Part C- AS TO THE SURGICAL PROCEDURES PERFORMED AT BUNDABERG BASE HOSPITAL and HERVEY BAY HOSPITAL REFERRED TO IN THE TERMS OF REFERENCE, AND AS TO THE PROCEDURES PERFORMED AT HERVEY BAY HOSPITAL

(b)(i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel or other medical practitioners at Bundaberg Base Hospital (BBH) or other Queensland public hospital

The Medical Board of Queensland has as one of its principal responsibilities the maintenance of standards of clinical practice in the medical profession. Where a medical practitioner has a case to answer on allegations of "*unsatisfactory professional conduct*", the Board has the legislative responsibility for instituting such proceedings in the Health Practitioners Tribunal or a Professional Conduct Review Panel.[1]

Unsatisfactory professional conduct is defined in the Schedule to the *Health Practitioners (Professional Standards) Act 1999* (Qld) to include:

> "*(a) professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers;*
>
> *(b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practise of the registrant's profession;*
>
> *(c) infamous conduct in a professional respect;*
>
> *(d) misconduct in a professional respect;*
>
> *(e) conduct discreditable to the registrant's profession;*
>
> *(f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person's wellbeing;*
>
> *(g) influencing, or attempting to influence, the conduct of another registrant in a way that may compromise patient care;*

[1] See s126 *Health Practitioners (Professional Standards) Act 1999* (Qld)

(h) fraudulent or dishonest behaviour in the practise of the registrant's profession;

(i) other improper or unethical conduct."

Under the Terms of Reference of this Inquiry,[2] the Commissioner is required to recommend disciplinary action in relation to medical practitioners, where appropriate, arising out of complaints received about clinical practice. The purpose of this part of the submissions is to collate the evidence relating to a large number of surgical procedures performed by Dr Jayant Patel and other practitioners at Bundaberg Hospital and elsewhere, which may constitute grounds for such action.

As a matter of practicality, there will be a range of serious surgical cases in which there is evidence of serious shortcomings in Dr Patel's professional practice. There will inevitably be other surgical cases showing less serious shortcomings which may give rise to possible disciplinary action. These submissions intend to attempt to differentiate between these classes of cases in terms of the recommendations the Commission might make. The Board's resources are necessarily limited and should be directed as efficiently as possible to achieving its legislative obligations. Accordingly, once successful disciplinary action is taken against a person in the position of Dr Patel, as a matter of practicality, other cases calling for possible disciplinary action or further investigation might ultimately not proceed down that path.

1. Surgical Procedures already under investigation by the Medical Board of Queensland and the subject of evidence at the Inquiry:

On 12 July 2005, the Board resolved to investigate four cases which had already been the subject of a considerable amount of evidence at the hearings of Inquiry No 1 of 2005.

1.1 Desmond Bramich (P11)

[2] Terms of Reference as amended 23rd September 2005-*2(e)(iii)*

Mr Bramich was a fifty-six year old man injured as a result of a caravan dislodging from its blocks and crushing him trapping him for ten minutes. His death was the pivotal point at which Sr Hoffman complained about Dr Patel.

Mr Bramich was admitted initially to the BBH emergency department on 25 July 2004 under Dr Gaffield's care at which time, and under his supervision, a drain was inserted into Mr Bramich's chest. A right flail chest with multiple rib fractures was diagnosed, but despite an x-ray a fractured sternum was not diagnosed at that time.

It is common ground that Mr Bramich progressed well after his initial treatment and on 26 July was transferred from intensive care to the surgery ward.

On 27 July he underwent physiotherapy late that morning which involved walking for approximately 15 metres. At approximately 1.00 p.m. that day he collapsed and was observed to be in a great deal of pain. Dr Boyd, then Dr Gaffield were called to assist him and he was immediately transferred to the intensive care unit ("ICU"). After that time and for approximately another 12 hours aggressive attempts to stabilise the patient (including resuscitation) were undertaken by number of clinicians. Dr Gaffield noted:

> *"unfortunately over the following 6 hours the patient continued his progressive unstable status and ultimately expired approximately 12 hours after the event on the ward."*[3]

Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement[4] and in her oral evidence[5]. The concerns emerged from her chronology as follows:

1. that Mr Bramich was the patient of another doctor namely, Dr Gaffield and Dr Patel assumed his care[6];

[3] DWK 42 – Statement Dr Keating DWK-42, Exhibit 448
[4] See [86] and following, TH 18-20
[5] Also see T137-140 and T140-148
[6] See T139.

2. that after a transfer had been arranged to Princess Alexandra Hospital in Brisbane Dr Patel interfered by ceasing the retrieval order[7];
3. that Dr Patel expressed the view that this was a matter that could be dealt with in Bundaberg as it was a "*simple thing as fractured ribs*"[8];
4. the patient was dyspnoeic, diaphoretic, blood pressure was fluctuating, in extreme pain, and in and out of consciousness;
5. Dr Younis attempted to resuscitate the patient assisted by a more junior practitioner namely Dr Boyd and other nursing staff;
6. Dr Patel dealt with a routine colonoscopy of another patient[9];
7. Dr Carter accompanied the patient for a CT scan;
8. Dr Gaffield noted that the patient had 3,000 mls of blood in his chest and that he did need to go to Brisbane. He re-activated the Royal Flying Doctor Service;
9. Dr Patel returned to the patient and commented that he was too ill to travel to Brisbane;
10. That Dr Patel performed a pericardiocentesis to extract fluid from around the heart. This was contraindicated from the ultrasound. He did so with a needle and stabbed around the patient's heart 50 times[10];
11. That Dr Patel was rude to the point of abusiveness to the patient's family
12. That her sentinel event form raising concerns about the patient had been downgraded by Dr Keating .[11]

Dr Carter at the request of Dr Keating investigated the care of the patient and prepared a case report. The areas of concern isolated by Dr Carter were as follows:

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[7] T140.
[8] T139.
[9] T140, T142.
[10] T141.
[11] This was incorrect- see evidence of Raven

1. *The delay in the arrival of the retrieval team. The request logged at 16:20, dispatched at 19:30 and arrived at 23:00;*
2. *Lack of co-ordination of care, two surgical teams involved. Mixed messages being conveyed to the family over the advisability of transferring the patient;*
3. *Pericardiocentesis being performed without any indication (see CT and PM report);*
4. *Lack of radiology support (CT not reported until 30 August 2004).*

Of the issues which emerged from the balance of the evidence and which involve other clinicians:

1. The inadequate/blocked drainage;
2. The physiotherapy administered to the patient;
3. The failure to transfer the patient earlier.

Inadequate/Blocked Drainage

The adverse event form[12] reported by Nurse Fox, in ICU, said:

> *"ICC drain, no water in underwater seal section".*

The shift supervisor noted:

> *"...awareness of need for H_2O in underwater sealed drainage ,unsure of who set up unit."*

The chart indicates that the underwater drain was not checked after 10.30 am that day, although the physiotherapy note indicates it was operational at 11.20 a.m.

Dr Gaffield said in evidence that the drain had appeared to work properly earlier in the surgical ward, but clearly after inserting the second drain, the resultant increased blood flow indicated it had been inadequate.

[12] Statement of L Raven Exhibit 162-annexure 9

Dr Gaffield could not say when the water would have been absent from the drain.[13]

Dr Younis said that the tube became blocked. He did not comment as to the situation of the water level, when the patient "*got haemopneumothorax and started deteriorating critically*"[14]. He placed these events at about 1300 hours.[15]

Dr Carter corroborated this: "*the right sided intercostal drain was noted to be non-functional at this time*"[16] - being the time when he was moved to ICU.

Dr Woodruff in reviewing the chart noted that the complaint from the patient that he was in pain and that blood was around the drain were indicative of a blocked underwater seal drain. Dr Woodruff stated that allowing the drains to remain in a blocked state whilst three litres of blood pooled in Mr Bramich's chest caused his death.[17]

As noted at the autopsy, there was a large amount of blood collected in the chest cavity.

This failure, Dr Woodruff commented, could not be attributed –

> "*to one solitary individual. There's Dr Patel in charge of the case, Dr Gaffield, who the patient was admitted under; there's the charge nurse; there's a whole succession of members of the team that should be working collaboratively together to ensure that an oversight such as this doesn't happen.*"[18]

The inadequate drainage could be concluded as a team failure.

Physiotherapy

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[13] T4603
[14] T3792
[15] T3792
[16] Dr Carter's report – DWK43 – D. Keating.
[17] T4280-4281
[18] T4339

Dr Ashby queried whether the physiotherapy administered to Mr Bramich may have been too vigorous for his condition particularly, given his as then undiagnosed fractured sternum. Dr Gaffield rejected this as an outmoded view of treatment.[19]

Failure to Transfer

Dr Ashby's evidence was that for Mr Bramich's optimal care he should have been transported to Brisbane once it was apparent he was stable, that is, by 26th July. Dr Gaffield, as the clinician responsible, rejected that contention. He stated that the patient would not have been accepted for transfer in Brisbane when he was stable on 26th July given the extent of the identified injuries. Once the patient deteriorated on 27th July, he was always too unstable to have been transported to Brisbane.[20]

> "*Q: In your opinion, was there any realistic prospect at any time from 2.30 p.m. of transferring Mr Bramich?*
>
> A: *Not safely*".[21]

Dr Gaffield expanded by referring to the logistical difficulties involved in transferring to and from airports and treating the patient within the confines of an aircraft. Dr Gaffield expressed the opinion that the patient would not have survived.[22]

Delay in the arrival of the retrieval team

Approximately 4 – 5 hours into the treatment of the patient, Dr Gaffield noted:

> "*acute event, the option of transferring the patient to a tertiary centre in Brisbane was entertained. This option was initially voiced by anaesthesia and nursing staff. The thoracic service was contacted in Brisbane for additional advice regarding management of the severe blunt thoracic trauma.*"[23]

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[19] Cf evidence of Dr Ashby at T2709-2710 with that of Dr Gaffield at T4579
[20] T4579
[21] T4603 and DWK 42 Statement D. Keating.
[22] T4603
[23] Report of Dr Gaffield DWK42 – statement Dr Keating

Dr Younis placed the initial discussion as to transfer from about 2-2.30pm before Dr Gaffield left for theatre.[24] However the RWBH note has a telephone call logged at that time but as addressed later no request for transfer.

It was **Dr Carter's** decision, according to his report of the incident, to arrange for the patient to be transferred to a tertiary centre in Brisbane, which had the capacity to provide thoracic surgery, long-term ventilatory support and blood bank.

To that end, a flight co-ordinator was contacted at 1620 to arrange a retrieval flight.

Dr Smith, a consultant emergency physician at the Royal Women's Hospital, in her statement[25] said that at 4.20 p.m. Dr Brazil, another emergency physician, received a telephone call from Dr Carter, a doctor at Bundaberg Base Hospital. Dr Smith said that she understood that there was a discussion in relation to Mr Bramich. There was no request for retrieval at that stage. (That accords with Dr Gaffield's statement referred to previously.)

At 1600 -1700 hours Dr Carter accompanied the patient for a CT scan to asses the risk of transfer-it seems common ground that this was a time when the patient was the most stable.[26]

At approximately 6.45 pm Dr Smith was contacted by **Dr Boyd** of Bundaberg Base Hospital and requested to arrange for the transfer of Mr Bramich to the PA Hospital. She did so and arranged for **Dr Jackie Butler**, a registrar from the RBWH to meet the Royal Flying Doctor Service at Brisbane Airport.

Normally there is a lead time of between 2-3 hours of bed confirmation in Brisbane and the retrieval team arriving in Bundaberg.

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[24] T3793
[25] Statement of Dr Sharon Smith, Exhibit 423
[26] T3804-5

According to the clinical coordination form, Dr Butler left the RBWH at approximately 7.30 pm to meet the RFDS plane at Brisbane Airport - the flight arrived in Bundaberg at 2300 hours.

Sr Hoffman's evidence[27] identifies that the delay was as a result of interference by Dr Patel.

Dr Younis is the only other witness to corroborate Sr Hoffman's version. He gave evidence that Patel did slow the transfer of the patient. He felt there was "*resistance from Dr Patel*". This was at approximately 1900 hours when he performed the pericardentesis. He felt Dr Patel's attitude was one of:

> "*BBH must keep the patient at all costs and questioned what would or could be done in Brisbane*".[28]

The evidence of Drs Carter and Boyd (the latter being present during almost the entirety of Mr Bramich's care in the intensive care unit), negated any suggestion of Dr Patel interfering with the retrieval team.

The effect of their evidence was that it was to be arranged, surgeon-to-surgeon, and that a delay had occurred in attempting to arrange a bed in Brisbane for Mr Bramich i.e. between the hours of 2.30 p.m. and 4.30 p.m. Dr Carter's evidence was that Patel did not become involved in the patient's care until after 4.00 p.m.

Of particular note, Dr Smith records –

> "*I also do not recall being contacted by anyone at Bundaberg Base Hospital or otherwise, and being asked to defer or cancel the retrieval. If this had occurred, it would ordinarily be documented on the clinical coordination form.*"

It must be borne in mind that Sr Hoffman ceased duty at 7.30 p.m. Though Dr Younis appears to support an allegation based on hearsay, Dr Smith's evidence about the records of the RWBH is support for the proposition that any intervention by Patel did not actually delay an evacuation. No other staff

[27] Statement [94] and, T148.
[28] DWK44 – telephone call Dr Younis, 27 September 2004

member supports Hoffman or Younis. Her allegation of delay is not supported by any of the other witnesses other than Dr Younis. Dr Smith, refreshing her memory from the records of the RWBH, is objectively well placed to comment.

The lack of co-ordination of care

The evidence of Drs Boyd, Carter and Younis is that approximately from 4.30 p.m. until 6.00 p.m. Dr Patel was involved in surgery[29] thus he was not involved in Mr Bramich's care at that time.

At Dr Gaffield's invitation Dr Patel became involved in the patient's care due to his greater experience. During that time Dr Gaffield was involved in other surgical treatments. It is apparent from the evidence that the intersection of two different surgical teams created difficulties with the care of Mr Bramich, particularly as the family were given conflicting information. Dr Carter's contemporaneous report supports this view.

Pericardiocentesis being performed

On the evidence of Dr Carter and Dr Younis there was not sufficient fluid around Mr Bramich's heart. This was borne out by the diagnostic ultrasound and autopsy. Dr Carter allows that out of an abundance of caution, given Mr Bramich's condition, it was appropriate to have carried out that procedure, in the hope that it may have alleviated the situation. No other witness supported Hoffman's account that Dr Patel stabbed the witness 50 times. This could only be hearsay.

Whilst it is clear that Dr Patel applied ten or more stabbing motions, no eye witness saw 50 motions, as stated (as hearsay) by Hoffman.[30] Nonetheless, other witnesses are critical of the technique employed by Dr Patel in carrying out the procedure. Dr Younis agreed with the proposition that 3-4 attempts would have been sufficient.[31]

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[29] but it was not routine
[30] No other witness corroborates Hoffman's hearsay version
[31] T3798-in answer to a question by the former Commissioner

Dr Ashby, the pathologist, gave evidence that whilst it did not assist Mr Bramich it caused no particular harm. It may have caused him discomfort whilst not altering his condition. Dr Carter concurred.

Dr Younis agreed and expanded indicating that in fact it may cause a pericardial tamponade[32] - it was not a "benign procedure".

Conclusion

The events of 27 July emerge as a confused picture of a patient suddenly deteriorating and *in extremis*. The issues identified by Dr Carter are pertinent.

Patel: The major criticism of Patel is that he interfered in the transfer, but other than Ms Hoffman and Dr Younis there emerges no evidence that Patel did so and it is negated by the evidence of Dr Smith and others. On the evidence of Dr Gaffield, Mr Bramich in any event was too ill to transfer on 27 July once he had deteriorated and prior to then, would not have been evacuated.

Dr Patel's performance of the pericardiocentesis was sub-optimal on all the evidence and may constitute an issue to refer for disciplinary action 'conduct of a lesser standard'.

Other clinicians

The issue which is of greatest significance is the blocked and/or inadequate drainage. It is submitted that Dr Woodruff's evidence is important on this issue. Given that the time period prior to this discovery is unclear there is insufficient evidence that the drainage failure can be sheeted home to Dr Patel over other staff. No referral for disciplinary investigation of any individual is justified. It was a team failure.

1.2 Una Connors (P14)

[32] T3799

Mrs Una Connors, a 74 year old woman, was admitted to the Bundaberg Base Hospital on 29 March 2004. She underwent a sigmoid colectomy (with Dr Patel as the Surgeon) on that same date. Mrs Connors' left ovary was also removed during that operation.

On 8 April 2004 Mrs Connors was discharged, only to be readmitted later that same day for wound dehiscence, which was repaired by Dr Gaffield.

Mrs Connors suffered a heart attack and had a difficult, "stormy" post operative recovery. She was later diagnosed to have ovarian cancer and referred to a gynaecological oncologist at the Royal Brisbane Hospital. Mrs Connors was not a suitable candidate for further operative treatment to remove gynaecological organs given her condition and recent heart attack.

Dr Barry O'Loughlin provided a Statement to the Commission which detailed a number of concerns in relation to the care given to Mrs Connors. These were:

1. Inadequate assessment of the patient;
2. Mrs Connors was not seen by a gynaecologist prior to the operation despite the advice of the gastroenterologist to the patient's GP;
3. There were indications that this was not simply sigmoid cancer and that the patient may have had ovarian cancer;
4. Wound dehiscence;
5. Sub-optimal treatment;
6. A post operative heart attack meant that she was not a candidate for the optimal treatment for ovarian cancer.[33]

The primary issues for concern are the appropriateness of operating without adequately assessing the patient's condition and the competence of the treatment provided to the patient.

[33] Statement of Dr Barry O'Loughlin, Exhibit 173A [39]

Appropriateness of operating without adequate assessment of the patient's condition

Ms Hoffman's evidence was that Mrs Connors should have had a CT scan to eliminate the risk of cancer as this may have led to a different form of treatment being offered other than surgery.[34] (It is clear that CT-Scans were ordered prior to surgery and on that issue Hoffman is incorrect.)

Dr Barry O'Loughlin stated that the CT-Scan indicated that this was not simply sigmoid cancer.[35] The results of the CT-Scan, dated 23 March 2004 were enigmatic. Upon examination on 22 March, there existed a large pelvic mass which was in contact with the uterus and possibly arose from either the uterus or large bowel but "*the exact origin of this mass is uncertain.*" Dr O'Loughlin gave evidence that in his opinion Mrs Connors was not adequately assessed prior to the operation and that her options were not properly considered before the sigmoid colectomy was performed.[36]

Post-operative developments and wound dehiscence

Dr O'Loughlin could not exclude a link between the operation and Mrs Connors' heart attack, stating that as the wound was not healing properly there may have been "*systemic changes which contributed to the heart attack.*"[37] It is clear that the resulting heart attack was one of the primary reasons Mrs Connors was not considered suitable for further operations in relation to treatment for ovarian cancer.[38] Dr O'Loughlin believed that had Mrs Connors been adequately assessed she would have been in a position to be treated with the optimal procedure for ovarian cancer.[39]

Dr Woodruff categorised the treatment of Mrs Connors as one in which Dr Patel contributed to an adverse outcome.[40] It was his evidence that "*there is*

[34] T101-102
[35] Statement of Dr Barry O'Loughlin, [32]
[36] T3965-3966
[37] T3966
[38] Letter from Dr Garrett, Fellow in Gynaecological Oncology Royal Brisbane Hospital and Royal Women's Hospital to Dr G Pratt Visiting Radiation Oncologist Bundaberg Base Hospital dated 8 December 2004
[39] Statement of Dr Barry O'Loughlin, [39].
[40] Woodruff Report, p121

sufficient indication of inadequate technique in the development of a wound dehiscence in itself."[41] Dr O'Loughlin too emphasised that the operation was not performed appropriately given the later wound dehiscence.[42]

Conclusion

The treatment of Mrs Connors does warrant further investigation with a view to disciplinary action by the Board. It seems likely that Dr Patel did not adequately assess Mrs Connors prior to operating and that he performed the operation at a less than satisfactory standard given the post operative difficulties faced by the patient. Furthermore, by conducting the surgery he denied Mrs Connors' future optimal care. She could not have further surgical intervention to remove her gynaecological organs followed by chemotherapy which would be the optimal treatment for ovarian cancer.

1.3 James Grave (P18)

Mr Grave was a 63 year old man who had a history which included hypertension, diabetes mellitus and ischaemic heart disease with an acute myocardial infarct in 1996.

On 6 June 2003 Mr Grave underwent a scheduled oesophagectomy for adeno-carcinoma of the gastro-oesophageal junction. The oesophagectomy report of 6 June 2003 reveals *"oesophageal/gastro-oesophageal junction mass mobile and palpable. Surrounding lymph nodes palpable, oesophageal wall and lesser curve of stomach."*[43] The histology report of that date noted that there were 9 of 14 metastatic lymph nodes and stated that macroscopically there were numerous enlarged involved lymph nodes identified at the gastro-oesophageal junction at the lesser curve and greater curve.

Mr Grave suffered vocal cord paralysis, respiratory failure post operatively, the development of myocardial infarction and peritonitis. Mr Grave returned three

[41] T4304
[42] T3966
[43] Chart – p. 57

times to the operating theatre due to wound dehiscence on 12 June and 16 June 2003 requiring suturing and on 18 June 2003 leakage from the jejunostomy site was oversewn in the operating theatre.

This was the second oesphagectomy performed by Dr Patel which had required a prolonged ICU stay. Dr Joiner raised concerns with Dr Keating as to whether this type of surgery should be performed in Bundaberg and whether the patient should be transferred to Brisbane.

Dr Younis, in Dr Carter's absence, reviewed the patient and advised that he would remain in ICU in Bundaberg.[44], after the third operation. Subsequently there was a delay in locating an ICU bed in Brisbane, necessitating a fourth operation in Bundaberg.[45]

The patient was transferred to the Mater Public Hospital on 20 June 2003 because of further complications. He was ultimately discharged home on 18 August 2003.

Mr Grave died on 8 January 2004.

Dr Woodruff's opinion was that Dr Patel contributed significantly to the adverse outcome. He referred to "*the litany of events there that contributed to his protracted post-operative course*"[46] and referred to the issues as outlined above as constituting the complications Mr Grave suffered as a result of his initial surgery by Dr Patel in Bundaberg. Although not attributing his death to the initial surgery and the subsequent re-admission for the complications Dr Woodruff is of the view that they all contributed to a deterioration of his condition.[47]

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[44] Upon Dr Carter's return, issues as to Bundaberg Hospital's ICU capacity to ventilate patients was addressed – see Review of Clinical Services – Woodruff Matuissi et al p. 33.
[45] T3786-Dr Younis
[46] T4366
[47] T4366

In essence, his weakened condition reduced his ability to be able to effectively deal with the cancer. Dr Woodruff noted his review had ceased on 18 August and his death was some three months later. Given that there had been a mestases identified from the original histopathology from the first operative procedure Dr Woodruff conceded that the procedure had hastened rather than necessarily contributed to his demise.[48]

That Dr Patel had the initial decision to operate. The CT scan had identified pre-operatively the disseminated disease. This would constitute a further error of judgment in recommending this operation.[49] The chart reveals that as late as 26 May a CT scan indicated an enlarged lymph node. The histopathology of 21 May said "*invasive adenocarcinoma*".[50] Furthermore, given his complications as outlined above:

> "Q: *So this is a litany of surgical ineptitude. Is it probably the worst example you've found in this audit of that degree of ineptitude?*
> *A:... It's .. yes ... it's as bad as any I believe."*[51]

He opined that Dr Patel contributed significantly to the adverse outcome.

The issues raised in the treatment of Mr Grave by Dr Patel include whether Dr Patel operated outside his scope of expertise and by virtue of the lack of skill used in the first and subsequent operations and the capacity of the Bundaberg Base Hospital to care for such patients.

These factors warrant a referral for disciplinary action.

1.4 P26

On 23 December 2004, P26 was a fifteen year old male who was involved in a motorcycle accident on a property near Woodgate. P26 hit a tree stump

[48] T4367
[49] T4366-4367
[50] Pages 59, 89-90.
[51] T4295

and sustained a severe laceration to his left groin, a laceration to his femoral vein and massive blood loss. P26 was resuscitated at the scene and airlifted from Woodgate to Bundaberg Base Hospital. Dr Stephen Rashford, who was the Director of Clinical Co-ordination and Patient Retrieval Services at the time, said that P26 required urgent surgical treatment to stop his bleeding and "*would not have survived to fly anywhere*" other than Bundaberg.[52]

He arrived at Bundaberg Base Hospital in a critical condition. Dr Risson, who saw P26 when he arrived at Bundaberg Base Hospital, described the patient as peripherally shut down and hypotensive and with extensive bleeding from the left groin.[53] P26 was immediately transferred to the operating theatre where Dr Patel performed a femoral vein repair and debridement and closure of the wound, P26 also received a blood transfusion. It is common ground among medical witnesses that this initial surgery was life saving.[54]

He was transferred to the Intensive Care Unit and intubated post-operatively. Within approximately 3 hours he was returned to the operating theatre for left leg compartment syndrome with a pulseless leg and upper and lower fasciotomies were performed. This was performed by Dr Patel. He was then returned to ICU.

Later that evening, approximately 4 hours later, he returned for the third time that day to the operating theatre with acute lower extremity ischaemia despite the thigh and leg fasciotomies. P26 had expiration and an arteriotomy with a bypass with gortex. He had good posterior tibial pulse at the end of that procedure. This surgery again was performed by Dr Patel. It was during this third occasion other medical staff apparently observed an injury to the femoral artery.

P26 was under Dr Patel's care until the morning of 26 December 2004. From that time he was under the care of Dr Gaffield.

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[52] Dr Stephen Rashford T2910
[53] Referral letter from Dr Risson to Dr Mark Ray dated 1 January 2005, exhibit 208
[54] Dr Carter T4075; Statement of Dr Jason Jenkins [22], exhibit 254 and T3697; and Statement of Dr Mark Ray [17], exhibit 257 and T3765;

Over the ensuing week the patient was placed in the surgical ward in Bundaberg and the rate of his deterioration over that time is the subject of controversy.

On or about 1 January 2005 contact was made with the Royal Brisbane Hospital in relation to transferring the patient in view of his deteriorating condition. P26 was transferred to the Royal Brisbane Hospital on 1 January 2005. Dr Ray described P26's condition on his arrival at the Royal Brisbane Hospital as follows:

> *"I could literally smell him when I entered the Emergency Department....He was in the resuscitation bay and he was lying on a trolley and was just really unable to converse with me effectively because he was profoundly sick, in a lot of pain, and very septic, and he had fairly- he was fairly floridly septic. He had a pulse that was racing and a temperature that was very high..."*[55]

P26 was taken to theatre where the fasciotomies were extended and the femoral vein repaired again. Dr Jason Jenkins then performed a through knee amputation the next day.

Dr Mark Ray stated:

> *"The first problem then is that P26 should have been moved to Brisbane after the initial operation. The second problem was that the second and third operations performed in Bundaberg were not performed well. The fasciotomies were inadequate and the "repair" to the femoral vein did not restore it's continuity. Moreover, the use of the prosthetic material was not in accordance with good practice.... The third problem was the delay in failing to move P26 from Bundaberg to Brisbane and the failure to recognise that this boy was very sick. The thing that disturbed me was that P26 had been seen by the consultant surgeon in Bundaberg earlier on the day that I saw him. The consultant had, notwithstanding the boy's temperature, stopped the antibiotics and ascribed his temperature to his venous line."*[56]

Some issues for concern raised by the treatment provided to P26 while at the Bundaberg Base Hospital include:

1. The decision not to transfer P26 until 1 January 2005;

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[55] Dr Mark Ray T3762
[56] Statement of Dr Ray [18]-[19], exhibit 257

2. Whether the fasciotomies were adequate;

3. The circumstances involving ligation of the femoral vein; and

4. The use of prosthetic material in the third operation.

1. *Failure to transfer P26 prior to 1 January 2005*

There is no doubt that P26 could not have been transferred to Brisbane before his first operation. Nor can it be doubted that that operation saved P26's life

A number of witnesses did raise concerns as to the failure to transfer P26 by or around the time of the third operation, or at the latest some time prior to 1 January 2005.

Dr Risson stated in evidence to the Commission that he believed that the patient should have been transferred to Brisbane "as soon as the patient was stabilised and there was no other life threatening injuries"[57] This view is shared by **Dr Kariyawasam**, who agreed in his oral evidence that in hindsight P26 should have been transferred as soon as he was stable following the initial surgery.[58]

The mother of P26 stated that she witnessed Dr Patel discussing whether P26 should be transferred to Brisbane with several other doctors prior to the third operation.[59] The mother of P26 apparently wanted her son transferred to Brisbane at that point but was told by one of the doctors that "*by the time they organised the plane from Brisbane it would take six hours and it would be too long by the time my son got to Brisbane. They decided to take him back to theatre.*"[60]

Dr Athanasiov apparently raised the possibility of transferring P26 to Brisbane with Dr Patel on 23 December 2004. It was his evidence that Dr

[57] Dr Risson T2815
[58] Dr Kariyawasam T3099
[59] Statement of the Mother of P26 [18]-[19], exhibit 137
[60] Statement of the Mother of P26 [20], exhibit 137

Patel thought that there was no reason to transfer P26 as there was little more that could be done at that point.[61]

Martin Brennan, a nurse in Intensive Care, also stated that Dr Athanasiov was considering transferring P26 and that he was later told by Dr Athanasiov that Dr Patel thought P26 should remain at Bundaberg.[62] Similarly nurse **Damien Gaddes** stated that Dr Athanasiov considered transferring P26 to Brisbane.[63] **Dr Boyd** also recalled the issue of transferring P26 being raised with Dr Patel but agreed that Dr Patel stated that there was no need to transfer.[64]

In relation to the week during which Dr Patel was on leave and Dr Gaffield had taken over the care of P26, Dr Boyd admitted that P26 should have in hindsight been transferred to Brisbane. Dr Boyd felt, however, that Dr Patel and Dr Gaffield had "*done everything that could be done....I didn't push the issue any further.*"[65]

Dr Risson gave evidence that a number of doctors and nurses had raised concerns about the appearance of P26's foot and the possible absence of a pulse.[66]

Dianne Jenkin, for example, stated that she "*was horrified at the state of his injuries*" and said to another nurse "*words to the effect of 'this boy's leg looks dreadful.*"[67] Her evidence is however untested at time of writing.

Viability of the leg

As to whether P26's leg could have been saved if he had been transferred, Dr Jenkins opines:

- "*I believe that if P26 had been transferred to Brisbane as soon as he had stopped bleeding, there is a significantly higher probability he would still have his leg*".[68]

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[61] Dr Athanasiov T2071
[62] Martin Brennan T2165
[63] Damien Gaddes T2133
[64] Dr Boyd T3851
[65] Dr Boyd T3850
[66] Dr Risson T2818-2819
[67] Statement of Diane Jenkins [19]-[20], exhibit 494

Dr Jenkins in oral evidence, reaffirmed that while he could not provide any guarantee, he believed that if P26 had been transferred he would have had "*possibly a slightly higher chance*" of keeping his leg.[69]

In his opinion, P26 should have been transferred following the initial surgery or after the third operation, and at the very least he believed Dr Patel should have sought advice from the Royal Brisbane Hospital.[70] Dr Rashford similarly believed that Dr Patel should have sought the advice of Brisbane vascular surgeons.[71]

Dr Jenkins, though, stated that the hospital staff were not really responsible for failing to recognise that P26 should have been transferred earlier, in that junior staff were looking after P26's care during the holidays and they simply did not recognise the patient's condition.[72]

Dr Ray also expressed concern at the failure of Dr Patel to even seek the advice of more experienced vascular surgeons.[73] In his opinion, the issue of transferring the patient should have been considered by Dr Patel after the first operation.[74] Dr Ray believed that had P26 been transferred to Brisbane quickly P26 *may* still have lost his leg but that this was an unlikely outcome.[75]

Nevertheless, **Dr Woodruff** gave evidence that P26's leg was in all likelihood lost by approximately two or three o'clock on the afternoon of the accident, and that there really was no question of P26 being in a position to have been transferred and treated in Brisbane by this time.[76] He also stated that "*all vascular surgeons have encountered late diagnosis of blunt arterial injuries*".[77] Dr Woodruff accepted that Dr Patel may have mismanaged the care of the

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[68] Statement of Dr Jenkins [20], exhibit 254
[69] Dr Jenkins T3703
[70] Statement of Dr Jenkins [22], exhibit 254
[71] Statement of Dr Stephen Rashford, exhibit 210
[72] Dr Jenkins T3706
[73] Dr Mark Ray T3766
[74] Dr Ray T3770
[75] Dr Ray T3768
[76] Dr Woodruff T4321, T4364
[77] Dr Woodruff T4321

patient following the life saving surgery, but felt that regardless, the leg would not have been salvageable.[78]

Post-operative care

The post operative care of P26 at Bundaberg, however, was regarded by Dr Woodruff as being sub optimal, in that P26 was becoming septic from approximately 29 December 2004. On the whole, Dr Woodruff stated that P26 would not be in a better position now than if he'd been transferred to Brisbane earlier but -

> *"he could have gone through the process without testing his chances to the degree that he did if he'd been transferred earlier."*[79]

Michelle Hunter, who nursed P26 on 30 December gave evidence that P26 was very unwell, with a grossly swollen foot which was purple, mottled and cold, he was tachycardic and had a temperature around 39 or 40 degrees.[80]

Diane Jenkins similarly stated that in the week Dr Patel was on leave P26's foot and leg were very swollen and that his foot was "*a dusty navy colour.*"[81] Ms Hunter stated that she spoke with the intern who was caring for P26 that day but she was told the doctors were aware of the patient's condition.[82]

Dr Gaffield, who had taken over the care of P26 while Dr Patel was on leave, stated that he believed that P26's leg appeared to be improving then there was no change until a sharp decline in the twenty four hours prior to his transfer.[83]

Dr Gaffield admitted he did not check P26's chart pathology results, limb observation charts and progress notes[84] then or at any time. Rather he relied

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[78] Dr Woodruff T4321
[79] Dr Woodruff T4322
[80] Michelle Hunter T2034
[81] Statement of Diane Jenkins [31], exhibit 494
[82] Michelle Hunter T2034
[83] Dr Gaffield T4585
[84] T4604

upon Dr Patel's verbal handover.[85] Further elucidation on this issue was not permitted by the former Commissioner.[86]

After considering the patient's pathology urine test results of 23 December 2004, which Dr Woodruff stated indicated dead and dying muscle, showing a rising white blood cell count and the lack of improvement, Dr Gaffield stated in evidence that he felt he should have transferred P26 earlier, possibly twenty four hours earlier.[87]

A Brief to the Zonal Manager, Dan Bergin, was provided by Dr Keating following an email to Dan Bergin, Peter Leck and Darren Keating from Dr Rashford which raised concerns at the delay in transferring P26.[88] This report found that "*ideally patient should have been transferred to RBWH when stable on or about 25-26 December 04.*"[89] It was noted in this briefing that the hospital would institute a policy of transferring patients with emergency vascular conditions to tertiary facilities once the patient becomes stable. Dan Bergin stated in his evidence to the Commission that no policy at Bundaberg Base Hospital had been located but that he had requested the Acting District Manager to develop this policy.[90]

Dr Keating gave evidence that he had intended to implement a written policy in relation to transferring patients but did not have the opportunity to do so prior to taking leave in April. Dr Keating merely spoke to Dr Patel and to Dr Gaffield and verbally mentioned the policy.[91]

Overall, it is clear that P26 should have been transferred as soon as he had been stabilised after the initial life saving surgery.

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[85] Dr Gaffield T4600
[86] T4601
[87] Dr Gaffield T4587
[88] Email to Dan Bergin, Darren Keating and Peter Leck from Dr Stephen Rashford dated 4 January 2005, attachment "SJR1" to the Statement of Dr Rashford, exhibit 210 and *A Briefing to the Zonal Manager* prepared by Darren Keating to Dan Bergin dated 5 January 2005, attachment "JGS7" to the Statement of Dr Scott, exhibit 317 and attachment 10 to the Statement of Dan Bergin, exhibit 383
[89] *A Briefing to the Zonal Manager* dated 5 January 2005 page 2 of Clinical Summary
[90] Dan Bergin T6006
[91] Statement of Dr Keating [174] and [177], exhibit 448

Notwithstanding this, when Dr Gaffield as the consultant assumed the patient's care it seems that, he did not undertake basic procedures to acquaint himself with the pertinent features of the case, nor it seems seek further guidance as to the management of the patient.

The responsibility for failure to transfer and to closely monitor the patient must rest with both Dr Patel and potentially Dr Gaffield. As to the latter, the evidence is incomplete and in his case further investigation is warranted.

However, even if P26 had been transferred following the initial operation, according to Dr Woodruff's evidence, there would still have been insufficient time for his leg to be saved.

2. *Adequacy of the fasciotomies*

In the opinion of Dr Jenkins, performing the fasciotomies on P26 was the appropriate treatment.[92] However, Dr Jenkins and Dr Ray were both of the opinion that the fasciotomies were inadequate.[93] Nevertheless, Dr Woodruff commented that although there was a delay in diagnosing P26's condition, ultimately P26's leg could not have been saved even if P26 was transferred earlier as "*the operation that was done to re-establish circulation did in fact re-establish circulation.*"[94]

3. *Ligation of the femoral vein*

Dr Risson, who assisted Dr Patel in theatre at the time of the first operation, said that he believed that the laceration to the femoral vein was repaired but in hindsight believes the vein was actually ligated.[95]

Dr Jason Jenkins stated that he believed Dr Patel "*did not recognise the venous anatomy*" and had ligated the vein with the other end retracting inside the abdominal cavity. In Dr Jenkins' opinion, had the vein been repaired, P26 would not have developed the difficulties with his leg.[96] However, Dr Jenkins

[92] Dr Jenkins T3701
[93] Statement of Dr Jason Jenkins [17], exhibit 254; Statement of Dr Mark Ray [18], exhibit 257
[94] Dr Woodruff T4321
[95] Statement of Dr Risson [38]-[39], exhibit 207
[96] Statement of Dr Jason Jenkins [16], exhibit 254

stated in evidence that the ligation of the femoral vein took place in the context of the patient "*bleeding to death and that was his only option, then's (sic) not necessarily an unreasonable thing to do.*"[97]

4. *The by-pass graft*

Dr Patel used gortex in performing the by-pass graft in P26's third operation. **Dr Jenkin** in a Statement supplied to the Commission provided the opinion that in some circumstances the use of synthetic material may not be unreasonable but in cases where the wound is possibly contaminated a vascular surgeon would not use gortex as it "*would almost certainly get infected, and this, in turn, is likely to lead to the rupture of the artery and perhaps even death.*"[98] Dr Jenkins stated that he believed approximately eighty percent of vascular surgeons would have used a vein rather than synthetic material.[99] However, in his oral testimony, Dr Jenkins stated that prosthetic grafts increase the chances of infection but the use of gortex here "*has no bearing on [P26's] outcome.*"[100]

Conclusion

Dr Patel's treatment must be viewed in the context of the initial surgery being life saving. However, the following comments can be made in relation to the treatment provided to P26:

(a) Dr Patel, as P26's treating surgeon, should have considered a transfer once P26 had stabilised rather than operating for the third time. At the very least, Dr Patel should have sought the advice of Brisbane specialists prior to operating for the third time.

(b) The fasciotomies performed were inadequate. It does seem that it was appropriate to perform fasciotomies, and the long term impact of the inadequate fasciotomies is

[97] Dr Jenkins T3698
[98] Statement of Dr Jenkins [15], exhibit 254
[99] Dr Jenkins T3702
[100] Dr Jenkins T3705

questionable, in that P26 appears likely to have still lost his leg.

(b) The use of the prosthetic material in performing a graft during the third operation was questionable in the circumstances of a motorcycle accident, given the evidence of Dr Jenkins.

(c) On the evidence given by Dr Woodruff, P26 would still have lost his leg despite remaining at Bundaberg, as there simply would not have been enough time to transfer P26 and operate in Brisbane.

(d) The post-operative care of P26 generally appears to have been suboptimal, and he certainly should have been transferred to Brisbane prior to 1 January 2005. Dr Woodruff stated that "*I believe the patient's management is definitely deficient from about this time on.*"[101] Nevertheless, Dr Woodruff was of the view that P26 would not have been in a better position than he is today had he been transferred earlier.

Dr Jenkins commented that:

> *"It is not easy to give you a cut and dry answer on this. He [Dr Patel] obviously thought the kid's leg was going all right, so you wouldn't have transferred him till the next day anyway. So, you know, and then the damage may well have been done by then anyway. So it may not have changed the outcome, is all I am saying, but if he'd come earlier it would have. I am not saying it is technically possible to change it."*[102]

On any view of the evidence, the patient would have been less compromised physically had he been transferred earlier and as adverted to responsibility rests with Drs Patel and potentially Dr Gaffield for this omission.

<u>*Conclusion*</u>

[101] Dr Woodruff T4322
[102] Dr Jenkins T3720

There are sufficient issues raised in relation to Dr Patel to warrant referral for disciplinary action as outlined above.

On the current state of the evidence it may warrant further investigation as to Dr Gaffield's management and failure to earlier transfer the patient.

2. Surgical Procedures currently under assessment by the Health Rights Commission and the subject of evidence at the Inquiry:

2.1 Ainslie, Frances (decd) (P164)

- Woodruff T4279; Table B2
- Woodruff Report at 133 ("*reasonable*")

2.2 Alexander, Noel (decd) (P71)

- Woodruff T4300

2.3 Anderson, Helen (P165)

- Woodruff Report at 133 ("*reasonable*")

2.4 Armstrong, Robert

2.5 Badke, Fredrick

2.6 Bailey, Kevin

2.7 Barber, Rhonda (P97)

2.8 Bender, Vicki (P171)

- Woodruff Report at 133 ("*reasonable*")

2.9 Blight, Darcy (P175)

- Woodruff T4340-4341
- De Lacy T3646-3647

2.10 Braund, Kerrie (decd) (P178)

- Woodruff Report at 133 ("*reasonable*")

2.11 Broome, Priscilla (P50)

- Woodruff Report at 133 ("*reasonable*")
- Statement of Dr Gaffield

2.12 **Buckley, Katherine (P181)**

- Woodruff Report at 133 ("*reasonable*")

2.13 **Bury, Evelyn**

2.14 **Carter, Matthew (decd) (P182)**

- Woodruff Report at 133 ("*reasonable*")

2.15 **Cox, Nelson (P15)**

- Keating statement paragraph 340
- Woodruff Report at 121
- Statement of Dr O'Loughlin dated 10 August 2005 at [13]-[23]
- Transcript Dr O'Loughlin 3962-3963, 3964

2.16 **Cuthel, Dawn (P109)**

2.17 **Deakin, Phillip (P16)**

2.18 **Dorron, Noel (decd)**

- Woodruff report at page126- Dr Patel maybe contributed to adverse outcome.

2.19 **Douch, Kelly**

2.20 **Ell, Ian**

2.21 **Filmer, Suzanne**

2.22 **Finch, Raymond (decd) (P207)**

- Woodruff Report at 134 ("*reasonable*")

2.23 **Fleming, Ian (P126)**

- Woodruff Report at 121
- Fleming T2510-2535
- Statement of Dr Boyd dated 17 June 2005 at [15]-[19] and dated 29 June 2005 at [12]
- Boyd T3823

2.24 **Forrester, Michelle**

2.25 **Fowles, Nora**

2.26 **Gibson, Valerie**

2.27 **Grambower, Janice (decd) (P220)**

- Woodruff Report at 134 ("*reasonable*"), then placed in Table B3 in Dr Woodruff's statement (patients adversely affected by Dr Patel), subsequently in evidence Dr Woodruff stated that there were others involved who played major contributing roles in Ms Grambower's death (at 4275). Also Woodruff T4347-4350.

- Dr Strahan T3270-3275, 3306-3307

2.28 Green, Leonard (decd) (P224)

- Woodruff Report at 127 ("*Dr Patel maybe contributed to adverse outcome*")

- Woodruff T4287 and 4288

2.29 Halter, Trevor (P20)

- Woodruff Report at 121

- Halter T2415-2423; and Statement (Exhibit 171)

2.30 Hendricks, Margaret

2.31 Holder, George (P230)

- Woodruff Report at 135 ("*reasonable*")

2.32 Hopton, Donna

2.33 Howard, Margaret

2.34 Hurley, Ronnetta

2.35 Jackson, N Kerry

2.36 Jones, Elwyn (P137)

- Woodruff Report at 135 ("*reasonable*")

2.37 Karan, Serab

2.38 Karnauchow, Leo

2.39 Kemps, Gerard (P21)

Mr Kemps was initially admitted to the Bundaberg Base Hospital on 6 December 2004. His wife described him as looking anaemic around 3 December 2004 which resulted in Mr Kemps making an appointment to see his general practitioner. Mr Kemps was referred to the Bundaberg Base Hospital by the GP with suspected internal bleeding and symptoms of tiredness and difficulty swallowing.[103] His medical history included an aortic

[103] Statement of Aleida Kemps, annexure "AJK1," exhibit 126; Dr Smalberger T1960

procedure two years before which required a transfer to the Intensive Care Unit of the Royal Brisbane Hospital.

Dr Smalberger performed an endoscopy which revealed a mass at the gastro-oesophageal junction. The tumour apparently extended below the oesophageal sphincter. Dr Smalberger then ordered CT Scans of Mr Kemps' chest. The results of that scan revealed enlarged lymph nodes and shadows in the lungs, which suggested to Dr Smalberger that Mr Kemps' cancer was not limited to his oesophagus.[104] He explained to Mr and Mrs Kemps that he believed that Mr Kemps should be transferred to Brisbane and that keyhole surgery was an option.[105] Dr Smalberger stated in evidence that he believed Mr Kemps should have been treated with radiotherapy, chemotherapy a stent or a combination.[106] Dr Smalberger referred the patient to the Department of Surgery as he had found that Brisbane hospitals required the support of a surgeon for a transfer.[107] Dr Patel, however, spoke with Mr and Mrs Kemps and informed them that Mr Kemps would be operated on in Bundaberg and that he would perform an oesophagectomy. Mrs Kemps recalled that Dr Patel said "*It is a big operation but it is nothing because I've done hundreds of them.*"[108] Dr Patel arranged for Mr Kemps to be discharged home for two days, to return on 19 December 2004.

A number of staff raised concerns that Dr Patel had insisted that P44's ventilator be turned off in order to make a bed available in Intensive Care for Mr Kemps.[109] Dr Carter stated that Dr Patel indicated to him that he needed the bed in ICU and Dr Carter agreed to review P44's chart.[110] Dr Patel had apparently requested Dr Joiner turn off the patient's ventilator the evening before, but Dr Joiner refused.[111] Dr Carter gave evidence that when he reviewed the patient he determined that "*there was no chance of Mrs P44*

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[104] Dr Smalberger T1962
[105] Aleida Kemps T1896-1897; Dr Smalberger T1963-1964
[106] Dr Smalberger T1994
[107] Statement of Dr Smalberger [7], exhibit 133
[108] Statement of Aleida Kemps, annexure "AJK1," exhibit 126
[109] Statement of Martin Brennan [7]-[10], exhibit 154; Statement of Damien Gaddes [14]-[15] and annexure "DG1", exhibit 146; Statement of Toni Hoffman [135], exhibit 4
[110] Statement of Dr Carter [59], exhibit 265
[111] Statement of Dr Joiner [9], exhibit 307

making any recovery from her stroke."[112] His evidence was that Dr Patel had pressured him to turn the patient's ventilator off but that he could and did ignore the pressure and made an appropriate decision, discussed the matter with P44's family and switched the ventilator off.[113]

On 20 December 2004 Dr Patel performed an Ivor Lewis Oesophagectomy on Mr Kemps. Damien Gaddes, the anaesthetic nurse, gave evidence that he told Dr Patel during the surgery that the bellovac drain was half full and blood was draining into the bellovac, but was told that this was what the drains were for.[114] It was his evidence that all theatre staff could not believe that Dr Patel ordered the patient to be moved to the Intensive Care Unit as they believed he was haemorrhaging.[115] Dr Berens too spoke of abnormal blood loss during the procedure and agreed that Dr Patel was made aware by all the staff members that there was "*active bleeding going on in the abdominal cavity and he [Dr Patel] just looked at it and he said 'It doesn't need opening of the abdomen at this stage.*"[116] Despite the evidence of internal bleeding Mr Kemps was transferred to Intensive Care.

Mr Kemps continued to bleed post operatively and was returned to theatre for a laparotomy, Dr Patel also performed a splenectomy. Mr Kemps received thirty nine units of blood.[117] **Jenelle Law**, the scout nurse for the procedure, stated that she had given the scrub nurse 75 large sponges and 15 raytec and "blood and blood clots were all over the floor."[118] Dr Patel was unable to locate the source of the bleeding and Mr Kemps died on 21 December 2004.

The Death Certificate records the cause of death as *"refractory shock"* with other conditions listed "*as aortic bleeding post operative, resection of oesophageal cancers and primary oesophageal cancer*".[119] The certificate was completed by **Dr Athanasiov**, who only held the retractors during both

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[112] Statement of Dr Carter [60], exhibit 265
[113] Statement of Dr Carter [62]-[63], exhibit 265; T4021-4023
[114] Statement of Damien Gaddes [18]-[19], exhibit 146
[115] Statement of Damien Gaddes [20], exhibit 146
[116] Dr Berens T1923
[117] Woodruff Report, p122
[118] Statement of Jenelle Law [14], exhibit 160
[119] Statement of Aleida Kemps, annexure "AJK2," exhibit 126

surgeries and was told the cause of death by Dr Patel.[120] Dr Athanasiov admitted in evidence that it would have been better for a more senior doctor who believed he knew what the cause of death is to complete the certificate.[121] The case was not referred to the Coroner, which was a cause of concern for some staff members including Dr Berens and Dr Carter.[122]

A number of staff raised both oral and written concerns after the death of Mr Kemps. It was following Mr Kemps' death that Dr Keating informed Dr Patel that he was not to perform any further oesophagectomies.[123]

Dr Fitzgerald was of the opinion that Bundaberg Base Hospital did not have the capacity to provide the standard of care required for a patient who had undergone an oesophagectomy.[124] **Dr Berens** suggested that the difficulty for Bundaberg Base Hospital in relation to oesophagectomies is that the hospital did not have the resources to care properly for patients with post operative complications.[125]

Dr Athanasiov gave evidence that Dr Patel had said to him following this surgery that possibly they should not be performing oesophagectomies.[126]

Dr Risson also gave evidence that Dr Patel said during the second operation "*words to the effect 'maybe I should start thinking about not doing these types of procedures anymore'*".[127]

Dr Woodruff stated that:

> *"to contemplate a major procedure such as an oesophagectomy, particularly when the CAT scan shows some ectasia or dilation and disease of the thoracic aorta, you can almost guarantee that (a) the tumour is not curable and (b) any attempt to separate it from this diseased aorta is going to produce aortic bleeding, and suturing that*

[120] Dr Athanasiov T2066
[121] Dr Athanasiov T2067
[122] Statement of Dr Berens [20], exhibit 128; Statement of Dr Carter [], exhibit
[123] Dr Keating T6822
[124] Further statement of Dr Fitzgerald [7], exhibit 226
[125] Statement of Dr Berens [20], exhibit 128
[126] Dr Athanasiov T2057
[127] Statement of Dr Risson [21], exhibit 207

type of aorta is not dissimilar from trying to keep the yoke inside a non-cooked egg, suturing the eggshell."[128]

Conclusion

There are a number of issues for concern raised by the treatment given to Mr Kemps including:

1. Dr Patel's judgment in choosing to perform an oesophagectomy given Mr Kemps' medical history and co-morbidities,
2. Dr Patel operating outside his expertise and that of the Bundaberg Base Hospital;
3. Dr Patel's decision to transfer Mr Kemps to the ICU despite the evidence of internal bleeding,
4. a junior doctor completing the death certificate; and
5. the decision not to refer the case to the Coroner.

Dr Woodruff said in relation to Dr Patel's judgment in deciding to perform the oesophagectomy:

> *"I cannot understand how anybody could even contemplate doing this operation with that history."*[129]

2.40 Kerr, Kathleen (decd) (P243)

- Woodruff Report at 135 ("*reasonable*")

2.41 Knust, Alan (P2)

- Woodruff Report at 135 ("*reasonable*")

2.42 Lealiifano, Matteo

2.43 Lee, Coral (P5)

2.44 Lester, Vicki (P108)

[128] Dr Woodruff T4291
[129] Dr Woodruff T4291

- Woodruff Report at 136 ("*reasonable*")
- Lester T2455-2471 and Statement (Exhibit 176)
- Keating statement para 334-337

2.45 Mallett, Katrina

2.46 Matteschek, Megan (P103)

2.47 McDonald, Dorothy

2.48 Monaghan, Brian (P267)

- Woodruff Report at 136 ("*reasonable*")

2.49 Morris, Mervyn (decd) (P28)

- Woodruff Report at 127 ("*Dr Patel maybe contributed to adverse outcome*")
- Woodruff T 4293 and 4308

2.50 Nagle, Eric (decd) (P30)

- Woodruff Report at 124
- Transcript- Carter; Druce; Miach; Pollock; Risson; Woodruff
- Statements of Kay Boisen, Lindsay Druce, Pollock, Risson, Woodruff

2.51 Pauza, George

2.52 Peterson, Douglas (P104)

2.53 Phillips, James (decd) (P34)

- Transcript- Dr Carter, Hoffman, Dr Joiner, Miach, Woodruff, Dr Younis
- Statements- Dr Carter, Toni Hoffman, Dr Joiner, Dr Miach, Dr Woodruff, Dr Younis, Karen Stumer RN

2.54 Punch, Tori (P285)

- Woodruff Report at 137 ("*reasonable*")

2.55 Rhodes, Doreen

2.56 Robbins, Desmond

2.57 Sanders, Edward

2.58 Scott, Allan

2.59 Small, Anacorita

2.60 Smith, Christopher (P298)

2.61 Snowden, Vera

2.62 Stanley, Jaykeb

2.63 Stuart-Sutherland, Jean (P38)

- Woodruff T4326 ("*procedure banned in the United States*")
- Woodruff Report at 130 ("*maybe contributed to adverse outcomes*")
- Statement of White
- Statement of Tapiolas
- Statement of Dr Gaffield

2.64 Sullivan, Kevin

2.65 Swanson, Nancy (P41)

- Statement of Toni Hoffman
- Swanson T2447-2454 and Statement of Nancy Swanson (Exhibit 175)

2.66 Van Vliet, Lyn (P102)

- Statement of Dr O'Loughlin dated 10 August 2005 at [24]-[30]
- Dr O'Loughlin T3963-3964

2.67 Walk, Keith (Decd) (P98)

- Woodruff Report at page 130 ("*maybe contributed to adverse outcome*"). However, in his statement Dr Woodruff chose to reclassify this case to Dr Patel "*did contribute to the adverse outcome*" (PWHW-4).
- Woodruff T4292 and 4307

2.68 Watson, Audrey

2.69 Williams, Grace (decd) (P46 and 329)

- Woodruff Report at 139 ("*reasonable*")

3. Other surgical procedures the subject of evidence at the Inquiry- procedures conducted by Dr Patel at Bundaberg Base Hospital, in respect of which he was, to his knowledge, the

subject of conditions imposed upon him in Oregon in November 2000.

3.1 Oregon conditions

On 7 September 2000 the Oregon Board of Medical Examiners and Dr Patel entered a Stipulated Order. Under this Order Dr Patel agreed not to perform surgeries "*involving the pancreas, any resections of the liver, and constructions of ileoanal pouches.*"[130]

In addition to this term, Dr Patel was also to obtain second opinions prior to operating on "*complicated surgical procedures*" from surgeons approved by the Investigative Committee of the Board.[131] An amendment to the Stipulated Order was made on 1 November 2000, under which Dr Patel was also ordered to obtain second opinions prior to operating on "*complicated surgical procedures*" from a surgeon with an unrestricted, full licence in Oregon and who is board certified as well as fully credentialed and privileged at the institution at which Dr Patel cared for the patient.[132] "*Complicated surgical procedures*" are defined in Attachment A to the Stipulated Order. Those surgeries requiring second opinions include firstly major surgeries, that is abdominal-perineal resections, esophageal and gastric surgeries. Secondly, those surgeries involving high-risk patients with severe co-morbidities or classification of 4 or 5 in accordance with the American Society of Anaesthesiologists. Thirdly, post operative patients with more than two days hospitalisation in the Intensive Care Unit, more than eight days hospitalisation or those with the onset of clinical deterioration.[133]

3.2 Barry Johnson

Dr Patel saw Barry Johnson, a fifty-seven year old male, at the Bundaberg Base Hospital on 16 September 2003 after he developed painless jaundice secondary to a mass in the head of the pancreas. Mr Johnson was scheduled for a possible Whipples procedure. On 22 September 2003 Mr Johnson was

[130] Stipulated Order, 7 September 2000, at 4.1
[131] Stipulated Order, 7 September 2000, at 4.2
[132] Amendment to Stipulated Order, 1 November 2000, at 4.2
[133] Stipulated Order, 7 September 2000, Attachment A.

admitted to Bundaberg Base Hospital and Dr Patel performed a cholecystojejunostomy and gastrojejunostomy. Mr Johnson initially appeared to be doing well post-operatively and was transferred from the Intensive Care Unit to the surgical ward on 24 September 2003. He died at the hospital on 1 October 2003, with the cause of death listed as pancreatic cancer.

The issues for concern raised by the treatment given to Mr Johnson include the failure of Dr Patel to diagnose or address the patient's deteriorating condition, possible inadequate records on the consent form, and the fact that Dr Patel intended to perform a Whipple's procedure, which was a prohibited procedure under the Oregon Stipulated Order.

Failure to adequately diagnose and address the patient's deteriorating condition

Dr Woodruff stated that the decision to perform the cholecystojejunostomy and gastrojejunostomy, given the finding on surgery that the mass was actually 10-15 cm in diameter and the CT scan report revealed that there was a pancreatic carcinoma, was a correct one. However, Dr Woodruff was concerned at the fact that while the patient appeared to be doing well initially following surgery, as supported by the full blood count results, his white cell count steadily increased indicating that the patient was becoming septic.[134] This coupled with the evidence that Mr Johnson began developing pain and that bile was draining through the drain suggested to Dr Woodruff that Mr Johnson developed biliary peritonitis. Dr Woodruff said that Dr Patel did not attempt to diagnose or address the patient's condition. Dr Woodruff indicated that some surgeons may feel following an unsuccessful palliation that it might be more humane not to operate further. However, he was of the belief that failing to re-explore was an error in judgment on the part of Dr Patel.[135] The Woodruff Report identified Dr Patel's level of care of Mr Johnson as having contributed to the patient's death.[136]

[134] Transcript 4288-4289 and Medical Records of Barry Johnson, Pathology Reports
[135] Transcript 4289-4290
[136] Woodruff Report, 52

Possible inaccurate record keeping:

In his statement supplied to the Inquiry, Dr Woodruff discussed possible inaccurate medical records kept by Dr Patel, stating that generally the medical records were not inaccurate but there were some anomalies including the consent form completed by Dr Patel and the patient in relation to this procedure.[137]Dr Woodruff explained that Dr Patel appeared to have added to the handwritten list of risks of the procedure, as the last two entries on the list, pneumonia and death, appear to be in a distinctly different script than the other 8 items on the list.[138] However, as made clear by Dr Woodruff it is unknown whether Dr Patel simply added it a short time later or after some other event, and so the true relevance of the possible addition is unknown.

Operation outside the scope of practice of the Bundaberg Base Hospital and prohibited by the Oregon Order:

Dr Woodruff emphasised that the operation Dr Patel intended to perform was outside the scope of practice for the hospital and it was "*inappropriate to do this form of surgery in that environment, particularly with no recourse to any other colleagues.*"[139]

Procedures involving the pancreas were clearly prohibited by the Oregon Stipulated Order, and Dr Patel was knowingly in breach of those conditions when he operated on Mr Johnson.

Conclusion:

There are concerns as to Dr Patel's treatment of Mr Johnson in addition to issues of performing these types of operations at Bundaberg and in breach of the Oregon Order. It is submitted that this case should be referred to the Board for possible disciplinary action.

3.3 Antoine Gautray

[137] Statement of Dr Peter Woodruff, [25]
[138] Transcript 4342
[139] Transcript 4289-4290

patients requiring such procedures or who were seriously ill would be appropriately referred;

- *at that time I had insufficient evidence to link Dr Patel's performance to particular adverse outcomes, the only information we had were complaints that Dr Patel was carrying out procedures outside his capacity and that of the hospitals."*

Dr Fitzgerald formally referred his concerns about Dr Patel to the Medical Board in a letter dated 24 March 2005.[145] Dr Fitzgerald said that his expectation was that the Board in its investigation would have looked at Dr Patel's clinical expertise but also obtained information on his behaviour to staff in terms of assessing whether he was guilty of any professional misconduct.

On 9 April 2005 the Minister for Health, Mr Nuttall, announced that a comprehensive review would be undertaken of safety and quality at the Bundaberg Hospital. Two days earlier, on Thursday 7 April 2005, the Director General of Health Dr Steve Buckland visited Bundaberg Base Hospital with the Minister to speak with staff. At the conclusion of that visit, Dr Buckland was told by Dr Keating that he had undertaken a Google search and had found that Patel had restricted registration in Oregon and had been withdrawn from the register in the State of New York.[146] Dr Buckland said he returned to Brisbane on the Ministerial Plane without mentioning it to the Minister and that night at home, he conducted his own Google search to confirm that Dr Keating had told him. Dr Buckland passed this information onto Dr Fitzgerald, who in turn passed it onto Mr O'Dempsey. Accordingly, on 8 April 2005, O'Dempsey directed Demy-Geroe to prepare a report on all of the aspects relating to the registration of Dr Patel.[147] That report was put before the Board on Tuesday 12 April 2005 and forwarded to the Minister's office on Wednesday 13 April 2005. It was tabled in Parliament on Tuesday 19 April 2005 by the Minister for Health. It is respectfully submitted that from the above chronology it can be demonstrated that, once the staff of the Medical Board of Queensland became aware of concerns relating to the registration and clinical practice of Dr Patel, its ensuing action was timely and appropriate.

(e) In relation to (a) and (d) above, whether there is sufficient evidence to justify:

(i) referral of any matter to the Commissioner of the Police Service for investigation or prosecution; or

The Board is aware that Patel and Berg are currently the subject of police investigations, and it has assisted Police in those investigations.

The Board has no further submissions.

(ii) action by the Crime and Misconduct Commission in respect of official misconduct or disciplinary matters.

[145] Exhibit "GF-13" to Exhibit 225
[146] T5507
[147] Exhibit MDG-3 to the Statement of Demy-Geroe, Exhibit 24

Mr Gautray, a seventy-six year old man, was admitted to the Bundaberg Base Hospital on 3 September 2004 with jaundice, abdominal pain and weight loss. A CT scan revealed a lesion in the head of the pancreas. There were several small bony lesions.[140] On 9 September Dr Patel performed a Whipple's procedure.

Mr Gautray died on 22 September 2004. The cause of death certificate noted that Mr Gautray died as a result of klebsiella pneumonia and inactivity, with the Whipples operation contributing to the death. [141]

The issues raised by the treatment of Mr Gautray include:

1. the procedure being banned under the Oregon Order;
2. this type of operation being beyond the scope of Bundaberg Base Hospital and Dr Patel's clinical judgment in operating in this case; and
3. Dr Patel's clinical judgment in operating in this case.

Whipples Procedures at Bundaberg Base Hospital:

Toni Hoffman, in evidence to the Inquiry, stated that Whipple's procedures should be done in tertiary hospitals given the complexity of such procedures.[142] Dr Woodruff was less definitive, on the other hand, suggesting that this was an example of a case where Dr Patel *may* have operated outside his scope of expertise or that of the hospital.[143]

Operating on Mr Gautray:

Dr Woodruff stated that Dr Patel significantly contributed to the adverse outcome in Mr Gautray's case.[144] He also questioned Dr Patel's motives in operating on Mr Gautray, stating that he believed "*there was a lack of*

[140] Medical Records of Antoine Gautray, Patient Report of 7 September 2004 and T4286
[141] Sr Hoffman disputed the primary causation of death- T112,however other evidence does not raise this as an issue
[142] Transcript page 112
[143] Woodruff Report,
[144] Statement of Dr Woodruff, sworn 15 August 2005 at p5 para (d)Table B3

judgment in even putting the patient forward for this type of operation."[145] Given Mr Gautray's CT scans indicated other possible small lesions, which Dr Woodruff thought suggested possible metastatic disease, surgery was questionable.

Procedure banned under the Oregon Order:

Under the Oregon Order, Dr Patel was prohibited from performing operations involving the pancreas. The treatment of Mr Gautray raises issues as to Dr Patel's clinical judgment and is a clear example of a procedure which Dr Patel was banned from performing in Oregon.

Conclusion:

The performance of the type of procedure banned in Oregon coupled with the lack of judgment in operating at all upon Mr Gautray given the CT Scan results warrant the referral of the matter for possible disciplinary action by the Medical Board.

3.4 P238

P238 was a fifty-four year old female admitted to the Bundaberg Base Hospital on 30 June 2003. P238 had previously undergone a pancreato-duodenectomy at the Royal Brisbane Hospital on 25 February 2002 and had suffered a number of complications following the Whipples procedure. P238 then attended the Royal Brisbane Hospital for a drainage of the pseudocyst in February 2003.

On 30 June 2003 Dr Patel performed a pancreatic cysto-gastrostomy upon P238, assisted by Dr Igras. P238 died at the Bundaberg Base Hospital on 2 July 2003.

Dr Woodruff stated in evidence that P238 did need surgery, but should have been referred to the Royal Brisbane Hospital. Performing surgery in

[145] Transcript p. 4286

Bundaberg given her medical history was said to reflect "*more than a lack of judgment on Dr Patel's behalf. I question the man's motive.*"[146]

This case further was identified in the Woodruff Report as one in which Dr Patel *may* have operated outside his scope of expertise or that of the hospital.[147]

Conclusion

Operating on P238 at Bundaberg raises issues as to Dr Patel's clinical judgment and whether he performed operations which were outside his own expertise or that of the Bundaberg Base hospital. In addition, Dr Patel was banned from performing surgeries involving the pancreas.

In performing an operation banned by another regulatory body Dr Patel's conduct would fall within the definition of "*unsatisfactory professional conduct*". This case should be referred to the Board for possible disciplinary action.

3.5 Dorothy Bryen

Dorothy Bryen was a seventy-six year old woman who was admitted to the Bundaberg Base Hospital on 8 June 2003. Dr Patel operated on Ms Bryen on 9 June 2003 and repaired an incarcerated epigastric hernia.

During the course of the operation Dr Patel damaged the small bowel which he then repaired during the surgery. Mrs Bryen was discharged on 15 June 2003 but was readmitted on 20 June 2003.

She was subsequently transferred on 30 June 2003, ventilated, to the Mater Private Intensive Care Unit.

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[146] Transcript, p 4281
[147] Woodruff Report at 132

The issues for concern include the error made during the procedure and the procedure being one of those banned under the Oregon Order. It warrants referral for disciplinary action.

4. Other cases which may be recommended to the Board

4.1 P273

P273 attended the Bundaberg Base Hospital on 16 April 2003 for a colonoscopy and OGD for anaemia. At that time, however, the colonoscopy was not performed and the patient was discharged home with the procedure rebooked.

P273 returned to the hospital on 21 May 2003. Dr Patel performed the colonoscopy on this date, despite the patient apparently being very disoriented and confused.[148]

Dr Woodruff believed that P273's care did not reflect the "*same clinical magnitude or impact*" as some of the other cases he had considered, but he did regard Dr Patel as having contributed to an adverse outcome.[149] The issue raised by Dr Woodruff in his evidence to the Commission was whether performing a colonoscopy under these circumstances, where P273 was highly disoriented, was appropriate.[150] Dr Woodruff stated that he believed it was "*inappropriate to proceed with any sort of invasive procedure that's not lifesaving on somebody so disoriented, confused that she was unable to state what procedure she's having or the date of her birth. So, to me, this raised questions about the appropriateness of case selection and why he was actually doing the procedure.*"[151]

This case, involving questionable consent is one which could be recommended to the Board for further investigation in the event that other

[148] Day Surgery Record 21/05/03, recorded in the pre-operative nursing assessment
[149] Dr Woodruff T4308 and Statement of Dr Woodruff Table D3; in the Woodruff Report this case is treated as one in which Dr Patel *may* have contributed to an adverse outcome at 129
[150] Dr Woodruff, T4295
[151] Dr Woodruff T4295

successful disciplinary action has not already concluded. However, it is submitted that the treatment of P273 does not represent a clear case warranting disciplinary action.

4.2 P276

The Woodruff Report initially identified Dr Patel's care of P276 as being reasonable.[152] In his Statement to the Commission, however, Dr Woodruff revised his assessment of this case and stated that Dr Patel may have contributed to the adverse outcome.[153]

P276 was admitted to the Bundaberg Base Hospital on 17 July 2004. An eighty-two year old man, he was transferred by the RFDS from Eidsvold Hospital with PR bleeding.

On 17 July 2004 Dr Patel, with the assistance of Dr Kariyawasam, performed a sigmoid colectomy. P276 was transferred to the ward on 24 July but then began experiencing pain in his chest on 25 July, when the nursing notes record that he was "*becoming less lucid. Colour pale.*" He went into respiratory arrest and was transferred back to the Intensive Care Unit where he was intubated.

P276 died at the hospital on 25 July 2004 with the cause of death listed as "*coronary occlusion and emergency sigmoid colectomy*"[154].

In his Statement to the Commission, Dr Woodruff considered the nursing notes, which record only small or no PR bleeds, lead to a question of appropriateness of operating upon P276 given his age and condition.[155] Further, the patient's history of myocardial infarction and the ECG results also led Dr Woodruff to form an opinion that "*consultation and more conservative*

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[152] Woodruff Report, 137
[153] Statement of Dr Woodruff "PWHW-4"
[154] Medical Certificate of the Cause of Death 26 July 2004
[155] Statement of Dr Woodruff "PWHW-4"

management by Dr Patel may have produced a better outcome."[156] Dr Woodruff believed that P276's symptoms were "*more likely caused by the onset of a heart attack than a significant bleed from the bowel.*"[157]

This case is another example of one which may reflect poor judgment on Dr Patel's part. While poor clinical judgment may amount to "*unsatisfactory professional conduct*", it is submitted that this is not a case that should be referred to the Board for further investigation, in the circumstances where there are more serious cases of possible *"unsatisfactory professional conduct".*

4.3 Mona Slater (P297)

Mrs Slater was an eighty-eight year old female operated on by Dr Patel at the Bundaberg Base Hospital on 15 December 2003. Dr Patel performed a low anterior resection. Mrs Slater remained unwell following the procedure and died at the hospital on 24 December 2003, with her cause of death listed as cardiopulmonary respiratory failure, fluid overload and low anterior resection. Other conditions listed on the death certificate include hypertension, angina, gout and atrial fibrillation.[158]

Dr Woodruff questioned whether, during the operation on 15 December, there was a ureteric injury.[159] In his opinion, Mrs Slater's anuric renal failure *may* have been caused by some damage to the uretus during the operation.[160] This possibility in itself would not be sufficient to refer the matter to the Board for possible disciplinary action. However, Dr Woodruff also questioned Dr Patel's motivation in performing such an operation on an elderly woman and at Bundaberg. In evidence, Dr Woodruff stated this operation was:

> "*a challenging operation and there are undoubtedly better places and more expert colorectal surgeons that would have a greater chance of success in a difficult situation like that.*"[161]

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[156] Statement of Dr Woodruff "PWHW-4"
[157] Statement of Dr Woodruff at 5
[158] Medical Certificate of the Cause of Death 24 December 2003
[159] Woodruff Report, 129 and Dr Woodruff T4325
[160] Dr Woodruff T4325
[161] Dr Woodruff T4325

Performing this operation, in addition to indicating a possible lack of judgment, appears to be in breach of the Oregon Order governing complicated surgical cases. Under the Oregon Order Dr Patel was to seek second opinions before operating on "*complicated surgical cases*". It is noted that the definition of "*complicated surgical cases*" includes surgeries involving high risk patients. High risk patients are those with "*severe co-morbidities, including uncompensated heart failure, severe chronic obstructive pulmonary disease and renal failure...*"[162]

It is submitted that Mrs Slater's chronic renal failure places her within the category of a high risk patient governed by the Oregon Order as one in which Dr Patel needed to obtain a second opinion prior to operating.

It is further submitted that this case should be referred to the Board for possible disciplinary action as it appears to indicate a lack of professional judgment on the part of Dr Patel and a breach of the conditions imposed by the Oregon Board of Medical Examiners.

4.4 Harold Roach (P36)

P36 was admitted to the Bundaberg Base Hospital on 18 January 2005. A seventy-three year old man at the time of admission, he was suffering abdominal pain and was found to have a subacute bowel obstruction. On 22 January 2005 Dr Patel performed a subtotal colectomy for obstructive colon carcinoma. P36 was unwell following surgery, he was hypotensive and tachycardic, and he was intubated and ventilated on 24 January 2005. P36 was also suffering from increased abdominal pressure. On 25 January 2005 Dr Patel performed an exploratory laparotomy finding an ischaemic colon just distal to the anastomosis. An ileostomy was performed at this time. P36 developed an atrial flutter but appeared to be doing better and was extubated. However, he required resuscitation on 10 February 2005 and was intubated

[162] Oregon Stipulated Order, Attachment A

and ventilated again. P36 was subsequently transferred to the Mater Hospital in Brisbane on 14 February.

This patient's care was initially classified as one in which Dr Patel may have contributed to the adverse outcome.[163] Dr Woodruff, however, reclassified this case in his Statement to the Commission as one in which Dr Patel had contributed to the adverse outcome as Dr Woodruff regarded the decision not to perform a colostomy at the first operation as "an error of judgment which significantly contributed to the adverse outcome."[164] Dr Woodruff repeated this view in his evidence to the Commission where he stated that to perform the first operation on 22 January 2005 "without some form of colostomy and/or diversion was an error of judgment."[165]

The care of P36 is suboptimal but the issue is essentially one based on clinical judgment and may not warrant disciplinary action.

4.5 Warren Stanaway (P40)

Warren Stanaway was admitted to the Bundaberg Base Hospital on 23 February 2004 for an elective re-anastomosis of double barrel colostomy. Mr Stanaway returned to theatre on 28 February 2004 for a laparotomy as his condition had deteriorated and he had considerable pain and a fever. The laparotomy indicated there was fluid in the peritoneal cavity. Dr Patel drained the fluid and noted that there was an enterotomy in the small bowel. Mr Stanaway was intubated on 29 February 2004.

On 3 and 4 March 2004 there was some concern raised as to whether Mr Stanaway should be transferred to the Royal Brisbane Hospital.[166] Dr Patel requested a second opinion from Dr Anderson who suggested a further laparotomy. On 4 March 2004 Mr Stanaway underwent the laparotomy and Dr Patel drained an abscess and performed a loop ileostomy. He was transferred

[163] Woodruff Report at 129
[164] Statement of Dr Woodruff, "PWHW4"
[165] Dr Woodruff T4324
[166] Dr Berens T1952 and Inpatient Progress Notes 4 March 2005 10:00 review by Dr Berens

from Intensive Care to the ward on 10 March 2004 and discharged on 14 March 2004 at his request, but he returned on 15 March 2004 as he was unable to cope at home.

Dr Woodruff identified this patient's care as one in which Dr Patel had contributed to an adverse outcome.[167] In his evidence to the Commission, Dr Woodruff stated that the finding of a two millimetre enterotomy in the small bowel on 28 February 2004 revealed a technical problem, and having to perform a further procedure leading to draining an abscess and performing a loop ileostomy reveals "*a technical performance that is definitely deficient.*"[168] **Dr Berens**, who had reviewed the patient in Intensive Care, was concerned that Dr Patel denied there was a leak of the anastomosis yet performed the operation on 4 March 2004 as if he were repairing a leak.[169] **Dr Anderson** was of the opinion that the loop ileostomy could have been performed on 28 February as opposed to having to operate again at a later date and he questioned whether the procedure on 28 February was indeed adequate.[170]

Dr Patel's care of Mr Stanaway appears to have been sub-optimal. This case is one which should be referred to the Board for possible disciplinary action.

4.6 Ian Vowles

Dr Patel first operated on Mr Vowles to remove a malignant tumour in Mr Vowles' bowel in December 2003. Mr Vowles had a history of bowel cancer and was regularly scheduled to have colonoscopies. Dr Patel performed one such colonoscopy on 14 September 2004. This colonoscopy revealed a polyp in the bowel which Dr Patel advised was benign.[171]

Dr Patel recommended a total bowel removal and this was performed on 4 October 2004.

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[167] Woodruff Report at 124-125
[168] Dr Woodruff T4326
[169] Statement of Dr Berens [7] and T1917
[170] Dr Anderson T2766-2767
[171] Statement of Ian Vowles [6]

Mr Vowles was then readmitted on 25 October 2004 for revision of the ileostomy. There were further complications with the surgery, namely that the ileostomy was flush with the skin.

On 4 May 2005 Mr Vowles was referred to Dr O'Loughlin. Dr O'Loughlin found that the stoma was unsatisfactory as the ileostomy was narrowed and was not situated above or flush with the skin.[172] The treatment Dr O'Loughlin said he would have advised would have been removal of the polyp with a colonscope. Dr O'Loughlin did perform a revision of Mr Vowles' stoma at the Royal Brisbane Hospital. The treatment of Mr Vowles appears to indicate not only deficient technique, in terms of the unsatisfactory stoma but the total removal of the bowel was said by Dr O'Loughlin to be "*unnecessary.*"[173]

It is submitted that this case should be referred to the Board for possible disciplinary action.

4.7 P170

P170, a thirty-one year old male, was admitted to the Bundaberg Base Hospital on 10 October 2004 for an elective right inguinal hernia repair scheduled for 11 October 2004. The Surgeon's Report noted that Dr Patel was the surgeon with Dr Kariyawasam his assistant. Dr Kariyawasam, however, gave evidence to the Commission that it was he who performed this operation under the direction of Dr Patel.[174]

The Surgeon's Report records that during the course of the operation the "*vas deferens [was] inadvertently divided.*"[175] This error was explained to the patient post-operatively. Dr Kariyawasam advised that this operation was a difficult hernia repair and he was learning skills by following Dr Patel's instructions, but that he did not feel that he was operating outside his depth

[172] Statement of Dr O'Loughlin [5]-[6]
[173] Statement of Dr O'Loughlin [7]
[174] Statement of Dr Kariyawasam [103] and T3102
[175] Surgeon's Report 11 October 2004

and he was confident with Dr Patel's instructions that he could perform the procedure.[176] He was of the opinion that the mistake could have happened to any surgeon.[177]

P170 had surgery again on 3 December 2004 for an infected scrotal haematoma. He was discharged that day but returned to the hospital on 7 December 2004 with an infection. A further operation to drain the scrotal haematoma was performed by Dr Kariyawasam on 9 December 2004. P170 was discharged on 17 December 2004. P170 was eventually referred to Dr de Lacy after his GP discovered he still had an infection. Dr de Lacy performed additional procedures on 1 June 2005. P170 states that Dr de Lacy advised him that part of his bowel was wrapped in the mesh and he had removed the mesh and inserted new mesh.[178]

Dr Woodruff categorised this patient's case as one in which Dr Patel contributed to the adverse outcome.[179] In his testimony to the Commission Dr Woodruff pointed both to the vas deferens being divided and the scrotal haematoma as evidence of "*deficient technical performance.*"[180] This case is one which warrants further investigation by the Board in terms of possible "*unsatisfactory professional conduct*" in relation to Drs Kariyawasam and Patel.

4.8 P136

On 14 May 2003 P136 was scheduled to have a right epididymectomy in day surgery at the Bundaberg Base Hospital. However, nursing staff mistook P136 for a patient with the same first name scheduled for a gastroscopy that day. Dr Patel performed the gastroscopy on P136.[181] An incident report completed on 14 May 2003 states that the staff had the right chart but the wrong patient.[182] Jennifer White RN stated that the nurse in the Day Surgery Unit just called the

[176] Dr Kariyawasam T3103
[177] Dr Kariyawasam T3103
[178] Statement of P170 [16], Dr de Lacy has not given evidence in relation to this comment
[179] Woodruff Report at 120
[180] Dr Woodruff T4300
[181] Progress Notes, note of Dr Kingston 14/05/03
[182] Annexure "LTR16" to Statement of L Raven, exhibit 162

patient's first name and he answered.[183] The Incident Report further notes that the nurse was directed to the patient without a formal nursing handover, and that neither Dr Patel nor the anaesthetist checked the patients arm band ID.[184] Staff discovered the error while P136 was still in the unit and the error was explained to the patient and he then underwent the scheduled procedure.[185]

The Woodruff Report identifies Dr Patel as having contributed to an adverse outcome in respect of P136.[186] Nevertheless, the mistake appears to be a hospital failure rather than one which can be attributed to Dr Patel alone,[187] and the hospital appears to have put in place measures to prevent further such mistakes. Jennifer White stated that in her opinion, "*it's the system's problem. Where there was a lot of patients booked on that particular list the staff were anxious to get through the procedures so they could go home on time, and at that stage endoscopy patients, there wasn't a checklist completed for them.*"[188] Dr Keating notes that changes would be made in relation to checking patient names and identification in the Day Surgery and operating theatres and that patients undergoing operations would be handed over to operating theatre staff by Day Surgery staff. [189] While operating on a patient without their consent is certainly a serious concern, Dr Patel's role in the mistaken identity may not be such as to refer the case to the Board for investigation leading to possible disciplinary action. A number of hospital personnel appear to have contributed to the error in this case.

4.9 P270

P270 was admitted to the Bundaberg Hospital on 7 March 2005. A sixty-eight year old woman, P270 was scheduled for repair of a para-oesophageal hernia and also underwent a splenectomy. On her return from surgery she began

[183] Jennifer White T1236
[184] Annexure "LTR16" to Statement of L Raven, exhibit 162
[185] Annexure "DWK76" to the Statement of Dr Keating, exhibit 448; Statement of Jennifer White [27], exhibit 71
[186] Woodruff Report at 122
[187] Dr Keating T6940
[188] Jennifer White T1237
[189] Annexure "DWK76" to the Statement of Dr Keating, exhibit 448

complaining of chest pain. P270 returned to theatre on 9 March 2005 for exploration as a result of wound dehiscence.

The Woodruff Report also identified this patient's adverse outcome as having been contributed to by Dr Patel.[190] In his evidence to the Commission, Dr Woodruff stated that this case provided another example of wound dehiscence which reflects a procedure "*classified as technically deficient.*"[191] The treatment of P270 provides further evidence of Dr Patel's technical errors but, it is submitted that this case is not of sufficient seriousness to be referred to the Board for further investigation.

4.10 Carl Robinson (P288)

P288, a seventy-four year old male, had a low anterior resection on 14 April 2003. Post operatively P288 suffered a number of complications. Initially P288 had an anastomotic leak, which Dr Patel treated with a colostomy on 20 April 2003. On 18 July 2003 P288 underwent a colostomy reversal. He was then transferred to the Bundaberg Base Hospital by the QAS on 3 August 2003 with wound infection and breakdown.

Dr Woodruff stated in relation to this patient's care that P288's post-operative admission for infection "*raises questions of surgical detail and technique.*"[192] Dr de Lacy's concerns related to Dr Patel's failure to fully remove the tumour and what he perceived to be an attempt by Dr Patel to mislead the pathologists in relation to the sample provided.[193] There do appear to be valid concerns with respect to Dr Patel's clinical competence in relation to his treatment of P288.

4.11 P37

[190] Woodruff Report at 124
[191] Dr Woodruff T4324
[192] Dr Woodruff T4324
[193] Dr de Lacy T4432 and Statement of Dr de Lacy attachments "GAD2" and "GAD3", exhibit 252

P37 was admitted to the Bundaberg Base Hospital on 10 August 2004. On 13 August 2004 Dr Patel, assisted by Dr Kariyawasam, operated on the seventy two year old patient to repair an incarcerated ventral hernia.

P37 commented that she was in pain after the operation. On 25 August 2004 Dr Kariyawasam performed an evacuation of the haematoma after a CT Scan revealed that there was a collection or haematoma in the abdominal wall.

Ms Hoffman's concerns[194] were said to be that Dr Patel allegedly attempted an evacuation without analgesia and that he stated that the patient was doing well when she required admission to the Intensive Care Unit following surgery.[195] The inpatient notes do record an attempted evacuation leading to a decision that the patient would require further surgery on 25 August 2004.

Dr Woodruff noted that the Surgeon's Report of 13 August 2004 recorded serosal tear with the diathermy. The need for an evacuation of the collection or haematoma was the reason for identifying this patient's adverse outcome as one that was contributed to by Dr Patel.[196]

Based on Dr Woodruff's opinion of the care given to P37 this case is likely to warrant possible disciplinary action by the Board.

4.12 P306

Dr Patel performed a colectomy on this sixty-two year old patient on 6 January 2004 after she perforated the diverticulum. Post-operatively P306 suffered with infection and deep vein thrombosis in the left leg. A second operation was performed after the stoma retracted.

The Woodruff Report identified this patient's adverse outcomes as one in which Dr Patel contributed.[197] The need for a second operation reflected, in Dr

[194] Based on information from Karen Stumer
[195] Statement of Toni Hoffman at [60] and T111
[196] Woodruff Report, 124 and T4325
[197] Woodruff Report, 125

Woodruff's opinion, an "*unquestionably deficient technique.*"[198] This case is one which could be referred to the Board for possible disciplinary action.

5. Patients the Commission has heard evidence regarding, but whose care is unlikely to warrant disciplinary action

5.1 Marilyn Daisy (P52)

A chronology of her care is as follows:[199]

23/08/2004	The patient was seen in the Outpatients at the Nephrologist Private Clinic by Dr Miach. He referred her to Royal Brisbane Hospital and asked the patient to return in six weeks time.
24/08/2003	The patient was seen in Outpatients in a medical ward review. A below knee amputation was planned and also to optimise renal function and to exclude significant coronary artery disease.
07/09/2004	The patient was seen again in Outpatients in a medical ward review. She was assessed as suitable for a below knee amputation.
07/09/2004	The patient was seen in Outpatients in s surgical ward review by Dr Patel. He notes that she is for a below knee amputation.
20/09/2004	The amputation was carried out by Dr Patel.
21/09/2004	The patient was seen by Dr Patel in the ward postoperatively.
21/09/2004	The patient was seen by a surgical medical officer.
22/09/2004	The patient was seen by Dr Sanjeeva, Surgical PHO.
22/09/2004	The patient was seen by Dr Smalberger and others on a ward round.
23/09/2004	The patient was seen by Dr Patel. He ordered removal of a drain and steri-strips and indicated he will review the stump.
23/09/2004	The patient was seen by Dr Smalberger and others.

[198] Dr Woodruff T4327
[199] Exhibit 100 and Statement Dr Keating

23/09/2004 24/09/2004 25/09/2004	The patient was seen by Dr Miach
27/09/2004	The patient was seen by Dr Patel. He indicated to continue physiotherapy.
27/09/2004	The patient was seen by Dr Smalberger.
27/09/2004	The patient was seen by Dr Miach.
28/09/2004	The patient was seen by Dr Patel, He recommended the patient be transferred to the medical ward and noted that the stump was healing well, that there were no concerns surgically that the patient should be followed up in the outpatients department and that she should be seen at the outpatients department in two weeks time.
02/10/2004	The patient was transferred from the surgical ward to the medical ward for dialysis. The patient was wanting to be discharged and was advised that it would be against medical advice.
04/10/2004	The patient was seen by Dr Gardner. He noted some problems with the stump, that the patient is to have a permacath inserted by Dr Gaffield the next day and that the patient is to have a surgical review of her stump by Dr Patel's team. She was to have the temporary catheter out as soon as the permacath was put in and can potentially go home after dialysis if the surgical team is happy.
04/10/2004	The patient was seen by a Surgical PHO, who noted that the stump looked okay with a small area of wound breakdown on the lateral edge of the wound. He ordered daily dressing and review.
05/10/2004	The patient was seen by a surgical house officer. He reviewed chest x-rays with Dr Gaffield and ordered the patients return to ward.
06/10/2004	The patient elected to be discharged from hospital despite advice from a medical officer that she may become unwell and even die.
09/10/2004	The patient presented to the emergency department indicating that she was advised to present by the medical ward for dressing change.

11/10/2004	The patient cancelled an outpatients appointment with Dr Miach.
12/10/2004	The patient had her dressing changed in emergency.
12/10/2004	A surgical ward's outpatients note indicates appointment with no entry.
19/10/2004	The patient had a dressing change in the emergency

Dr Jenkins, the vascular surgeon revealed three issues in relation to her care which concerned him. Firstly, that she had not been offered the option of saving her leg with a by-pass operation. Secondly, that the surgeon, Dr Patel, had not reviewed his work and had not seen her since the initial surgery. Thirdly, that the sutures remained in place despite the lapse of six weeks since the surgery.[200]

Option of procedure other than amputation

Dr Jenkins outlined alternatives which might have avoided the surgery. If the patient suffered dry gangrene and was non-life threatening it would be appropriate to attempt to save her leg. If she had wet gangrene, which was infective, then the appropriate treatment was either urgent revascularisation (which is not an option in Bundaberg) or amputation. He qualified his opinions indicating he did not know how her arterial tree appeared as prior to the surgery. He said that unless she had had an angiogram or ultrasound then that was difficult to discern.[201]

In essence the only reasons, according to his evidence, not to offer an option of revascularisation was that she was too unwell, if she did not desire it or had a degree of gangrene on her lower extremity.[202]

Dr Miach, as her treating renal physician swore that he was unaware that she had been admitted by Dr Patel for a below knee amputation.[203] He further

[200] Para 9 of Statement of Jason Jenkins. See also his exhibit 17.
[201] He expanded upon this to the extent that if she had significant small vessel disease then the probability is low that she would have had a limb that was salvageable – T3718 – T3727.
[202] T3727.

gave evidence that as a consequence he was unaware of her post-operative care. He said that she was extremely ill by the time that he was able to consult with her. This will be dealt with in greater detail further in these submissions.

Dr Smalberger gave evidence that he recorded that the amputation had been planned in his notes of 7 September.

Dr Kariyawasam, who assisted Dr Patel in the surgery, was unable to enlighten the Inquiry as to whether the patient had been offered any other option as to amputation.[204]

Review of the patient

Dr Jenkins' understanding was that the patient had not been reviewed at all by the surgeon and Dr Miach's evidence was that Dr Patel had left her in the ward under his care without advising Dr Miach although she was suffering from severe kidney failure and diabetes. By the time that he saw her she was almost comatose and suffering from uraemic encephalopathy. Dr Jenkins opined that he would have expected a review of the surgery the morning after it had occurred.[205]

Dr Miach complained that he had not been advised until one of his junior doctors – and it seems likely that it was Dr Smalberger from the evidence – advised him that she was an inpatient. Dr Miach said that given her severe kidney failure he would have expected to have been consulted and involved in the management of the kidney failure. Once he became involved in her care he treated her extensively for weeks until she recovered and was stable sufficiently to travel to Brisbane for further treatment. Dr Miach maintained that as she was admitted under the surgical unit she remained their responsibility.

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[203] See statement of Dr Miach para 76.
[204] See T3101.
[205] T3728.

Cross-examination of Dr Miach revealed the following:

- That he suspected his staff as medical people knew nothing of the forthcoming procedure and probably would have informed him. However, exhibit 100 reveals 24 August and 7 September that the out-patient clinic review notes indicated a planned amputation in the writing of Dr Smalberger, a medical physician.
    - 19 September there is a ward review pre-operatively by Dr Smalberger.
    - 22 September a review including medical team consisting of Dr Smalberger and others. It is clear from records that there was an acute deterioration on that day in renal function.[206]
- 23 September Dr Miach attended patient. Dr Miach conceded that she has been seen by the medical team prior to his attendance on 23 September.
- Dr Miach ultimately indicated that she was reviewed by a physician within the Department of Medicine who had organised her admission.
- Dr Smalberger was undertaking daily ward rounds but was particularly alive to cardiac issues with this patient.[207]
- It was he who recommended on the second post-operative day that Dr Miach become involved and when that did not occur until the third day he made a direct referral to that.

The sutures remaining in the amputated stump

Dr Jenkins is critical of the fact that the sutures remained in situ for up to six weeks by the time he saw her in Brisbane and his letter[208] indicated that the sutures were both painful and difficult to remove. By the time he gave evidence he had become aware that against medical advice she had

[206] See T1620-1621 and exhibit 100. Progress notes 23 September.
[207] T1978.
[208] Exhibit 17.

discharged herself on 6 October. Nonetheless he indicated that there were particular issues involving indigenous patients such as their reluctance to remain in hospital that would indicate that particular care needs to be taken with their admission.

According to Dr Kariyawasam's statement[209], there were no arrangements made by the medical team for the outpatient's surgical follow-up. It is his understanding that follow-up appointments would usually be arranged by the ward clerks after a note had been made in the chart. He stated that their surgical team was not made aware of her self-discharging on 6 October 2004 and had they been informed a follow-up would have been arranged for continuing monitoring of the wound. Dr Woodruff in his evidence[210] indicated that this case was not as straightforward as it initially had seemed in that there were at least three people involved in her care in Bundaberg. She was also sent off for another procedure to another hospital. It did not excuse the oversight of leaving the sutures in place but made it explicable. It was placed on the list of adverse outcomes in relation to Dr Patel because although the circumstances were explicable, they did not exonerate him for some responsibility.

Conclusion

There is insufficient evidence to indicate whether there were other options offered to the patient in relation to procedures other than amputation. This is not simply a matter that goes to clinical judgment but really goes to the issue of informed consent. Secondly, as to the issue of the failure to inform Dr Miach and therefore attend to her renal needs this is not as clear cut given on the evidence a member of his team albeit from a slightly different focus was attending her both pre-admission and also within two days of her operative procedure. Whilst there was clearly a breakdown in communication this is of less significance than it had first seemed. As to the third issue of the non-removal of the sutures, clearly this was an adverse outcome for the patient in that the sutures presented considerable difficulty for her. Whilst Dr Patel

[209] Para 94.
[210] T4304

contributed to this outcome it could not be said that he was solely to blame given the patient's self discharge and the involvement of other practitioners as Dr Woodruff stated. The ground which may well fall for consideration for possible disciplinary action is the lack of informed consent to this procedure by the patient and possibly as to the failure (given the patient's co-morbidities) to plan for her holistic care. As Dr Miach indicated he would have expected to have been consulted about the amputation as a matter of courtesy. In this case consultation may be seen as a necessity given her very considerable needs in relation to her chronic renal failure.

Further references in the evidence are as follows:

Statements – Jason Jenkins, Kariyawasam, Miach

Transcript – Jenkins 3695-3697, 3717-3718, 3727-3728;)
Kariyawasam 3101-3102)
Miach – 286-288; 1567-1570, 1573-1574, 1591-1594,)
1613-1629, 1657-1659)
Smalberger – 1977-1978)

5.2 Linda Parsons (P99)
Exhibit 100,101

Statement- Parsons; Dr Boyd – Ex 108, 106, 109, 112, 113
Transcript- Woodruff 4324; Parsons 1716-1774; Boyd 2824-2828

5.3 Geoffrey Smith

Statement Ex 174

6. Clinical Practices at Hervey Bay Hospital

Terms of Reference

(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 Commissions of Inquiry Order (No. 1) of 2005.

6.1 Gloria Green (P430)

This was an elderly patient aged seventy-nine at the time of admission, she was a resident of Torbay Nursing Home with core morbidities being severe dementia and cardiac problems. She was initially admitted in the accident and emergency unit after a fall in which she sustained a mid shaft spiral closed left humerus fracture. Initially, a plaster was applied to her arm, which she removed overnight. In a summary of her admission prepared by a resident medical officer[211], on 27 July the patient was booked for manipulation to occur under sedation.[212]

Prior to this time the note in the summary states:

> "*Proximal fragment, punctured skin – 11 am 0.8 cm wound applied in theatre by Dr Naidoo*".

In cross examination of Dr Naidoo, a further nursing note was put to him which corroborated there was a broken area of skin noted over the fracture site[213]. He denied that and maintained there was no open wound at the time of the initial surgical procedure.

He elected to perform the procedure conceding it was not ideal, for the following reasons:

1. The internal fixation with a plate and screws would have failed because of the nature and extent of her osteoporosis and because of the difficulty to control the patient and her need to be frequently sedated.
2. The ideal procedure, he stated, would have been intramedullary nails and supplementary fixation. He discounted this because the equipment was not available and would have been required on loan. The second reason is it would have increased the risk of mortality because of her general medical condition. He confirmed that he had sought an opinion as to this from the duty anaesthetist.

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[211] This is part of an annexure relating to this patient to the statement of Dr Sean Mullen
[212] as due to her general medical condition, Dr Naidoo stated that the anaesthetist elected to perform the procedure under sedation rather than full general anaesthetic
[213] Nursing note 27 July 2000

Dr Naidoo indicated that despite the fact that she had already removed one plaster cast herself prior to his surgical procedure of 27 July, nonetheless this was the preferable option on the day.

Secondly, as there was not an open wound it was not contra-indicated. He accepted that if it was an open wound the situation would have differed.

The summary further notes that on 29 July, the bandages were soaked and there was hemoserous fluid. The bone was seen medially. Dr Naidoo was phoned and advised: "*leave it in situ and re-bandage*".

Dr Naidoo also accepted the note on 30 July 2000, a note which provided that:

> "*PT still same/deteriorating ↓↓/confused... - back slab on ... - Dr Naidoo informed last night and she is medically too unwell – discussed ... James, Medical PHO*".

He accepted that prior to his going on leave on 31 July he did not review the patient himself despite the fact she had been deteriorating since the procedure on 27 July as advised. He states that he may not have been rostered on from 29-31July.

He accepted that he made no formal arrangements, or indeed informal arrangements, for the handover of her care to another medical practitioner skilled or experienced in orthopaedics.

Dr Naidoo accepted that on 2 August 2000 Dr Mullen became involved with the patient at that time. According to Dr Mullen's evidence, in his statement[214] and his oral evidence, he then took the patient to surgery and applied an external fixator, and generally attended to the now exposed and infected wound. Dr Mullen's procedure whilst the wound was open was appropriate although, as it became apparent, was also fraught with difficulty because of the patient's dementia.

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[214] Exhibit 330, paras 6-12

On his return, Dr Naidoo resumed the care of the patient when he observed the external fixator was loose with dislodgment of the pins and fragmentation of the fracture.

Eventually on 10 August the patient had her arm amputated.

Dr Naidoo accepted Dr Mullen's opinion, that he had not seen a "*closed ... non-open fracture of the humerus in a low velocity situation in an old patient end up with amputation*".[215]

Dr Naidoo accepted Dr Mullen's opinion that with these sorts of situations one needs to attend in a fairly prompt period of time to deal with the problem[216]. This is borne out by the fact that Dr Naidoo[217] had been admonished by Dr Hanelt after the amputation had occurred in that he expected Dr Naidoo to notify Dr Mullen of a patient such as Mrs Green when he was to be absent on leave and hand-over to Dr Mullen informing him of the condition of the patient and her needs.

Dr Naidoo did not accept Dr Mullen's indication that the delay would have led to the outcome of the amputation.[218]

Conclusion

There are two particular issues arising from Mrs Green's care. Firstly, the original procedure carried out by Dr Naidoo on the 27 July and, secondly, the lack of review and/or handover by Dr Naidoo.

As to the first issue, it is clear that the matter was particularly complicated because of the presence of significant other medical conditions in Mrs Green's presentation. Neither of the courses adopted by either surgeon was ultimately successful in securing the fracture. Dr Naidoo did concede that if

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[215] T5450
[216] T5453
[217] Cross-examination by Counsel for Dr Hanelt
[218] T5453

the wound was open, that Dr Mullen's election to leave the wound open and attempt the procedure he did was appropriate. The nursing notes certainly reveal that there was an open wound at the time that Dr Naidoo carried out the first procedure. It may well be decided that this was a difference of opinion and it was a difference in clinical judgment between the two doctors.

The second issue is far more significant. There was clearly an ongoing need for close attention to Mrs Green's condition. When there must have been concern as to the effectiveness of the procedure and also the presence of her other significant symptoms, the only physical occasion there was a review by Dr Naidoo was on the day after the procedure. He was contacted at least twice thereafter until he went on leave during which he was made aware that the patient was deteriorating. It is unclear whether those contacts were on the weekend when he was not rostered on. Even if it were so, given the complexity of the patient's condition and the deteriorating nature of it, there should have been arrangements made as he was later admonished by Dr Hanelt[219]. This issue and the ultimate very significant consequences may well sound in the matter being referred for possible disciplinary action as constituting a standard of care which is less than expected of one's peers.

6.2 J. Howard Osborne

Statement paras 23-26

This was a patient who Dr Mullen ultimately at the invitation of the theatre sister took over an operative procedure being performed by Drs Krishna and Sharma. He described that there was a fracture of the femur which had occurred during placement of the nail which had been put in place. The patient had also sustained a fractured ankle because of the extended period of time the patient had been anaesthetised and the blood loss. Dr Mullen was of the view that it was best that he attended to the fractured ankle as quickly as possible to return the patient back to the ward as the anaesthetists were concerned about the temperature and the general condition of the patient.

[219] T6706

He conceded that where a fracture has occurred whilst nailing a femur is not unexpected. His concern was that the selection of device to use in that particular situation was inappropriate because the device was a newer device which required greater skill to place and often needed two assistants as there was no external support to hold the patient in place, the device being a retrograde femoral nail.[220]

Drawing on his own experience as a trauma surgeon and given the difficulty in use of that device his view would have been that it was the wrong selection and again Dr Naidoo should have been supervising the situation.

He had understood that as he was on duty that evening Dr Naidoo had been the orthopaedic specialist on duty during the day. It was Dr Mullen's evidence that he had been contacted several times by nursing staff during difficulties encountered.[221]

The surgical note records that the patient was anaesthetised at 1.36 p.m., that the surgery commenced at 2.24 p.m. and finished at 6.45 p.m. with the patient departing from the operating theatre at 6.55 p.m.[222] The operation report confirms that Dr Mullen was involved in the operative procedure on that date.

Dr Krishna's evidence was:

- That he had not sought to contact Dr Naidoo.
- That it was a comminuted complex fracture.

It was not part of his scope of practice document.[223] However he drew attention to the fact that the operation was performed in 2003. The scope of practice document was drawn up in 2004.

He had performed a couple of these procedures and thought it was not unreasonable to perform it unsupervised. Whilst Dr Sharma indicated to Dr

[220] T5767
[221] T5768
[222] See operating room nurse's report
[223] See annexure 6 to Dr Krishna's statement

Mullen he would have preferred assistance, Dr Krishna was comfortable without it.

He defended his choice retrograde nail as being appropriate and which he had known of since 2001.

He had had the assistance of Drs Sharma and Hugh McGregor.

The retrograde femoral nail as appropriate as there were two fractures close to the knee joint which this was particularly designed for.[224]

6.3 Allan Smith (P436)

This patient sustained an injury whilst falling from a boat ladder in March 2004.

Dr Krishna initially operated upon the patient on 28 March by performing an open reduction internal fixation of the right hip, achieved with a pin and plate.

The patient unfortunately developed wound infection which required a month in hospital.

Dr Mullen reviewed the patient on 18 July 2004 and highlighted the particular issues of note:

- He was a heavy man,.
- There was a large amount of force involved in the fall.
- this was a fracture of the proximal intertrochanteric region of the right femur .He opined that it was a dangerous area because it is difficult to get fixation there.
- The fracture was also comminuted;

[224] T6487

- His opinion was that the fixation used was inadequate, that is, there were only four screw holes in the plate to fix the bone to the shaft whereas there should have been between eight and twelve.

In addition, Dr Mullen opined there was at the time of the surgery other techniques available which were better suited to the circumstances such as using a long plate or a big nail that goes into the canal of the bone which can provide more stability[225].

- The x-ray revealed non- union of the fracture

- There was loosening of the fixation, particularly the screw within the femoral head and a "*windscreen wiper effect* "[226]. But that in itself did not indicate that the fracture hasn't healed, maybe that the fracture had been loose and then subsequently healed. But it did indicate that the fracture was unstable still.[227] He conceded however that it was not easy to determine that and he had to consult with the patient twice to form that diagnosis.

He conceded that his statement at p. 6 was incorrect as he had not seen the patient some nine months later but approximately three months later[228].

As at the date of the review the causation of the non-union was obscure as to whether it was due to non-fixation or infection.

- The patient had complained in outpatients over a 9 month period of pain and non-weight bearing on the hip;

- There was no supervision by Dr Naidoo of Dr Krishna[229];

- Ultimately, the patient underwent a total hip replacement on 6 December 2004 by Dr Mullen which could have been avoided.

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[225] T5778
[226] Ex 370-extract re Allan Smith
[227] T5801
[228] T5803
[229] Para 34 Statement Dr Mullen

In his oral evidence Dr Mullen was more forthright indicating that the failure of fixation because there was an adequate device used on a very unstable fracture in a heavy man.[230]

In cross-examination Dr Mullen conceded that the treatment received by him would be standard for injury which would be slightly higher and less unstable.[231] Hence an intratracheal fracture a pin and plate with four holes would be "a good device and works well".[232]

In subsequent correspondence to the patient's general practitioner, the patient was making an uneventful recovery[233].

Dr Krishna

Whilst accepting many of the features as described by Dr Mullen, Dr Krishna rejected that the suggestion that either of the techniques described by the latter as being preferable that is a long plate with a different type of screw into the ball of the femur or intramedullary nailing, into the canal of the bone, were appropriate.[234]

The essential difference for Dr Krishna that in his view this was not a subtrochanteric but rather an intertrochanteric fracture.[235]

He also maintained that he had followed up the patient adequately and had not required supervision:

- The patient was comfortable and able to bear weight;
- x-rays of 7 May 2004 indicated new bone was forming and the fracture had healed;

[230] T5800
[231] T5799
[232] T5799
[233] Ex 370
[234] T6495-6
[235] T6496

As he had deep vein thrombosis and was monitored weekly by his general practitioner, the general practitioner could be contacted if there was a problem.

Conclusion

In essence, this case does not warrant further investigation for disciplinary action as there is clearly a difference in opinion which can be differentiated on perusal of the x-rays as to what type of fracture it was.

Secondly the cause of the non-union is unclear as Dr Mullen says Dr Mullen also conceded that there was a history of infection and that area of the body is notorious for non-union of bone.

If it were a sub-trochanteric fracture the chances of non-union were high and implant failure was high because of muscle imbalances[236], whereas if it was intra-trochanteric the fixation achieved good stabilisation. The resolution of that difference of opinion by having regard with the x-rays.

It was his view that if an apparatus requiring 8-12 screw holes would have been inappropriate because the instability and the fractures were not in the shaft it was all above the less trochanter. However his opinion necessarily rested on the fact as to whether the fracture was the intra-trochanteric location.

6.4 Brendan Thomas (P434)

This patient was aged fifteen upon his admission following a football injury. There was a closed reduction of the fractured wrist in surgery.

The patient was reviewed by Dr Mullen on 18 and 25 September, consecutively one and two weeks after his surgery. On the latter date the x-rays confirmed that the fracture was still well aligned, there was a 5° dorsal angulation at the fracture site but that was within acceptable limits. He was planned for further review in another four weeks.

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[236] T6518

The review notes indicate that he was subsequently seen in the orthopaedic review clinic on 23 October but it is unclear by whom. The patient was next seen on 6 November by a Dr Bacon and subsequently not until 29 May and 16 June 2003, both times it would appear from the signature, by Dr Sharma.

The critical issue according to Dr Mullen was that in this type of injury where there was instability of the joint a further loss of reduction does not occur necessarily within the first couple of weeks but it develops in a period of between six and twelve weeks post injury. Dr Mullen's concern in relation to Mr Thomas' injury was that it was poorly treated with a lack of supervision in the aftercare and that as a result the patient required major reconstruction in Brisbane with Dr Peter Rowan, a hand and upper limb surgeon.[237]

Whilst he does not criticise Dr Sharma who carried out the review in May and June 2003 it was Dr Mullen's view that he should have been supervised by Dr Naidoo or an experienced orthopaedic surgeon. Dr Mullen noted that it was a difficult fracture because it often led to problems with stability of the joint and the fracture could move position over a period of time in the post-fracture weeks and therefore needed close supervision. It was his understanding that the patient would be followed-up through the outpatient orthopaedic clinic.[238]

When he reviewed the patient in February 2004 Dr Mullen's diagnosis was that he was suffering from a subluxation of the distal radioulnar joint of the right hand side from a malunited galeazzi fracture. In Dr Mullen's view junior staff would not necessarily recognise that the joint remained unstable.

Although the long term outcome is satisfactory for the patient because of the operative procedure carried out by Dr Rowan it would have been less traumatic in terms of the surgical procedure if it had been corrected at an earlier time.[239]

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[237] See para 31 of his statement. See also T5769.
[238] T5770
[239] T5771

Conclusion

There is not a ground for a referral for disciplinary action against Dr Sharma. In relation to Dr Naidoo, it is part of the broader issue of possible lack of supervision which was made available to Drs Krishna and Sharma. The criticism of Dr Mullen flows from the proposition that the original surgery was appropriate.

The post-operative care offered to the patient was inadequate. An area of uncertainty emerges as it appears from the x-ray evidence that apparently shows that the degree of angulation was more than 15° in the x-rays ordered on 30 October 2003 by Dr Mullen.[240] Whether that sounds in any consequence in relation to the initial surgery, indeed the follow-up of the instability, or some error by the radiographer is a matter which could call for further investigation.

6.5 Dylan Neil (P446)

This was a young patient fifteen years old who presented with a fractured left tibial plateau after falling while playing football. He described a twisting injury to his leg as his knee impacted on the ground. He was operated on 24 May 2004 by Dr Naidoo, assisted by Dr Krishna. It was a comminuted displaced fracture whereby the fracture extended into the knee joint.

On 2 June, Mr Neil returned to surgery for the insertion of percutaneous screws to the left lateral tibial plateau.

It was noted:

> *"the wound has healed well without problems, he has a normal gait and a good range of motion".*

A recent x-ray shows the fracture union in good alignment.

Dr Crawford's critique of the care of Mr Neil was that the screws inserted during the first operation were too short to get across the *"two bits of bone*

[240] T5790-T5792

and hold them together... There was a bit of bone and there was a bit of bone from the joint which had not been put back into place".[241]

The observations of Dr Crawford arose from the x-rays taken post-operatively between the two operations. As the discharge summary makes clear, after the x-rays were viewed (and Dr Naidoo accepted this) a decision was made to return to the operating theatre on 2 June.

Dr Crawford stated that the second operation was to try to pull the bone back together "*but I suspect it wasn't recognised that the bones were in the wrong place and couldn't be pulled together with just the screws...*".

It was also his view that the wound should have been re-opened to put the bone back together, in effect, to replace it appropriately.

Dr Naidoo rejected that the second operation was ineffectually performed in that the wound should have been re-opened. Dr Naidoo said that may well have led to infection.

In any case, it is clear that the patient has in the short term recovered well and is functioning, in the words of Dr Crawford, "*surprisingly well*". However, in the longer term he opined, in answer to questions from Counsel Assisting:

> "*Does it seem reasonable to conclude that the prospects of his suffering arthritis later are increased because of the way these procedures were performed? ... Yes.*"

Dr Naidoo rejected this opinion and indicated that the likelihood of osteoarthritis is really predicated at the time of injury, rather than as a result of subsequent treatment. Whilst there is no note of him having reviewed the patient subsequently, Dr Naidoo swore that he had done so.

The x-rays following the first procedure revealed that the procedure (which Dr Crawford conceded was a difficult one to perform) had not been successful in terms of its outcome. Based on the opinion of Dr Crawford, it would not seem that this matter would warrant referral for possible disciplinary action for lack of competence on the part of Dr Naidoo.

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[241] T6309

6.6 Rita Jackson (P444) HBH UR070090

Ms Jackson was a patient who was first brought to the attention of the inquiry by Dr Mullen[242] who identified that she had had a big toe fusion that was performed without her consent and it led to significant disability and was being treated by Dr Blenkin in Brisbane. Dr Mullen's criticism was that the procedure was carried out by Dr Krishna unsupervised at Hervey Bay. Dr Mullen said that the supervision should have been followed up by Dr Naidoo. In his oral evidence Dr Mullen said that if a toe is fused in the wrong position it would allow for poor function of the foot and it is quite difficult to get the position right. It would take "*a fair amount of experience to do that. So I do believe that it should not have been done by Dr Krishna*"[243].

This patient was also reviewed by Dr Crawford on 2 June this year. He noted that she had had a first MTP fusion on 3 September 2003. He noted in her history that she had a significant bunion and that she sustained a deal of pain from her joint. In the history he took from her he noted that there was an issue in the outpatient notes[244] that she had not fully understood the procedure and it was postponed at that time. She was subsequently seen some eight days later and was consented for a bunionectomy and MTP fusion. She had originally been consented for bunionectomy. Dr Crawford noted that in his review there had been some degenerative changes on the original x-rays and whilst it was difficult to be sure she did have some degenerative changes and fusion may well have been a reasonable option.

Dr Crawford noted that she had sustained ongoing problems and had impaired enjoyment of former activities. He noted that the angle of the fusion on the x-ray suggested that it was 15° but clinically less significant. Upon his review he provided options for further treatment which would in his opinion

[242] See para 32 of his statement, exhibit 330
[243] T5773
[244] 13 August 2003 noted in his report 9 June 2005

provide her with a reasonably good chance of making her significantly better than she is now.

The issues which then arise are – firstly, performing a procedure which was not properly consented in that she had apparently consented to a bunionectomy and not a fusion and secondly, the issue in relation to the performance of the actual procedure. As to the latter issue Dr Anthony Wilson gave evidence that this would fall within the type of procedure that Dr Krishna would have been able to perform unsupervised. As to the skill with which it was performed it is noteworthy that Dr Crawford in his evidence indicated that the correct position for the fusion was achieved and the joint was appropriately stiffened but not quite in the right position. In his words:

> *"If you saw that someone who is competent had done this and achieved the same result, I mean, it wouldn't ring any alarm bells ...*[245]

Therefore on the second issue there seems to be an issue of differing clinical judgment rather than issues which would merit disciplinary action. The former issue appears to be resolved satisfactorily as Dr Crawford notes in his report in relation to the subsequent consent noted 21 August 2003. There is also in the patient consent form the addition which appears of the fusion "MTP J initials including RJ".[246]

6.7 Judith Harris

Judith Harris was a patient highlighted also in Dr Mullen's evidence. Her complaint to the Health Rights Commission is currently under investigation.[247] She sustained a distal tibial shaft fracture and tibial and fibular fractures on 4 January 2005. She slipped and fell whilst walking in a paddock and was transported to the Hervey Bay Hospital. She was assessed in a backslab and admitted to a ward.

[245] T6306
[246] Pages 155 and 156 of the chart
[247] T6489

Due to staff shortages, surgery was postponed and she was discharged to return to surgery. She underwent an open reduction internal fixation of the left tibia and fibular on 11 January 2005 performed by Dr Krishna.

She had a prolonged stay in hospital for 11 days due to some bleeding from the medial wound.

She subsequently returned and was admitted on several occasions to both Maryborough and Hervey Bay Hospitals due to wound infections and required antibiotic treatment. She sought treatment with Dr Mullen who on-referred her to Dr Journeaux at the Mater Hospital in Brisbane. Upon his examination in May 2005 Dr Journeaux observed that upon examination and review of the x-rays there was an obvious non-union of both the tibial and fibular fractures. According to Dr Journeaux' report she would require further surgical work including removal of metalwork, excision of dead bone and perhaps bone transportation. He suggested a consultation with Dr Tetsworth.

The essence of the issues are firstly, the performance of the procedure by Dr Krishna as an SMO rather than a qualified orthopaedic surgeon and secondly, the standard of the procedure performed.

Dr Krishna himself during the performance of this procedure indicated that he had required assistance from Dr Naidoo and had been told to in effect "open up the patient and contact Dr Naidoo if necessary". When he commenced to operate he indicated the fracture was very comminuted, distal fibular and confirmed by the chart.[248] Dr Naidoo did not attend and there is a further note where there was no surgical assistant available despite requests from Dr Krishna noted. Dr Krishna's evidence was that he contacted Dr Naidoo twice to attend.[249] This was a procedure on the assessment of Dr Naidoo, that Dr Krishna required supervision. Dr Naidoo's evidence was that that would relate to a more junior assistant specialist which notation is left blank in the relevant form. Nonetheless he accepted he was not available to assist Dr

[248] See p. 203 of the chart
[249] T6494

Krishna. This may be a matter requiring further investigation of Dr Naidoo's apparent failure to attend to supervise Dr Krishna when requested to do so.

6.8 Madge Payne (P445) UR108708

This patient's treatment was highlighted by Dr Crawford as being similar to that administered to Rita Jackson. This case is subject to current investigation by the Health Rights Commission. The patient was reviewed by Dr Crawford on 2 June 2005.

She was first seen at the Hervey Bay Hospital on 28 July 2003 with bi-lateral painful bunions and x-rays showed severe degenerative changes in the first MTP joint. She had an arthrodesis of her left first MTP joint on 27 August 2003. Dr Crawford noted that she healed well without significant problems. Subsequently on 27 July 2004 she had a right first MTP fusion. She healed unremarkably although she subsequently noticed to have stiffness of the "DOP" joint on her right side.

She had formerly been a keen dancer but is unable to stand on the front of her foot with her ankle flexed. She was unable to do some other activities because of the limited movement in the joint of her toe and other symptoms. On examination which was confirmed by the x-ray there is a significantly greater degree of extension at the IP joint whereas on the right side there was approximately only a 5° extension. Dr Crawford noted that she has two particular problems. One is the functional limitation due to the lack of extension in the position in which the IP joint has been fused.[250] In essence Dr Crawford concluded that on one side:

> *"the left side – she had a very good result. Everything seems to have been done completely appropriately. On the right side she had the same problem as the previous patient mentioned P444 had, that the joint just wasn't – didn't quite have enough of an angle on it and she had ongoing difficulty walking because of that. Subsequently I similarly*

[250] See exhibit 407 for a more extensive description of the treatment and difficulties sustained by Mrs Payne.

had to perform corrective surgery in Maryborough to readjust the angle."[251]

Dr Crawford's criticism centred around the lack of supervision for Dr Krishna as contained in the following passage of evidence:

> *"... had there been supervision in place at the time of that second operation in her case and the operation in P444's case, that moderate angle difference might have been discerned by the specialist and corrected there and then? ... That's correct yes."*[252]

It is submitted that Dr Krishna's conduct in performing the operation showed an error in judgment in the error in the angle of fixation in the second operation whereas he had successfully performed the same operation on the same patient a year earlier.

Her adverse outcome which now appears to be rectified by Dr Crawford's subsequent procedure would not warrant a referral for disciplinary action in relation to Dr Krishna.

This was a procedure Dr Krishna was assessed as being able to perform without supervision.

6.9 William Skene (P442)

Dr Crawford reviewed this patient at the outpatient department at Hervey Bay Hospital on 2 June 2005. He presented with pain in his left foot mainly complaining of pain underneath the plantar aspect of the left foot where he indicated he had two lumps.

The patient was first seen in the outpatients clinic on 31 October 2003 where it was noted that he had bi-lateral hammer toes more severe on the left side and no callosities at that time. The x-rays demonstrated osteoarthritis. Dr Crawford's view was that the outpatient notes showed a brief but reasonable assessment of the problem.[253]

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[251] T6307
[252] T6315
[253] Report prepared by Dr Crawford exhibit 405

The patient was reviewed on 14 November 2003 at the same department for consenting and the notes indicate it was for correction of the hammer toes to the four lesser toes and fusion of the MTP joints with K wires.

The patient underwent surgery on 28 January 2004 involving excision of the second and fourth metatarsal heads, excision of POP joints to the lesser four toes, extensive tenotomies and K wiring. Subsequently reviews on 6, 13, 19 and 27 February were uneventful save for superficial infection noted on the second review date. On 12 March the wiring was reviewed and the toes were noted to be viable.

Dr Crawford's impression was that the first clinical review was reasonable but it was not noted that he had a history of rheumatoid arthritis and that the MTP joints were dislocated on x-ray which were apparent from the films from October 2003[254]. The decision to go ahead with surgery did seem reasonable to Dr Crawford. The majority of the procedure would have been the right thing to do except for the decision to fuse the MTP joints. In oral evidence Dr Crawford expanded:

> *"The aim of the operation is to stiffen one row of joints in the toes and excise a second row and leave them floppy, which would be a standard procedure, and that's what the patient was booked for. So the patient was actually booked for appropriate surgery but when the operation was performed the patient actually had two rows of joints stiffened rather than just one, which was I think, clear because of his ongoing pain and symptoms. He subsequently had corrective surgery which I performed in Maryborough to excise one of the rows of joints that had been stiffened, which basically put him back to the situation he would have been if he had had the original surgery. So I think his final outcome is the same as it would have been. In fact I am not aware of it being a prescribed operation, to actually stiffen both rows of joints."*

Dr Crawford added in answer to a question from Counsel Assisting that if an orthopaedic surgeon had supervised Dr Krishna it is not something that a surgeon might have permitted Dr Krishna to do.[255]

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[254] Exhibit 405.
[255] T698

Dr Krishna in examination-in-chief by Counsel Assisting accepted that the surgery was unsupervised but did not consider calling for supervision.

Dr Krishna responded that he performed this procedure in an inappropriate fashion which necessitated further operative procedures being performed by Dr Crawford with this patient[256]. It is a matter which may warrant further investigation with a view to discerning whether this was performed with the skill of a lesser standard than that which might be expected of a non-specialist medical practitioner.

6.10 Marilyn Costello

This patient suffered a flexion contracture of the left middle and little fingers. Most of the contractures were confined to the proximal interphalangeal joints but a tight cord is also felt on the radial aspects of the volar surface of the fingers. It was also noted that she had a Dupuytren's contractual release in the right hand. Dr Sharma in a letter to a general practitioner on 31 July 2003[257]:

> *"I have advised her about the condition and have told her that we could do a surgical release but the common observation is that flexion contractures of the interphalangeal joints are hard to correct, and so there is no guarantee that surgical correction will improve this contracture. However, she wishes to have the surgical release to see whether it improves ... and will put her name on the waiting list for an attempt tor release those contractures, but as I have said this may not improve the flexion contracture of those fingers."*

On 8 December 2004 Dr Sharma performed the surgery to effect a release of the Dupuytren's contracture.

Subsequently, she was reviewed by Dr Crawford in the outpatients clinic at Hervey Bay Hospital. Her complaint on seeing Dr Crawford in June 2005 was the contracture in the scar, although she still had limitation of extension at her PIP joints and had limited flexion at the DIP joints. She was unable to indicate

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[256] T6501
[257] Check whether this has been tendered

whether the restricted flexion of the DIP joints was present pre-operatively or not.

On examination Dr Crawford noted that she had scar over the palmar aspect of the hand. The scars had formed keloid and although she had other scarring on her body they had not formed keloid.

Dr Crawford noted that the patient had persisting Dupuytren's disease in the palm over the middle ray. He noted the movements in her PIP joint which indicated varying levels.

In terms of whether future operative procedures may improve her situation Dr Crawford advised that revision with Z-plasties may be beneficial. However he gave the proviso that with or without further release, the disease will not gain her increased flexion and she will need to still have further occupational therapy.

He referred her on to Dr Rowan who provided a report dated 11 August 2005. On examination Dr Rowan noted a persistent contracture of the PIP joints particularly of the middle right and little fingers. It was Dr Rowan's view that she would require scar revisions but concurred with Dr Crawford's view that they would not fix her dystrophic symptoms.

Dr Sharma's letter of 31 July 2003 appears to have expressed appropriate caution in relation to the possible outcomes of the proposed procedure. In those circumstances, it is difficult to see any warrant for referral for disciplinary action in relation to Dr Sharma's management of this patient.

7. Pattern of Practice

Part 7 and in particular Section 125 of the *Health Practitioners Professional Standards Act* 1999 relevantly provides:

> *"(1) A registrant's board may start disciplinary proceedings against the registrant if it reasonably believes a disciplinary matter exists in relation to the registrant.*

(2) Without limiting subsection (1), a registrant's board may start disciplinary proceedings against the registrant on the basis of -

(a) a single complaint received about the registrant; or

(b) a number of complaints about the registrant, including, for example, a number of complaints suggesting a pattern of conduct or practice."

It is open on the evidence for there to be a referral in relation to a pattern of practice for the following three patients:

1. Gloria Green;
2. Judith Harris; and
3. J. Howard Osborne.

In these particular cases it is said by a number of witnesses that Dr Naidoo was unavailable at critical times. The evidence is controverted in relation to Mrs Harris in that Dr Naidoo maintains he was conducting a clinic at that time. It is arguable that these three cases may constitute a pattern of practice.

If the Commission finds on the evidence as a totality that Dr Naidoo failed to supervise in a generalised sense this would add support to this avenue being investigated.

A central complaint in relation to each of them is Dr Naidoo's unavailability at critical times.

7.1 Impairment

Part 7 of the *Health Practitioners Professional Standards Act* 1999 applies if the Board believes because of a complaint, relevantly for these purposes, that a registrant may be impaired the Board may decide to deal with the registrant under this Part as an alternative to the investigation pattern.

"*Impairment*" relevantly includes a mental impairment, disability, condition or disorder that detrimentally affects, or is likely to affect, the registrant's physical

or mental capacity to perform the registrant's profession and includes substance abuse or dependence.

However this is caveated if the Board reasonably believes a suspected matter may provide a ground for suspending or cancelling the registrant's registration and then must investigate the matter pursuant to the investigation part or a further matter pursuant to s. 126 for hearing by the Health Practitioners Tribunal[258].

If the registrant is impaired the Board may impose conditions upon the registrant's registration requiring supervision, entering into an undertaking or referring the matter pursuant to s. 126 for hearing by the panel or tribunal.[259]

Dr Naidoo has given both oral and written evidence as to the fact that he is currently on stress leave and more pertinently that he was diagnosed in August 2000 that he was suffering from depression by Dr Andrew Christenson, a psychiatrist.

He has been hospitalised in the New Farm Clinic for depression three times. Once in 2003 and again in 2004. It is of note that the 2000 period was significant for three weeks and for two weeks in each of 2003 and 2004.[260] It may be of relevance noting for instance the patient Gloria Green was treated in July 2000 and Dr Naidoo's depression was first diagnosed in August of that year.

Dr Naidoo had been discharged it seems for approximately 2-3 weeks by the time Mrs Harris had her operative procedure in the Hervey Bay Hospital. It may well be that the nature of Dr Naidoo's condition has no bearing upon any relevant referral for disciplinary action. However it is a matter that warrants further consideration by the Commission and the Medical Board.[261]

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[258] Section 268 sub-section (2)
[259] See s. 299
[260] See exhibit 431
[261] See statement of Dr Andrew Christensen, exhibit 439.

It is also of note that in relation to Dr Krishna in his scope of practice as annexed to his statement DK6 Dr Naidoo had approved that the procedure should have been done under supervision.[262]

[262] See DK6 exhibit 424