4.

Submissions

Bundaberg Hospital Patient Support Group

Please quote these details in your reply

OUR REF: IJB:SE: BUN247-01

YOUR REF:

DATE: 26 October 2005

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Mr Geoff Davies
Commissioner
Queensland Public Hospitals Commission of Inquiry
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Dear Commissioner

RE: FINAL SUBMISSIONS

Please find enclosed a copy of the **Bundaberg Hospital Patient Support Group** final submissions.

Yours faithfully,
CARTER CAPNER

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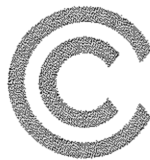
QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BUNDABERG HOSPITAL PATIENT SUPPORT GROUP – FINAL SUBMISSIONS



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EXECUTIVE SUMMARY

(a) The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners, with particular reference to Dr Jayant Patel and persons claiming to be overseas-trained medical practitioners.

1. The Queensland Medical Board failed to discharge its statutory obligations pursuant to the *Medical Practitioners Registration Act*, 2001, to ensure that Patel was both eligible for registration, qualified for registration as a medical practitioner and fit to practice in the profession.

2. Proper investigation of the application should have included careful consideration of all relevant documents, including the Oregon Medical Board "Verification of Licensure" certificate. Had the Medical Board properly investigated the application, the restriction on practice is likely to have been discovered and Patel would not have been registered. In particular, it is difficult to contemplate that Patel would have been registered in circumstances where he had been dishonest on his application to the Queensland Medical Board for registration in the first instance.

(b) (i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel at the Bundaberg Base Hospital.

1. Dr Patel should not have been permitted to conduct surgery, give medical advice or any medical treatment on any patient in Bundaberg (or elsewhere) without having undergone appropriate credentialing and privileging and without having been appropriately qualified. Patel should not have been permitted to supervise, train or otherwise oversee the surgical department or any other medical practitioner without being adequately credentialed and privileged.

2. Dr Patel's surgical skills, clinical judgement and clinical competence were significantly below the standard to be expected of a competent and skilled surgeon.

(b) (ii) The employment of Dr Patel by Queensland Health.

(iii) The appointment of Dr Patel to the Bundaberg Base Hospital.

1. Queensland Health and the Bundaberg Base Hospital failed to adequately investigate Dr Patel's qualifications. The credentialing and privileging procedure was not undertaken. The obligation to "check" Patel's references and qualifications was simply delegated to Wavelength Consulting. The failure to adequately investigate his qualifications resulted in the exposure of patients to a surgeon who lacked appropriate qualifications.

2. Dr Patel should have been supervised after his appointment as a Senior Medical Officer. In the absence of credentialing and privileging, his skills as a surgeon were essentially unknown. Appropriate supervision should have been in place.

3. Patel should never have been appointed to the Director of Surgery position.

4. Dr Patel should have been credentialed and privilege in accordance with the Queensland Health procedures.

(b) (iv) The adequacy of the response by Queensland Health to any complaints received by it concerning Dr Patel.

1. Staff and management at the Bundaberg Base Hospital failed to comply with legislative and policy requirements in respect of the reporting of complaints, adverse events and sentinel events.

2. The complaints system in place at the Bundaberg Base Hospital in April 2003 was inadequate.

3. The conduct of Mr Leck and Dr Keating in respect of the complaints that were made by Toni Hoffman was unsatisfactory.

(b) (v) Whether or not there were any reprisals or threatened reprisals made by any official of Queensland Health against any person who made the complaints referred to in (iv) above.

1. The Bundaberg Hospital Patient Support Group relies upon the submissions made by the Queensland Nurses Union in respect of these matters.

(c) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or persons claiming to be medical practitioners, at the Bundaberg Base Hospital or other Queensland public hospitals raised at the Commission of Inquiry established by a Commissions of Inquiry Order (No. 1) of 2005.

1. The conduct of Dr Gaffield in the case involving Des Bramich was below the standard to be expected of a competent and skilled surgeon.

(d) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above, both:

(i) within the Bundaberg Base Hospital; and

(ii) outside the Bundaberg Base Hospital.

1. The failure by the Bundaberg Base Hospital to adequately deal with complaints made by patients is dealt with under Terms of Reference *(b)(iv)* above.

2. The investigation by Dr Fitzgerald failed to adequately identify and respond to the significant concerns that were being expressed by staff. The lack of credentialing and privileging, the failure to adequately check his qualifications and the failure by the Bundaberg Base

Hospital management to adequately manage the complaints and the conduct of Dr Patel were clearly matters that needed urgent attention.

3. The conduct by the management of the hospital and the hierarch of Queensland Health following the disclosure of these matters reflected a culture of "tolerating problems rather than addressing them"[1].

4. The patients are to be compensated in accordance with the package which is not limited by the Scale of General Damages promulgated pursuant to the *Civil Liability Act*, 2003. This arrangement reflects the unsatisfactory state of the law where persons who suffer serious injury are not fairly and justly compensated under the Civil Liability Scale of General Damages.

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1 Woodruff report, page 44.

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BUNDABERG HOSPITAL PATIENT SUPPORT GROUP – FINAL SUBMISSIONS

History

1. The Bundaberg Hospital is situated within the Bundaberg Health Service District. The hospital provides a wide range of general clinical services and some specialty areas including, but not limited to, renal and breast screen. The facility profile indicates that the hospital has 140 available beds with an occupancy rate of 78.3%. The Bundaberg Hospital is 350 kilometres away from its main referral hospitals of Royal Brisbane and Princess Alexandra Hospitals[2].

Employment of Patel

2. Prior to April 2003, several surgeons had occupied the position of Director of Surgery. The position was vacant from early 2002 and filled temporarily. Patel commenced as Director of Surgery in April 2003 and remained at the hospital until April 2005.

3. The Director of Surgery position at the Bundaberg Base Hospital had previously been occupied by Dr Nankivell. Dr Nankivell resigned the position in January 2002. Dr Sam Baker thereafter acted in the position until he resigned on 30 November, 2002. The position of Director had been advertised on two occasions, closing in September, 2002.

4. Dr Jayasekera applied for the position of Director of Surgery in late 2002. Initially, he was not interested in pursuing the position as he wished to obtain employment closer to Brisbane. Despite that, he was encouraged by Dr Kees Nydam to apply for the position and did so.

5. At this time there were only two applicants for the position. One was Dr Jayasekera. The second was a surgeon from Yugoslavia.

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[2] Woodruff report, page 11.

6. Dr Jayasekera was interviewed by Mr Leck, Dr Nydam and Dr Pitre Anderson. The position was awarded to the Yugoslavian surgeon, despite the fact that he had never practised in Australia. He ultimately rejected the position.

7. Following that rejection, Dr Anderson raised, at a "sub-committee" meeting the issue as to why the position had not been offered to Dr Jayasekera. No response was received from Mr Leck. Dr Jayasekera was not appointed.

8. The position was again re-advertised.

9. Dr Patel applied for the position in late 2002.

10. John Bethell of Wavelength Consulting states that on 14 November, 2002 his firm received a verbal request from Dr Nydam to find and refer a surgeon for the position of Senior Medical Officer at the hospital. Dr Patel contacted Wavelength Consulting. On 13 December, 2002 Bethell sent him some information about Bundaberg and the hospital. He expressed interest in the role and on the same day sent a copy of his CV.

11. Dr Bethell gave evidence in relation to the following matters relating to Patel's original application:-

    11.1 He had a telephone conversation with Dr Patel, and subsequently sent Dr Patel generic information about Bundaberg and the Bundaberg Base Hospital[3];

    11.2 Dr Patel expressed interest in the position, and forwarded his CV to Wavelength;

    11.3 Patel provided Wavelength with a bundle of references with the application[4];

    11.4 Wavelength forwarded Patel's CV to Dr Nydam;

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[3] Paras 7 and 8, Ex 41.
[4] See attachment JHB3 T678-679

11.5 Dr Nydam reviewed the CV, and had discussions with Dr Patel by telephone (Nydam paras 15 and 17.);

11.6 On 20 December 2002 Nydam emailed Wavelength confirming proposal to offer Patel employment at the BBH;

11.7 On 20 December 2002 Bethell contacted Drs Feldman and Singh as referees for Patel. These referee checks were consistent with the written references, although there were signs of problems, in that he had problems dealing with other staff, and "*sometimes took on complex cases handed to him by colleagues. He found it hard to say no.*"[5] Notwithstanding this, Dr Bethell in evidence said that "*it certainly seems ambiguous in retrospect, but at the time the whole feeling of the references was that Dr Patel was a very high quality candidate*".

11.8 On 20 December Dr Bethell emailed Nydam and notes the gap in Patel's employment history in his CV:-

> *"One minor issue of concern that I had was that he has not worked for nearly a year. I am not sure if the QMB might have an issue with this."*[6]

11.9 Dr Patel subsequently forwarded a further version of the CV with an amendment that represented that his employment in Oregon was current. This was the version forwarded to the Medical Board. Dr Bethell did not note the false change in the CV by Dr Patel. He gave evidence that he did not compare the two versions until shortly before he gave evidence to the previous Commission in June this year.[7]

11.10 On 24 December 2002 Dr Nydam forwarded an appointment letter to Wavelength. On 29 December 2002 Patel confirmed his acceptance of the position by email to Wavelength;

11.11 Patel was initially to be employed as an SMO.

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5 Refer attachments KN4 and KN5 to ex.51
6 Ex.43
7 T688. Revised CV submitted to MBQ is Ex.45

Patel's process through the Medical Board

12. On 6 January 2003, Patel completed an application for registration with the Queensland Medical Board (QMB). This was forwarded to Wavelength, along with certified copies and original documents in support of his application.

13. On 17 January 2003, Susie Tawse from Wavelength forwarded to the MBQ the relevant applications and accompanying material for Patel's proposed registration.[8] The letter indicated that the "*certificate of good standing*" was to follow.

14. The provision of a letter of good standing was a mandatory requirement for the Medical Board in its determination. It was the subject of a significant amount of correspondence between Dr Patel, Wavelength and the Medical Board. In particular[9]:-

    14.1 It was referred to in the letter from Wavelength of 17 January 2003 as "to follow";

    14.2 17 January 2003 Dr Patel emailed Susie Tawse from Wavelength to advise that the Oregon Board of Medical Examiners would issue a "*verification letter of good standing*", which he would forward through in the following few days.

    14.3 Susie Tawse from Wavelength faxed Ms McMullen of the Medical Board indicating that the application at that stage "*does not include a letter of good standing*".

    14.4 By letter dated 28 January 2003 Ms Tawse from Wavelength forwarded the document described in that letter as "*certificate of good standing*" to the Medical Board.

    14.5 The document, which was forwarded to the Medical Board, was not in fact a "*certificate of good standing*". It was a document titled "*verification of licensure*".

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[8] Attachment MDG12 to ex.24

15. Ms Tawse, who was an officer with Wavelength was not called to give evidence, nor did she provide a statement. Ms McMullen from the Medical Board was similarly not called to give evidence, nor did she provide a statement.

16. On 19 January 2003, Patel forwarded to Wavelength the Oregon verification of licensure. This contained a reference to "*public order on file. See attached*". The reference to the public order on file, was a reference to restrictions that had been placed upon Dr Patel's practice in the State of Oregon.

17. Dr Nydam completed and submitted the necessary area of need application to Queensland Health to support Dr Patel's appointment[10]. On 11 February 2003, the QMB approved Dr Patel for registration as a senior medical officer (Demy-Geroe para 38).

18. The QMB issued a letter on 12 February 2003 approving Dr Patel for special purpose registration as a senior medical officer. The letter stated that *"Registration is contingent upon you practising as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration."*

19. The Medical Board process had involved a review of Dr Patel's application, and supporting documentation. Dr Patel was interviewed by Dr John Waller on behalf of the QMB.

20. Dr Waller did not give evidence at the previous Commission of Inquiry or at this Commission. He has not provided a statement to the previous Commission or to this Commission.

21. One of the central issues for consideration by this Commission is how Dr Patel came to obtain registration as a senior medical officer, notwithstanding the previous disciplinary action that had been taken

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9 See the bundle of correspondence which is ex.50 - *Wavelength Consulting documents relating to Dr Patel*

10 Nydam para 23.

against him in the State of Oregon, and was a matter of public record in that jurisdiction.

22. Patel deliberately took action to hide the information that would have led to his previous history being revealed. Nevertheless, he could not have succeeded in his attempts were it not for the failure on the part of the Medical Board of Queensland, Wavelength Consulting, to perform the necessary checks of Dr Patel and obtain all appropriate information.

23. It is clear that Patel acted dishonestly in the following ways:-

    23.1 His CV was changed so as to mask the fact that he had not worked for 12 months prior to his appointment to Bundaberg;

    23.2 He failed to disclose to the Medical Board of Queensland the limitations upon his practice imposed by the Oregon Medical Board;

    23.3 The "*public order*" referred to in the verification of licensure was not attached.

24. Wavelength Consulting failed to identify the problems with Patel, notwithstanding the following matters which may have highlighted the problems which later became evident:-

    24.1 Dr Patel changed his CV between the first time he approached Wavelength, and when he later made application to the Medical Board. This change in the CV masked the fact that he had not been employed for 12 months prior to his appointment at Bundaberg. Wavelength was aware that Dr Patel had not been employed in that period of time and this may have been a matter of concern for the Medical Board;[11]

    24.2 The reference checks conducted by Wavelength indicated some level of concern about Dr Patel and his relations with staff. It is acknowledged that, in light of the apparent glowing

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11 Ex 43

references that Dr Patel had attached from late 2001, Wavelength perhaps saw these as relatively minor. Dr Patel had not included any recent written references although Dr Bethell indicated that written references were of use as introductory material only;

24.3 Dr Patel did not have any references from a person who was in a supervisory capacity over him. This again should have been a matter of concern;

24.4 Wavelength failed to identify the reference to the public order on file;

25. The Medical Board of Queensland failed in its obligation to appropriately check Dr Patel's credentials. The Medical Board itself has acknowledged that the failure to discover the disciplinary history of Dr Patel is "*inexcusable*"[12]. The Medical Board did not have a certificate of good standing for Dr Patel, and has acknowledged that the "*verification of licensure*" was known by it not to amount to a clear statement of good standing[13].

26. The review of Dr Patel's application by the Medical Board did not alert it to the reference to "*public order*". The Medical Board had no other formal mechanism for checking on Dr Patel's standing.

27. A personal interview was conducted by the Medical Board with Dr Patel, and his application and accompanying material was reviewed at that interview. The interviewer failed to recognise the problems with Dr Patel's previous registration. The interviewer, Dr Waller, has not given evidence, and so no conclusion can be reached as to whether matters relating to Dr Patel's practice in Oregon were covered in that interview.

12 Paragraph 44, Statement of Demy-Geroe.
13 Paragraph 46, Statement of Demy-Geroe.

Credentialing and Privileging

28. At the time of Dr Patel's employment at the Bundaberg Base Hospital, Queensland Health had in place a policy to ensure that all medical practitioners within Queensland Health would have their credentials and clinical privileges peer reviewed[14].

29. The policy made the following requirements clear:-

    29.1 All medical practitioners within Queensland Health facilities were required to have their credentials and clinical privileges periodically peer reviewed by a credentials and clinical privileges committee;

    29.2 "Credentials" were the formal qualifications, training, experience and clinical competence of medical practitioner;

    29.3 "Clinical privileges" referred to the range and scope of clinical responsibility that a practitioner may exercise. Clinical privileges may relate to areas of clinical practice, use of facilities or specialised equipment, <u>or the performance of specific operations or procedures</u>[15];

    29.4 The district manager is responsible for ensuring that a process is in place within the district to enable peer review of credentials and clinical privileges;

    29.5 The district manager was responsible for ensuring that all medical practitioners within the district had their credentials and clinical privileges periodically reviewed.

30. The guidelines for medical practitioners allow for a mechanism to exist for the granting of temporary privileges for short-term privileges, without recourse to the full committee[16].

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[14] See exhibit 279 *Credentials and Clinical Privileges for Medical Practitioners*, August 2002 and *Credentials and Clinical Privileges Guidelines for Medical Practitioners*, July 2002.

[15] Refer particularly to Glossary, Definitions, References section at page 4 of the Policy and further section 2.3 at page 11 of the Guidelines.

[16] Section 7.3 at page 11of the guidelines.

31. The guidelines allow for the review of clinical privileges. The guidelines provide as follows:

> *"A review of clinical privileges appropriate when there are indicators of clinical competence such as outdated practices, clinical disinterest or poor outcomes"*[17].

32. Patel did not go through any or any adequate process of checking his credentials and clinical privileges.

33. Were the Queensland Health policy to have been followed, Patel's credentials and privileges should have been checked on at least one of the following times:-

    33.1 At the time of his original appointment;

    33.2 At the time of his appointment as Director of Surgery;

    33.3 At the renewal of his contract in April 2004;

    33.4 At any of the times when concerns were raised about the scope of his clinical practice, for example, the appropriateness of Dr Patel performing esophagectomies.

34. The failure to establish a credentials and privileges committee has been attributed to the refusal of the relevant specialist college to nominate a person to sit on that committee. In this regard, it is noted that the policy does not mandate membership from the relevant college. Further, there is evidence that the committee had existed in the past without any membership from the relevant college[18].

Patel is made Director of Surgery

35. When Patel first arrived in Bundaberg the position of Director of Surgery remained vacant. Dr Nydam in his statement states that Patel was along with Dr Gaffield the only two candidates to fill the vacant position. Dr Nydam says that he felt that Patel had the better general surgical experience, and so Patel was offered the position of Acting

[17] Guidelines, pages 11 and 12.
[18] See attachment "SPB3" of Statement of Dr Sam Baker (Exhibit 410).

Director of Surgery immediately upon his arrival[19]. There was no other documentation put before the Commission relating to Patel's appointment as Director of Surgery.

36. There was no correspondence to the Medical Board notwithstanding the original advice from the Medical Board in relation to Dr Patel that "*registration is contingent upon you practising as a senior medical officer*".

The first year – April 2003 – April 2004

37. The first sign that Patel may not have been capable of exercising good clinical judgement was the first oesophagectomy performed on James Phillips, Patient P34, on 19 May, 2003. Mr Phillips was at end-stage renal failure, on dialysis and suffering hyper kalemia[20].

38. On 23 April, 2003, an oesophageal biopsy was undertaken. There was poorly differentiated invasive adenocarcinoma associated with Barrett's oesophagus. There was no evidence of metatarsus. Mr Phillips subsequently died on 21 May, 2003.

39. Soon after the death, Glennis Goodman (former DDON) and Toni Hoffman met with Dr Darren Keating. Ms Hoffman raised three specific issues:

    39.1 Dr Patel had allegedly written that the patient was stable when in fact they were on maximum Inotrope therapy and support;

    39.2 Dr Patel was rude, loud and allegedly did not work collaboratively with the ICU medical and nursing staff; and

    39.3 That the ICU in Bundaberg was Level 1 and as such was not capable of providing the level of care that was required to support such surgery.

40. Dr Keating had no recollection about the issue of whether oesophagectomies should be performed at the Bundaberg Base

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19 Statement of Nydam paragraph 35.
20 Woodruff report, page 124.

Hospital being raised on that occasion. He suggested that she should speak to Dr Patel about the reasons for the comment. Dr Keating perceived that Ms Hoffman was more concerned about interpersonal relations between the ICU nurses and Dr Patel. Follow-up by Dr Keating with Ms Goodman indicated that the discussions had gone well.

41. The Woodruff report suggests that this was an appropriate opportunity for intervention for management. A multi-disciplinary meeting, chaired by the DMS, the Director of Surgery, Director of ICU and the Nurse Unit Manager of ICU in attendance would have been an appropriate forum to discuss the issues and document a decision regarding the surgical capability of the Intensive Care Unit. Communication of such a decision or outcomes for the staff that initially raised concerns would have been appropriate.

42. Moreover, this may also have been an appropriate opportunity to have Patel credentialed and privileged. Two of the issues raised by Hoffman, in particular the capability of the Bundaberg ICU in handling a patient such as Mr Phillips following an oesophagectomy, were matters that related directly to credentialing and privileging issues.[21]

43. A short time prior to 1 June, 2003, Peter Dalgleish lodged a complaint about Dr Patel. He complained that a procedure on his ear to remove a skin lesion was performed on the wrong area of his ear[22].

44. Dr Keating asserts that on receipt of the complaint he proceeded to investigate it. He identified that the lateral margin of a skin cancer had only been removed at the surgery. He discussed the patient with Dr Patel who agreed to review him the following week. He further conversed with the patient on 3 June, 2003 to inform him of the arrangements. A second complaint was received from Mr Dalgleish on 11 June, 2003.

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21 Refer paragraph 34 above.
22 Statement of Dr Keating (Exhibit 448), paragraph 318.

45. Peter Leck became aware of the complaint at that stage. Mr Leck thereafter handled the complaint and further surgery was carried out on 22 July, 2003.

46. On 6 June, 2003 Patient P18 was admitted to the Intensive Care Unit in preparation for an oesophagectomy. Around 5 June, 2003 Dr Joiner, Anaesthetist and Ms Hoffman met with Dr Keating to raise concerns about the proposed admission of P18 on or about 6 June, 2003. Dr Patel had indicated that it was proposed that P18 would undergo an oesophagectomy. The surgery envisaged was as complicated as the first oesophagectomy performed on Patient 34 (Phillips).

47. Ms Hoffman and Dr Joiner place the meeting before the admission of Patient P18. Dr Keating suggests the meeting was after that admission[23]. Either way, Patient P18 was the second oesophagectomy performed by Dr Patel.

48. Following the oesophagectomy on 6 June, 2003 both Dr Joiner and Ms Hoffman questioned whether oesophagectomies should be done in the Bundaberg Hospital. Soon after the surgery, Dr Joiner suggested transfer of the patient to Brisbane, but Dr Patel refused. The issue was referred to Dr Keating. He asked the Acting Director of ICU, Dr Younis, to review the patient. Dr Keating reported that Dr Younis indicated the patient could stay in Bundaberg Hospital. Two days later, the patient was transferred to the Mater Hospital, Brisbane, due to complications.

49. On Dr Carter's return, Dr Keating met with him to discuss the concerns raised by Ms Hoffman. Dr Keating said that Ms Hoffman was concerned that the Bundaberg Hospital ICU should only electively ventilate patients for 24 to 48 hours. Dr Carter indicated that this was flexible and could be extended for 3-5 days depending upon the circumstances.

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[23] Exhibit 307, paragraphs 4-6 – Statement of Dr Joiner; Statement of Ms Hoffman – Exhibit 4, paragraph 13.

50. Dr Keating states that on 1 July, 2003 he received a message from Dr Peter Cook from the Mater Hospital in Brisbane. Dr Cook had telephoned Mr Leck to discuss P18. Dr Keating contacted Dr Cook who advised that P18's course had been very difficult. Dr Cook expresses concern about this type of operation being performed at Bundaberg Hospital in that the operation required robust intensive care back up. Dr Keating indicated that he would discuss his concerns with the Director of Surgery and Anaesthetics and with the credentials and privileging committee at the hospital.

51. After Dr Carter returned from leave, Dr Keating spoke with both Dr Patel and Dr Carter about the issue of patients and extended ventilation in the ICU. Dr Carter suggested that a period of 72 hours was acceptable before considering transfer of the patient. Both Dr Patel and Dr Carter accepted that transfer should occur if it was required. Both of them were of the opinion that oesophagectomies could be performed at the Bundaberg Hospital[24].

52. Dr Carter however adds that at second aspect of his concern was "patient choice". Dr Carter adds that both oesophagectomy patients appeared to be poor choices by Dr Patel.

53. Dr Keating states that after discussions with Dr Patel and Dr Carter, he concluded that it was appropriate to permit Dr Patel to perform oesophagectomies and that Dr Carter had indicated that the ICU was capable of handling these patients post-operatively.

54. This second episode involving Dr Patel and his performance of complex surgery raised two critical issues.

55. The first issue was a serious question of the capabilities of the Bundaberg Hospital to cover the surgeries such as oesophagectomies and Whipples procedures. There were clearly divergent views as to whether Bundaberg Hospital had the relevant capacity. Dr Joiner, Dr Cook and Ms Hoffman believed that the hospital did not have had the

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[24] Exhibit 448, paragraph 55-56.

appropriate capacity. Dr Younis, Dr Carter and Dr Patel considered it did have such a capacity. This was a significant issue that fell squarely within the credentialing and privileging criteria of the hospital.

56. The second significant issue was Dr Patel's judgement in respect of the individual patient. Dr Carter suggested the patients were inappropriate choices for such complex surgery. There was a dispute between Dr Patel and Dr Joiner as to whether Patient P18 should have been transferred. Dr Patel appeared to be performing this surgery without himself considering whether the hospital had the relevant capacity to cope with such surgery.

57. Dr Keating acknowledges he was the "newcomer" to the hospital. So was Dr Patel. As the Woodruff report identifies, a multi-disciplinary meeting to address the concerns raised and decision regarding clinical privileges for Dr Patel in line with the service capability of ICU was clearly called for. Instead, Dr Keating simply chose to accept one view over another in circumstances where he was clearly unqualified to make the decision.

58. On 19 June, 2003 and later in September, 2003, Ms Hoffman again complained about the hospital performing outside its capabilities[25].

59. On 28 October, 2003 Dr Keating received a complaint from Ian Fleming. Dr Keating spoke to Fleming on 30 October, 2003. The version suggested by Mr Fleming should be preferred over that offered by Dr Keating.

60. On 19 June, 2003 and later in September, 2003, Ms Hoffman again complained about the hospital performing outside its capabilities[26].

61. On 28 October, 2003 Dr Keating received a complaint from Ian Fleming. Dr Keating spoke to Fleming on 30 October, 2003

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25 See below and Exhibit 4, TH3 and TH6.
26 See below and Exhibit 4, TH3 and TH6.

62. Dr Keating advised Mr Fleming that he heard that Mr Fleming had lodged a complaint against Dr Patel. Dr Keating stated:

> *"I must tell you that he's a fine surgeon with impeccable credentials and we are lucky to have him here in Bundaberg. I understand you are bleeding internally since the operation, but this can be caused by many factors."*

63. Mr Fleming described four complaints. Those complaints are detailed in his statement and evidence before the Commission. Dr Keating contests that evidence and suggests that the issues as described by Mr Fleming were not discussed. The evidence of Mr Fleming should be preferred over the evidence of Dr Keating.

64. On 21 November, 2003 Patient P198 complained about swelling and bruising of the scrotum following repair of his inguinal hernia. Dr Keating responded to the complaint, providing an explanation, reassurance and offering three options. The options were to attend his local General Practitioner, attend the Emergency Department for immediate review or seek an early review at Dr Patel's outpatient clinic. Dr Keating believes that Mr Dempsey took the last option.

65. Dr Patel was not approached in respect of this complaint.

66. Six days later, on 27 November, 2003, Nurses Gail Alymer and Lyn Pollock complained about wound dehiscence and other complications associated with surgery performed by Dr Patel. Alymer and Pollock were told by Keating that he needed data to support any such complaint.

67. On 6 February, 2004 Dr Keating had been provided with an unsigned and undated complication report through the Director of Nursing, Paddy Martin. Dr Keating replied with the statement "If they want to play with the big boys – bring it on." Dr Keating states that he did not expect those words to be repeated and they were said in the context that if the nursing staff wished to raise these issues, it required data to back-up the concerns. He asked Patty Martin to provide him with that data and expected that it would be provided. He states that he was

not told that there was a 100% complication rate in Dr Patel's performance of this procedure.

68. By February, 2004, Dr Keating had been the recipient of many and diverse complaints about Dr Patel. He was aware that:

    68.1 Nurses and other staff were complaining about Dr Patel's competence and the conduct of surgery;

    68.2 Dr Miach and nurses from the Renal Unit had concerns about the placement of catheters by Patel;

    68.3 Patel had demonstrated, ostensibly, a lack of judgement in patients who he subjected to serious and complicated surgery;

    68.4 There had been serious conflict of opinion about the extent to which Bundaberg Hospital ICU could cope with the serious surgery being undertaken by Dr Patel.

69. On any version of events, these various conflicts could not all be attributed to personality conflicts. It was clear that Dr Patel had significant difficulty in determining the full extent of his own capabilities in particular, his capabilities in conjunction with the hospital capacity. In the words of the Woodruff report:

> "*Given that several senior clinicians had expressed concerns regarding the patient outcome from Dr Patel's surgery, consideration could have been given at this stage to obtaining formal external peer review.*"

70. Dr Patel's contract was about to be renewed for a second term. It was an appropriate time, given the history, to have him credentialed and privileged. This was never done.

The second year – April 2004 – October 2004

71. On 27 February, 2004, Dr Keating received a complaint from Geoffrey Smith. Mr Smith indicated that he was unhappy about Dr Patel using local anaesthetic to remove a lesion on his shoulder. He had requested general anaesthetic for the procedure as he was fearful that local anaesthetic did not work. Although Dr Patel had persuaded him

to have a local anaesthetic, during the procedure it became clear that the local anaesthetic was not working.

72. Mr Smith was clearly unhappy with Dr Patel's attitude towards him throughout this time. Mr Smith subsequently complained to the Health Rights Commission and was referred back to the hospital. Dr Keating met with Mr Smith and was followed-up with a written apology.

73. Dr Keating suggested Dr Patel was counselled about his manner in such situations. Dr Patel's response was to purportedly accept the criticism.

74. Less than ten days later, Vicki Lester wrote to the hospital seeking travel costs for transfer to Rockhampton Hospital.

75. Ms Lester's complaint was summarised in a note from Dr Keating's secretary[27]:

> *"She then stated that she has been to see Dr P. here and he states that there was nothing there. She has since seen her GP and had another x-ray (January 04). Her GP believes that packing is still there, and was sending her to Rockhampton. I spoke to DMS who advised that PTSS won't be funded as there are two surgeons available at Bundaberg."*

76. The effect of the complaint was that Ms Lester had undergone surgery at the hands of Dr Patel and had returned, concerns that packing had been left in her wound. Dr Patel had advised her that there was no packing in the wound. The patient had returned home, but subsequently believed that there was packing present. She attended upon her General Practitioner. Her General Practitioner undertook an x-ray and concluded that there was in fact packing present and that Dr Patel was obviously wrong. Rather than refer Ms Lester back to the Bundaberg Hospital, the General Practitioner appears to have decided to refer Ms Lester to the Rockhampton Hospital.

77. That action, on one interpretation, could be a significant criticism of Dr Patel. Moreover, the conduct by the General Practitioner is indicative

of a lack of faith in Dr Patel as a surgeon. Nothing further was done in respect of the complaint until 2005.

78. In or about March of 2004, Ms Hoffman provided a portion of her complaints to Mr Leck. The extract of the letter appears at TH10. The complaint by Ms Hoffman clearly identifies several significant issues that require urgent consideration. The issues that require consideration relate to matters associated with the credentialing and privileging of Dr Patel.

79. On 2 July, 2004, a complaint was received in respect of Patient 131. She complained that after a normal screening mammogram, she presented to Dr Patel in July, 2003 with an itchy area around her right nipple. He diagnosed eczema and prescribed a steroid cream. The patient did not attend the follow-up appointment in September. She did present to Dr Gaffield in October, 2003 for a review of another unrelated surgical condition. He reviewed the nipple area and recommended review in three months.

80. At the next review by a surgical principal house officer, the complaint had not resolved. Further investigation revealed Padgett's Disease of the breast. The patient demanded a double mastectomy which was performed. Dr Patel was approached about the issue and advised that the error was based upon a normal mammogram. Dr Keating accepted that explanation.

81. On 2 July, 2004 the ASPIC minutes revealed that the wound dehiscence rates were high. Complaints had been made in respect of Dr Patel's surgery and a possible connection to wound dehiscence rates on previous occasions. Gail Alymer had raised this as an issue as early as mid-2003.

82. Again, the Woodruff report suggests these events should have led to an external peer review of the cases and consideration of restriction of the clinical privileges of Dr Patel.

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[27] Exhibit 448, DWK77.

83. On 2 August, 2004 Ms Hoffman reported the death of Des Bramich as a sentinel event. The sentinel event form had been delivered to Mr Leck, Ms Mulligan and Dr Keating. The allegations of the staff against Dr Patel had included delayed transfer, verbal abuse of Ms Bramich in the ICU and grossly inappropriate attempts at pericardial drainage when the patient had been inextremous[28].

84. Mr Bramich was admitted to the Bundaberg Hospital on 25 July 2004 with serious chest injuries, after a caravan which he was doing work on collapsed on top of him.

85. Mr Bramich was initially admitted to the intensive care unit, but after he stabilised was transferred to the surgical ward.

86. Mr Bramich was diagnosed following x-rays of having broken ribs. It is apparent that Mr Bramich also had a fractured sternum, which did not show up on any of the x-rays or CT scans which were taken.[29]

87. On 28 July 2004 Mr Bramich was returned to the ICU after collapsing and reporting pain and difficulty in breathing.

88. It was subsequently revealed that he had severe into the lung, and that the intercostal catheter which had been placed to drain fluid from his lungs had not been working properly. Dr Woodruff has attributed Mr Bramich's death to a failure on behalf of the team to monitor his health appropriately. He notes that, in the absence of a major arterial injury, which was not revealed in the post-mortem, the only explanation for the death was that the drain had not worked.

89. After Mr Bramich was returned to the ICU, there were attempts to arrange a transfer. There were allegations made that Dr Patel had stopped the transfer so that the patient could be treated in Bundaberg. This does not appear to have been supported by the other doctors who were involved at the time, including Dr Carter.

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28 Woodruff report, page 34-35.
29 Refer evidence of Dr Ashbury

90. It appears that by the stage when a transfer to Brisbane was being considered, the patient's condition was too unstable.

91. The death of Mr Bramich precipitated the complaints by Ms Hoffman. There were two forms filled out in relation to aspects surrounding Mr Bramich's death. The first was an adverse event form relating to the failure of the ICC drain. This was filled out on 28 July 2004. It was submitted by Ms Fox, and reported through Ms Hoffman.

92. Some days later, Ms Hoffman filled out a sentinel event form in relation to the death of Mr Bramich. Mr Bramich's death was also reported to the coroner. A significant concern for the Commission should be the role of Dr Gaffield in the treatment of Mr Bramich.

93. Following the concerns expressed at the death of Mr Bramich, appropriate intervention would have been a multi-disciplinary team review of the circumstances. External peer review of Dr Patel was required. The death of Mr Bramich gave rise to serious concerns about clinical care.

94. On 20 August, 2004 a complaint was received in respect of Patient P127. The complaint form was received by DQDSU on 20 August, 2004. The complaint was in respect of wound dehiscence and was referred to the next surgical Errormed meeting.

95. On 8 October, 2004 Linda Parsons complained to Dr Kees Nydam about the conduct of Dr Patel and Dr Boyd. Details of Ms Parson's complaint are contained her statement and evidence.

96. On 11 October, 2004 Terry Bellamy underwent surgery performed by Dr Patel. The surgery was in respect of a right inguinal hernia. Mr Bellamy gave evidence that he saw Dr Patel for an assessment and he booked him in for surgery on the same day. Dr Patel advised him it was a large hernia and would be basic surgery and he should be back at work within two weeks.

97. After the surgery Dr Patel advised that he had severed the right vas. The discharge summary noted that the right vas was accidentally severed. Dr Patel advised Mr Bellamy that he had a 50/50 chance of having children in the future.

98. Mr Bellamy had serious ongoing pain and impairment of movement. He required further surgery on 3 December, 2004 after an ultrasound showed a build-up of fluid. On 9 December, 2004 he required further surgery which involved an incision and drainage to reduce the scrotal haematoma. He was unable to work for four months.

99. On 6 May, 2005 he saw Dr De Lacy at the Mater Hospital in Bundaberg. On 1 June, 2005 Dr De Lacy was able to perform two procedures and remove the mesh that had been placed by Dr Patel. A new mesh was inserted.

100. Dr Keating and others in administration at the Bundaberg Hospital were unaware of this incident.

101. On 20 October, 2004 Ms Hoffman wrote to Mr Leck. Various statements and a copy of her concerns were emailed to Mr Leck on 22 October, 2004[30]. A copy of this email was forwarded to Dr Keating.

102. On 29 October, 2004 a further adverse event was lodged in respect of Dr Patel. Patient P15 underwent a laparoscopic calycectomy. Surgery was performed by Dr Patel on 26 October, 2004 and is generally recognised as being a straightforward procedure. Following the surgery the patient became "tachycardic, sweaty – abdo. distended".

103. Di Jenkin, a respected and experienced nurse, completed an adverse event report form that was delivered to DQDSU on 29 October, 2004. She specifically raised "surgical technique" as being in question.

104. The complaint was referred to the Errormed Committee. This committee was chaired by Dr Patel.

105. On 20 September, 2004, Marilyn Daisy underwent a left below knee amputation. She was quite unwell at the time and this was a lifesaving procedure[31]. The surgery was conducted by Dr Patel and he was primarily responsible for her management. Because she was, however, a patient with Diabetes and therefore a renal patient, there was some confusion as to the responsibility for the patient's management.

106. Dr Jason Jenkins examined Ms Daisy on 1 November, 2004. In correspondence of 2 November, 2004 to Dr Miach he stated:

> *"I was astounded when I discussed with P52 about when did she have her left below knee amputation and I understand she was quite unwell at the time and this was a lifesaving procedure, but this was performed on 20.09.2004, it is now 01.11.2004 and she still has sutures in her amputation stump some six weeks following the procedure. These sutures were heavily buried within the tissue and very difficult and painful to remove. I find it mind boggling that someone could leave sutures in for this long. It either shows a complete lack of understanding of diabetic disease and how to perform an amputation. I also find it strange that a surgeon that does the surgery has not seen the patient since the operation and to monitor the fact that the patient has an area of necrosis in the amputation stump which will require further debridement. Continued saline dressings are not going to heal this lady's amputation stump".*

107. Dr Miach provided a copy of this correspondence to Dr Keating on 8 November, 2004[32]. Dr Keating spoke to Dr Patel and asked him what happened. Dr Patel acknowledged that there had been a heated debate about who was caring for the patient and that the care had been taken over by Dr Miach. He was unsure as to who was responsible for the follow-up.

108. Dr Patel could not explain why the patient had not been followed-up and reviewed earlier. He acknowledged that it should not have happened but also said that the medical team had not sought a surgical follow-up.

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30 Exhibit 4, Statement of Toni Hoffman, paragraph 125.
31 Report of Dr Jason Jenkins, 2 November, 2004, Exhibit 17.
32 Exhibit 448, paragraph 198.

109. The history of this patient again underscored serious concerns about Dr Patel's clinical judgement and his ongoing relationships within the hospital.

Evidence of Ms Hoffman

110. Ms Hoffman first raised concerns about the scope of surgery performed by Dr Patel at the Bundaberg Hospital in June 2003. On 18 June 2003 she emailed the then Director of Nursing, Glennis Goodman, regarding the patient P18 who had had an oesophagectomy performed by Dr Patel. Further, the next day on 19 June 2003 Ms Hoffman emailed Dr Keating and indicated quite clearly her view that this type of operation should not be performed at the Bundaberg Base Hospital. She specifically stated "*I believe we are working outside our scope of practice, for a level one intensive care unit*".[33]

111. Ms Hoffman became aware in around February 2004 of the directive by Dr Miach that his patients were not to be operated on by Dr Patel.[34]

112. In February 2004 Ms Hoffman, who was acting as director of nursing for a period of three weeks had a meeting with the District Manager Mr Leck and gave him a document headed "*ICU Issues with Ventilated Patients*".[35] According to Ms Hoffman this was essentially the same document as that which she gave to Mr Leck in October that year. It quite clearly raised concerns about the appropriateness of conducting complex procedures at the Bundaberg Hospital. Ms Hoffman indicated that she did not want Mr Leck to act on the information. It contained serious allegations however including the following:-

> "*My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.*

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33 The emails by Ms Hoffman re patient P18 (Mr Graves) are attachments TH2 and TH3 to exhibit 4
34 Para 48 of exhibit 4
35 Para 50 and attachment TH10 to exhibit 4

> *A secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital."*

113. Ms Hoffman raised concerns about Dr Patel formally after the death of patient P11 - Mr Bramich. Ms Hoffman completed a sentinel event form. In relation to Mr Bramich Ms Hoffman states (at para 86 and 87) that she attached the earlier document she had prepared about issues with ICU patients to the sentinel event form regarding Mr Bramich.

114. Ms Hoffman asserted that after the death of Mr Bramich, she spoke to Dr Martin Strahan who made inquiries about Dr Patel and concluded that *"there is widespread concern, but no one is willing to stick their neck out yet"*.

115. Ms Hoffman met with Mr Leck and Ms Mulligan on 22 October 2004 and formalised her concerns about Dr Patel. She provided Mr Leck with a copy of the document regarding her concerns with ICU patients.

116. The reporting of the sentinel event about Mr Bramich and the meeting between Ms Hoffman and Mr Leck and Ms Mullian on 22 October 2004 led to separate investigations about the clinical practices of Dr Patel. It appears that it became fairly quickly known around the hospital that there was an investigation going on.

117. Ms Hoffman became somewhat frustrated by the apparent lack of progress of these investigations, and went to the local member of parliament, Mr Messenger MP. It was only following Mr Messenger's intervention that the matters of concern about Dr Patel became public.

Kemps and Patient P26

Patient P21 - Gerard Kemp

118. Mr Kemps was born on 19 September 1933 and died on 21 December 2004 after Dr Patel performed an oesophagectomy.

119. Mr Kemps was first seen by Dr Smalberger in December 2004. Dr Smalberger conducted an endoscopy that revealed a large mass at

the gastro-oesophageal junction[36]. A biopsy revealed that the mass was malignant.

120. Dr Smalberger arranged for CT scans of the patients chest and abdomen. The CT scans revealed that the cancer was metastatic, with evidence of enlarged lymph nodes and lesions on the patient's lung (T1962). See also ex.131, which is the report of the CT scan of Mr Kemps.

121. Dr Clamberer stated the following in his statement (at para 5):-

> *"I was firmly of the view that the patient needed to be transferred to Brisbane. I considered that the best further management of the problem was likely to be a combination of the use of a stent (to keep the oesophagus open) and/or radiation and/or chemotherapy."*

122. Dr Smalberger arranged for one of his junior doctors to refer the patient to the Department of Surgery in order to obtain the necessary support for the patient to be transferred to Brisbane.

123. Dr Smalberger was not consulted any further. He states that he was informed later that Dr Patel had carried out an oesophagectomy and that the patient had died.

124. Dr Deter Berens, an anaesthetist at the Bundaberg Hospital gave evidence about the conduct of the operation on Mr Kemps by Dr Patel.[37] Dr Berens concedes in his statement that, as the anaesthetist, it was not possible to watch how the surgery was going. However he describes that during the operation, there was considerable bleeding and that the patient became unstable at times. At paragraph 17 of his statement, Dr Berens describes that after Dr Patel had completed the resection of the oesophagus, which was the second part of the operation, there was still considerable bleeding. He raised the issue with Dr Patel, however Dr Patel indicated that he did not think that the patient needed to be opened up again. He describes that the patient needed transfusions to keep his blood volume and

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36 Statement of Smallberger paragraph 4.
37 Exhibit 128 and T1935.

blood pressure up, and that it was clear that there was a lot of bleeding.

125. Dr Berens describes that Dr Patel went away and did other operations for a period of approximately 4 hours. Mr Kemps was taken back to theatre, and Dr Patel tried to locate the source of the bleeding. Dr Patel was unable to locate the source of the bleeding, and then concluded that there was nothing more that could be done. He completed the operation and sent the patient back to intensive care, where he died 12 hours later.

126. At paragraphs 22 to 24 of his statement, Dr Berens describes having reported his concerns about the treatment of Mr Kemps to Dr Carter, and subsequently Dr Keating. There was discussion about referring the death to the coroner, however it was decided that it was too late to refer the matter to the coroner by the time Dr Berens and Dr Carter had met with Dr Keating, which was on 23 December 2004.[38] The matter was not referred to the coroner, apparently because of concerns that the funeral was about to be held, or had already been held. According to Dr Berens, Dr Keating gave an assurance at that meeting that Dr Patel would not be doing any more oesophagectomies.[39]

Patient P26

127. This patient was a 15 year old boy who had been seriously injured in a motor cycle accident which occurred on 23 December 2004. He suffered life threatening injuries in the groin area. These involved major vascular injury to the femoral vein and femoral artery.

128. The patient underwent three operative procedures, all of which were performed by Dr Patel in the first 24 hours after he was admitted to hospital. The first was a repair of the femoral vein. The femoral vein was ligated. Dr Patel recorded in the clinical notes that the femoral vein had been repaired.

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[38] T1942
[39] T1956

129. Dr Patel did a further operation to repair the femoral artery. The third operation involved the carrying out of fasciotomies.

130. The patient was not transferred to Brisbane, despite the severity of his injuries, and despite the fact that there was no vascular surgeon available in Bundaberg at the time. (The only vascular surgeon in Bundaberg was Dr Thiele, who was away on holidays). The patient stayed in the Bundaberg Hospital until 1 January 2005 when he was transferred down to Brisbane. By that stage his leg was not salvageable, and he was required to undergo an amputation.

131. There is differing medical opinion as to whether the patient's leg could have been saved had he been transferred earlier. It is submitted that this is not a matter upon which the Commission should make any finding.

132. There appears to be no disagreement that the treatment of the patient was substandard, and in particular, that the patient should have been transferred to Brisbane considerably earlier.

133. The surgery performed by Dr Patel saved the patients life in the first instance. However, it was not a permanent solution, and the patient should have been transferred to Brisbane for specialist vascular surgery. Dr Jenkins describes at paragraph 16 of his statement (which is exhibit 254) that Dr Patel had ligated the femoral vein and the other end of the vein had actually retracted up inside the abdominal cavity and thrombosed. This meant that the blood could not return from the extremities of the limb through the vein.

Contract Renewal and Subsequent Events

134. By 24 December, 2004, Mr Leck had sought assistance from Queensland Health in respect of an investigation into the conduct of Dr Patel. Since the complaint by Toni Hoffman of 22 October, 2004, Dr Keating and Mr Leck had met with Dieter Berens, David Risson and Martin Strahan to discuss complaints about Dr Patel. Serious

concerns were raised in the discussions with those three doctors, although the ultimate conclusions were uncertain.

135. On 5 November, 2004 Mr Leck and Dr Keating meet to discuss an investigation into Dr Patel. Mr Leck considered that it was appropriate to have an external investigation. He subsequently contacted Dr Mark Mattuissi with a view to obtaining appropriate candidates for an investigation.

136. Subsequent investigations during the course of December by Mr Leck led to an arrangement with Dr Gerry Fitzgerald who conducted an investigation into Dr Patel early in the New Year.

137. Following the surgery involving Mr Kemps, Dr Keating offered Dr Patel an extension of his contract from 1 April, 2005 to 31 March, 2009. During the course of that process, he completed form to be delivered to both the Medical Board and the Department of Immigration. These forms indicated that Dr Patel's performance was "better than expected". His emergency skills, procedural skills, teamwork and college were "consistent with his level of experience" and his professional responsibility and teaching was "performance exceptional". Dr Keating made these statements to the relevant authorities, despite the cloud that was looming over the head of Dr Patel at the time. On any version of events, the assertions were simply not correct.

138. In early January, 2005 Dr Keating advises Patel that there are to be no more oesophagectomies performed at the hospital. Further complaints were received from the nurses at that time.

139. By mid-January, 2005 the investigation by Dr Fitzgerald was being organised. On 14 January, 2005 Dr Patel advised that he was not renewing his contract as Director of Surgery.

140. On 20 January, 2005 Dr Keating sought Mr Leck's approval to extend Dr Patel's contract to June/July, 2005. Mr Leck agreed. On 2

February, 2005 Dr Patel was offered the position of temporary full-time Locum, General Surgeon for the period 1 April, 2005 to 31 July, 2005.

141. On 14 and 15 February, 2005 Dr Fitzgerald and Sue Jenkins attended in Bundaberg to undertake their investigations. During the course of that investigation, they were advised that there were no patient complaints against Dr Patel. Dr Keating seeks to explain this omission by stating that he believed Dr Fitzgerald was interested only in "legal claims" not patient complaints. This is clearly inconsistent with the evidence of Dr Fitzgerald.

The Release by Messenger

142. Ms Hoffman gave evidence that, after the announcement by Dr Patel that he had had his contract extended, Ms Hoffman decided to contact Mr Rob Messenger MP, the member for Burnett. Ms Hoffman went to see him on 18 March 2005 and discussed her concerns. She provided Mr Messenger with a copy of the complaint which she had given to Mr Leck in October 2004 headed "*Issues to do with ventilated patients*".[40]

143. Mr Messenger tabled the letter from Ms Hoffman in parliament on 22 March 2005, and further mentioned the matter in parliament on 24 March 2005.

The Meeting of 7 April 2005

144. Mr Nuttall and Mr Buckland attended at the hospital on 7 April 2005 to meet with staff. According to Dr Buckland the purpose of the meeting was "*to fundamentally reassure the staff of [the Minister's] total support for them*".[41] Dr Buckland conceded that "*what came out of that meeting was a very clearly different message and what we found on the ground. I have to say in all honesty when we went in there we did not expect the sort of response that we - that we received, and it*

[40] Paragraphs 160-162, exhibit 4
[41] T5504

was very clear then there was a lot more to that than we had briefed."[42]

145. Dr Buckland conceded that he told the meeting that the audit process conducted by Dr Fitzgerald would be difficult to finalise as natural justice had not been afforded to Dr Patel.

Concerns of other Staff at the Bundaberg Hospital

146. There was widespread knowledge within the hospital about the concerns about Dr Patel's surgical practice. Most particularly, there was widespread concern about the conduct of certain operations at the hospital, and there was knowledge that Dr Miach had refused to allow his patients to be treated by Dr Patel.

147. Dr Miach himself gave evidence about his various concerns about Dr Patel and his surgical competence dating back to at least mid 2003. From early 2004 Dr Miach refused to let Dr Patel treat his patients.

148. Numerous staff gave evidence that they had heard about concerns about Dr Patel's surgical practice, and in particular that Dr Miach had refused to let his patients treat them.

149. Dr Berens in his statement (exhibit 1-8) at paragraph 6 says that he "*had some general misgivings about Dr Patel soon after I commenced working with him. I formed the view that, whilst he was quite efficient in certain procedures, his medical knowledge generally was not up to date.*" Further at paragraph 11 he states as follows:-

> "*I was aware that, right from the beginning of my time at the Bundaberg Base Hospital, ICU staff have not been happy with Dr Patel. This has been well known through the hospital. I became aware at some point in 2004 that Dr Miach would not allow Dr Patel to operate on his patients. He did not tell me directly. I heard it on the "grapevine". I was told by Dr Strahan in early 2005 that Dr Strahan would prefer that Dr Patel did not operate on his patients.*"

42 T5505

150. Dr Strahan gave evidence that he knew in the first half of 2004 about the concerns about Dr Patel's clinical practice. Dr Strahan was aware that Dr Miach did not have a very high opinion of Patel's competence as a surgeon. He was also aware that Dr Miach had given a direction that Dr Patel was not to operate on his patients.[43]

151. Dr Kariyawasam was made aware shortly after he started about the concerns about the high rate of infection and wound dehiscences by Dr Patel.[44] He further stated that he was made aware that Dr Miach was not using Dr Patel for catheter placements, but that he put this down to personality differences between Dr Miach and Dr Patel.[45]

152. Dr Boyd was aware through "*talk in the corridor*" that Dr Miach was refusing to send patients to Dr Patel.[46] He also was aware through "*talk in the corridor*" about the concerns of the ICU about Dr Patel.

153. Dr Carter states that he eventually became concerned about esophagectomies being performed at the hospital after the death of Mr Kemps. He noted that Dr Patel had performed six esophagectomies and five of those patients had died. Dr Carter stated that his review of the literature informed him that 90% of patients should survive at least one year after an esophagectomy.[47]

154. Dr Carter's view remains that Dr Patel was not the worst surgeon which they had had in the hospital.

Training and Support

155. A consistent theme throughout the evidence of staff from the Bundaberg Base Hospital is that the training provided to them in relation to the policies to be observed at the hospital was completely inadequate.

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43 T3279
44 T3109-3110
45 T3110
46 T3878
47 Paragraph 51 of exhibit 265

156. Most tellingly, Dr Keating was provided with no orientation or training when he commenced his employment at the hospital. Dr Keating had no previous experience within the Queensland Health system, and so had presumably little knowledge of the various policies and legislative guidelines that regulate health practice in this State.

157. This experience was consistent with evidence of other witnesses who were previously staff at the hospital.

158. Dr Boyd gave evidence that he had never received any training about the adverse event reporting process.[48]

159. Dr Kariyawasam gave evidence that he received no formal training about referral of matters to the coroner, but relied upon what he had read, and was not able to attend any of the training sessions about adverse event and sentinel event reporting.

160. Dr Anathasiov gave evidence that when he commenced at Bundaberg Hospital he had two mornings of introductory sessions which were general in nature, but could not recall being told about adverse events, sentinel events and the complaints procedure within the hospital.[49]

Adverse Event and Sentinel Event Reporting

161. The Bundaberg Base Hospital had, from at least February 2004, a dedicated and specific policy on reporting of incidents that were of clinical concern. The hospital had a separate unit, the District Quality and Decision Support Unit (DQDSU) which coordinated and recorded the recording of adverse events, and also recorded complaints made to the hospital.

162. The evidence in relation to this policy within the hospital was provided by Leonie Raven[50] and Jennifer Kirby[51].

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48 T3873
49 T2050
50 Exhibit 162
51 Exhibit 169 and Exhibit 170

163. Ms Raven gave evidence about the policy of the Bundaberg Hospital in relation to the reporting and recording of adverse events. In relation to reporting of adverse events, the relevant policy which applied from 1 June 2004 is included as attachment LTR4 to her statement. That policy provided for the reporting of incidents which "*could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage*". The purpose of the policy was to ensure that events which did or could have caused harm to a patient were reported so as to prevent their reoccurrence. The focus of the policy was on continuous learning and improvement, rather than investigation of breaches for this purpose of disciplinary or other action.

164. The procedure for reporting and dealing with adverse events is detailed at page 3 of the policy. It requires reporting of the adverse event by the staff member who was involved or discovered the adverse event. Their report is then forwarded to the DQDSU where it is risk rated and dealt with appropriately. The investigation will recommend any changes to the procedure or further training or counselling which may be required. The Bundaberg Hospital policy on adverse event reporting specifically embraced the concept of "*open disclosure*" to patients.[52] This required the hospital to give the patient and/or their family an explanation of what happened, an outline of steps taken to manage the event, an expression of regret, and information about how to make a formal complaint.

165. The hospital also had a policy on the reporting of sentinel events. This policy was consistent with the policy implemented across Queensland Health throughout the State. The original policy was effective from 1 June 2004.[53] The policy was revised, and the revised policy commenced on 1 November 2004.[54]

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52 See page 4 of the Policy
53 See LTR6
54 See LTR7

166. A "*sentinel event*" is described in the policy as "*an incident in which serious harm resulted to a person receiving health care*". In particular the definition of what is a sentinel event reflected the definition provided by the Australian Council for Safety and Quality in Health Care. It is included at page 2 of the policy.

167. When a sentinel event was identified, there was a requirement for immediate notification to the District Manager, the Director of Medical Services or the Director of Nursing. The procedure required a detailed investigation, referred to as a "*Root Cause Analysis*". Again, the policy required open disclosure with the patient and/or their family.

168. The policy was changed in November 2004. Under the revised policy, the District Manager was required to notify the Director General via the Secretariat, Risk Management Advisory Group immediately of any sentinel event notification report.

Requirements of the *Coroners Act 2003*

169. The *Coroners Act 2003* commenced on 1 December 2003.[55] Part 2 of the *Act* imposes the obligation on reporting deaths. In particular s.7 imposes an obligation upon any person who becomes aware of a death that appears to be a "*reportable death*" to immediately report that death to the state coroner.

170. Section 8 of the *Coroners Act 2003* defines "*reportable death*". Section 8(3)(d) provides that:-

> "*A death is a reportable death if:*
>
> *(d) the death was not reasonably expected to be the outcome of a health procedure.*"

[55] See endnotes to *Coroners Act 2003* s.5, and 2003 SL number 296

Terms of Reference

General

The Patient Support Group does not make any specific submission as to findings and/or charges to be laid against particular individuals. This does not mean we do not encourage the Commission to make such findings. Rather, the Patient Support Group puts its faith in the Commission as an independent and impartial body to deliver justice to the patients and their relatives for the conduct of the particular individuals involved.

(a) **The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners, with particular reference to Dr Jayant Patel and persons claiming to be overseas-trained medical practitioners.**

171. The Queensland Medical Board failed to discharge its statutory obligations pursuant to the *Medical Practitioners Registration Act*, 2001, to ensure that Patel was both eligible for registration, qualified for registration as a medical practitioner and fit to practice in the profession.

171.1 Patel supplied to the Queensland Medical Board a document entitled "Verification of Licensure" Certificate. The document was issued by the Oregon Board of Medical Examiners. The document included only the first page and omitted an attachment.

171.2 But there was clear reference to the attachment in the body of the document. The body of the document indicates that there

was a "*Public order on file. See attached*". The attachment included a passage:

> *"An amended stipulated order was entered on 12 September 2000. The order restricted licensee from performing surgeries involving the pancreas, liver resections and ileoanal reconstructions."*

171.3 Further investigation into Patel's qualifications would have revealed:

171.3.1 The New York State Board for professional medical conduct disciplined Patel in 1984 for entering patient histories and physicals without examining patients, failing to maintain patient records and harassing a patient for co-operating with the New York Board's investigation. The New York State Board for Professional Medical Conduct ordered a six month license suspension with a stay, three years probation and a fine on each charge;

171.3.2 Further, Patel's license to practice in New York was surrendered due to disciplinary action arising from the September, 2000 proceedings in Oregon. The surrender occurred on 10 May, 2001 and by consent his name was struck from the Roster of Physicians in New York State.

172. Proper investigation of Patel's application should have included careful consideration of all relevant documents, including the Oregon Medical Board "Verification of Licensure" certificate. Had the Medical Board properly investigated the application, the restriction on practice is likely to have been discovered and Patel would not have been registered. In particular, it is difficult to contemplate that Patel would have been registered in circumstances where he had been dishonest on his application to the Queensland Medical Board for registration in the first instance.

172.1 The failure by the Medical Board to discharge its statutory obligations in this instance are particularly significant in the context of the Berg history. The Commission heard evidence that a person named Berg, who was registered and practiced at Townsville as a Psychiatrist, was not so qualified. Berg treated patients and prescribed medication.

172.2 The process of Berg through the Queensland Medical Board and the Board's failure to identify his lack of qualifications (and fraudulent application) should have alerted them to the necessity to carefully check the qualifications of persons seeking registration in Queensland.

(b) (i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel at the Bundaberg Base Hospital.

173. Patel should not have been permitted to conduct surgery on, give medical advice or administer medical treatment to any patient in Bundaberg (or elsewhere) without having undergone appropriate credentialing and privileging and without having been appropriately qualified. Patel should not have been permitted to supervise, train or otherwise oversee the surgical department or any other medical practitioner without being adequately credentialed and privileged.

173.1 Wavelength Consulting failed to carry out adequate checks to determine the full extent of Patel's qualifications and any restrictions on his practice. The records from the Oregon Board of Medical Examiners, included by Patel in his application for employment, clearly indicates that there was a "*Public order on file. See attached*". Wavelength Consulting failed to investigate this matter.

173.2 Additional failures by Wavelength Consulting include the failure to notice the alteration in the CV (acknowledged by Wavelength

as a potential concern for the Medical Board) and the failure to adequately screen the referees.[56]

173.3 The Queensland Medical Board, in failing to adequately investigate the application, also failed in its obligations as described in the preceding paragraph.

173.4 Queensland Health and the Bundaberg Hospital, in failing to adequately investigate Patel's qualifications, also failed in their obligations to the patients.

173.5 It is readily conceded that had Patel's qualifications been adequately investigated, and the true nature of his surgical restrictions revealed, he would not have been employed at the Bundaberg Base Hospital. Had that been the case, he would not have been conducting surgery on any patients whatsoever.

173.6 The Bundaberg Base Hospital and the State of Queensland held out Patel as an adequately qualified and competent General Surgeon. Although he may have been capable of performing some surgical procedures, for the most part, there is serious doubt as to his surgical competence.

173.7 No patient in Queensland should have been operated on nor received medical treatment from Patel. Surgical procedures, advice, medical treatment, supervision and training carried out by him were carried out as a direct consequence of the negligence of Wavelength Consulting, the State of Queensland, the Medical Board and the Bundaberg Base Hospital. Any adverse outcome for a patient, whether a patient can prove it was as a consequence of the *negligent* conduct of Patel or simply as a result of his participation in the treatment, occurred as a consequence of the conduct of the abovementioned parties and the placement of Patel at the hospital.

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56 Refer in general paragraph 24 above.

173.8 No patient could have (or would have) consented to surgery or treatment conducted by Patel had they known the true facts. The risk of an adverse outcome with a practitioner such as Patel must have been significantly higher than the risk a patient would ordinarily face with a reasonably competent and skilled practitioner. The responsibility for any adverse outcome rests with Queensland Health, the Queensland Medical Board, the Bundaberg Base Hospital and Wavelength Consulting as a consequence of the negligent conduct.

173.9 The Patient Support Group does not seek specific findings from the Commission in respect of individual cases. Such findings would require the Commission to descend to detail in circumstances where the medical evidence may not have been fairly tested by reason of access to information by the various medical practitioners and/or the availability of evidence at the particular time that a witness was before the Commission.

173.10 Moreover, the Commission should recognise in a broad way that many patients suffered significantly adverse outcomes as a consequence of the surgical treatment, advice, medical treatment and supervision of Patel. These adverse outcomes would simply have been avoided had Patel not been employed, registered to practise and appointed to the Bundaberg Base Hospital.[57]

173.11 The specific findings in respect of individual patients are recorded in the evidence of Dr's O'Loughlin, Woodruff, De Lacy and Allsopp.

174. Patel's surgical skills, clinical judgement and clinical competence were significantly below the standard to be expected of a competent and skilled surgeon.

57 See *Chappel v. Hart* (1998) 195 CLR 232.

174.1 The evidence of Dr De Lacy and Dr Woodruff demonstrates that the surgery conducted by Patel was significantly below the standard expected of a competent and skilled surgeon.

174.2 The appointment of Patel, without supervision, placed him in a position whereby the quality of his surgical and clinical skills was difficult to assess. Moreover, the appointment of him as Director of Surgery placed him in a position where he was free to exercise his skills recklessly.

(b) (ii) The employment of Dr Patel by Queensland Health.

(iii) The appointment of Dr Patel to the Bundaberg Base Hospital.

175. Queensland Health and the Bundaberg Base Hospital failed to adequately investigate Patel's qualifications. The credentialing and privileging procedure was not undertaken. The obligation to "check" Patel's references and qualifications was simply delegated to Wavelength Consulting. The failure to adequately investigate his qualifications resulted in the exposure of patients to a practitioner who lacked appropriate qualifications. This consequence can be attributed to cumulative failures by Wavelength Consulting, the Queensland Medical Board, Queensland Health and the Bundaberg Base Hospital.

175.1 Queensland Health and the Bundaberg Base Hospital were prepared to rely on the Medical Board and Wavelength Consulting for the assessment of Patel's credentials. Although reliance, to some extent, was reasonable, the ultimate responsibility must rest with Queensland Health and the Bundaberg Base Hospital for employing Patel in these circumstances.

175.2 Patel should not have been appointed as Senior Medical Officer without supervision.

175.3 Despite the fact that, on the face of it, Patel was an experienced and competent surgeon, it was inappropriate to appoint him to a regional hospital without supervision as a Senior Medical Officer or as Director of Surgery.

175.4 Both Patel and Dr Gaffield's practical skills were unknown. Both should have been subjected to a period of supervision prior to ultimate appointment.

176. Patel should have been supervised after his appointment as a Senior Medical Officer. In the absence of credentialing and privileging, his skills and capacity as a practitioner were essentially unknown. Appropriate supervision should have been in place.

176.1 Patel was appointed as a Senior Medical Officer. His qualifications and his skill as a surgeon and clinician, irrespective of his experience, were relatively unknown.

176.2 In Bundaberg, Patel was exposed to a wide and diverse range of circumstances. As Director of Surgery, he had significant access to patients and was ostensibly entitled to perform complicated procedures and administer and supervise complex medical treatment.

176.3 Patel should have been carefully supervised at all times at the Bundaberg Hospital until such time as an appropriately qualified surgeon was satisfied that he had the skills to continue to operate.

177. Patel should never have been appointed to the Director of Surgery position.

177.1 Patel was appointed to the Director of Surgery position within days of arriving at the Bundaberg Base Hospital. Various explanations have been given as to why that appointment was made. Dr Nydam stated that he considered that it was largely

an "administrative" position. Mr Leck agreed with this assessment.

177.2 Both of these statements ignore the reality that the Director of Surgery had significant administrative control, supervisory responsibility and clinical roles within the hospital. The training and supervision of the junior staff and his position at the "Errormed" meetings meant that he played a pivotal role in the assessment of his own mistakes.

177.3 Moreover, this dismantling of the Otago audit system by Patel was a good example of the significant impact he might have on the clinical auditing and processes at the hospital. The suggestion that his role as Director of Surgery was essentially "administrative" also ignores the fact that he had a significant supervisory role *and was not supervised himself.*

177.4 In November, 2002 the District Manager had, in Dr Jayasekera, a qualified, credentialed and college approved surgeon to take on the position of Director of Surgery. Irrespective of whether he intended to take the position as a permanent place, he should have been appointed to the position.

178. Patel should have been credentialed and privilege in accordance with the Queensland Health procedures.

178.1 The credentialing and privileging procedures at the Bundaberg Base Hospital fell into disarray during the course of 2002. The major concern was the lack of available college representatives to assist in the credentialing and privileging process.[58]

178.2 The net result was that practitioners were undertaking medical procedures without adequate credentialing and privileging. As described in the body of this submission, there were several points during the course of Patel's tenure where he should have

58 Refer to paragraph 34 above.

been credentialed and privileged. The failure to do so was a fundamental error on behalf of the management of the Bundaberg Base Hospital.

178.3 Moreover, Mr Leck was ultimately responsible for credentialing and privileging Patel. As each complaint evolved, particularly those of Ms Hoffman in early 2004, the *only* step that Mr Leck could take (beyond suspension or refusing contract renewal) for Patel was to credential and privilege him. The issues raised by Ms Hoffman were precisely the issues that credentialing and privileging would address: the relevant skills of the doctor in question and the capacity of the hospital to deal with relevant surgical procedures.

178.4 The credentialing and privileging of Patel is likely to have significantly restricted his ability to perform certain surgery.

(b) (iv) The adequacy of the response by Queensland Health to any complaints received by it concerning Dr Patel.

179. Staff and management at the Bundaberg Base Hospital failed to comply with legislative and policy requirements in respect of the reporting of complaints, adverse events and sentinel events.

179.1 There was a failure to adequately deal with the sentinel events. This is exemplified in the cases of Bramich, Kemps and Phillips. There was also a failure to report those deaths in accordance with the obligations under the *Coroner's Act*. None of the deaths of the patients mentioned could have been said to have been "reasonably expected to be the outcome of a health procedure". Each of the deaths should have been reported to the Coroner.

179.2 The reporting system for adverse events was clearly inadequate. For example, Patient 15. The adverse event was reported by Di Jenkin to Dr Keating. Thereafter, Dr Keating referred the matter to the Erromed Committee, chaired by

Patel. Patel regularly sat as Chairperson on meetings that judged or assessed his own conduct.

179.3 Moreover, many adverse events and complaints were simply dealt with on an *ad hoc* basis by Dr Keating and not systematically recorded or collated. Although this has now been remedied to some extent, the reality was that at the time that Dr Fitzgerald came to carry out his audit, the main repository for the complaints relating to Patel was Dr Keating. His failure to disclose the patient complaints meant that Dr Fitzgerald was not aware of them.

180. The complaints, adverse events and sentinel events reporting systems in place at the Bundaberg Base Hospital in April 2003 were inadequate.

180.1 The systems in place at the Bundaberg Base Hospital in April 2003 did not adequately track and lodge complaints.

180.2 The complaints system included a system to monitor complaints by staff (incident reports) and to monitor complaints by the public.

180.3 The complaints and adverse events system as currently in place is adequate, provided that complaints are adequately monitored, tracked and taken seriously.

181. The conduct of Mr Leck and Dr Keating in respect of complaints made by staff and patients was unsatisfactory.

181.1 Ms Hoffman complained on several occasions in respect of various matters related to Dr Patel. Parallel complaints were also being made by other nurses in the Renal Unit and by other doctors.

181.2 An obvious response to the complaint was to have an external review at an early stage. The Woodruff report identifies this as

a sensible and adequate response. Despite the many opportunities that should have been taken to have such a review, Dr Keating and Mr Leck continued to ignore these complaints.

181.3 Had the complaints been taken seriously, it is likely that Patel would have been significantly restrained in the conduct of surgery.

(b) (v) Whether or not there were any reprisals or threatened reprisals made by any official of Queensland Health against any person who made the complaints referred to in (iv) above.

182. The Bundaberg Hospital Patient Support Group relies upon the submissions made by the Queensland Nurses Union in respect of these matters.

(c) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or persons claiming to be medical practitioners, at the Bundaberg Base Hospital or other Queensland public hospitals raised at the Commission of Inquiry established by a Commissions of Inquiry Order (No. 1) of 2005.

(d) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above, both:

(i) within the Bundaberg Base Hospital; and

(ii) outside the Bundaberg Base Hospital.

183. The failure by the Bundaberg Base Hospital to adequately deal with complaints made by patients is dealt with under Terms of Reference *(b)(iv)* above.

184. The investigation by Dr Fitzgerald failed to adequately identify and respond to the significant concerns that were being expressed by staff. The lack of credentialing and privileging, the failure to adequately check his qualifications and the failure by the Bundaberg Base Hospital management to adequately manage the complaints and the conduct of Patel were clearly matters that needed urgent attention.

185. The conduct by the management of the hospital and the hierarchy of Queensland Health following the disclosure of these matters reflected a culture of "tolerating problems rather than addressing them"[59].

    185.1 Following the disclosure to Mr Messenger of the correspondence from Toni Hoffman in March of 2005, the major focus of the hospital was not the serious allegations against Dr Patel, but the leaking of information. This simply served to further polarise the views in respect of Dr Patel rather than give serious consideration to investigating his qualifications and surgical competence.

    185.2 Thereafter, the conduct by Mr Buckland, Mr Nuttall and hospital administration at the meeting of 7 April, 2005 was to further polarise staff and send a clear message that these complaints were not to be investigated and dealt with appropriately, but rather to be simply brushed aside. This approach would not encourage other persons to come forward in the future and make complaints about conduct that they considered to be seriously detrimental to patients.

186. The patients are to be compensated in accordance with the package which is not limited by the Scale of General Damages promulgated pursuant to the *Civil Liability Act*, 2003. This arrangement reflects the unsatisfactory state of the law where persons who suffer serious injury are not fairly and justly compensated under the Civil Liability Scale of General Damages.

59 Woodruff report, page 44.

186.1 The Civil Liability Scale of General Damages was promulgated by the *Civil Liability Act*, 2003. The Scale of General Damages significantly limits the entitlement of injured persons to claim damages for pain and suffering and loss of amenities and other heads of damage.

186.2 In cases involving medical negligence, where an injury may be of a relatively transient nature, but nonetheless be very significant and painful, are very poorly compensated under the Civil Liability Scale of General Damages.

186.3 The State of Queensland indirectly recognises, by acknowledging that the Scale of General Damages should not apply to these claims, that the Scale of General Damages is fundamentally unfair and unjust. The Scale of General Damages and other restrictions on the right to recover damages imposed by the *Civil Liability Act*, 2003, should be abolished.

DATED this 26th day of October 2005

CARTER CAPNER

Solicitors for the Bundaberg Hospital Patient Support Group