence that the people who attended the meeting appreciated Dr Buckland's presence.[9]

> "You know, that occurred on the background of some acrimony that was occurring around cardiac services and it was great that he could come out and talk to us face-to-face. We really appreciated that."

8. This evidence is inconsistent with the submission advanced on behalf of Dr Aroney that Dr Buckland had some kind of set against Prince Charles Hospital and those who provided cardiac services there. There is no reason to doubt the accuracy of Dr McNeil's evidence. There is good reason to disregard the unfounded and unfair accusations made on Dr Aroney's behalf against Dr Buckland.

DATED 31 October 2005.

.....

P.D.T. Applegarth SC

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5 A matter addressed in statements from Dr Cleary (Exhibit 301) and others who were directly concerned with those matters.

6 Paragraph 18 of the submission under reply states "There are many failings of Scott's and Buckland's period of QH management, but the most profound is the dishonesty which became the management tool of choice".

7 Dr Walters was one of the cardiologists who attended the meeting of the Cardiac Society on 15 February 2004

8 T.4755; Exhibit 301C paras 109-110.

9 T.4755 ll.26-30.