Submissions

Dr John SCOTT

QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

FURTHER SUBMISSIONS ON BEHALF OF JOHN SCOTT

These submissions are made in response to the potential adverse findings notified to Dr Scott in a letter dated 18 October 2005 from the Queensland Public Hospitals Commission of Inquiry. They are supplementary to our previous submissions of 7 October 2005 (misdated September). The potential adverse findings are reproduced in bold below, with our submissions following immediately below each of them.

The introductory words to the list of potential adverse findings are: **With respect to your tenure as the General Manager of Health Services for Queensland Health that:**

Dr Scott was appointed to act as Senior Executive Director Health Services in November 2003; he was on long service leave from July to October 2004; appointed as SEDHS in November 2004, and his employment was terminated in July 2005. He acted as General Manager Health Services for some time after November 2003 - see the CV which is "JGS1" to his statement , ex 317, and paragraph 1.6 of that statement.

(a) **Following Dr Aroney writing to the Premier on 16 December 2003, in the company of Mr Dan Bergin and Dr Andrew Galbraith, you met with Dr Aroney on 8 January 2004 and commented to Dr Aroney that if he made further comments about Queensland Health <u>in the media</u>, <u>then Queensland Health would respond in kind.</u> The Commission may find that these comments were a threat of reprisals against Dr Aroney if he made any further disclosure or complaint about the provision of cardiac services at the Prince Charles Hospital.** (Underlining added)

1.1 It is wrong to say that the meeting of 8 January 2004 followed the sending of the letter of 16 December 2003 because it gives a false impression that the first thing caused the second. In a causal sense, the meeting followed Dr Aroney's decision to go to the media with his allegations about cutbacks and deaths. This is clear from Dr Aroney's statement ex 263 – paragraphs 17-23 (attachment A). Indeed, it was Dr Aroney's view that there was no response

at all to his letter to the Premier. That is why he decided to go to the media. The meeting was organised, according to Dr Aroney, as a result of his going to the media – see paragraph 23 of his statement.

1.2 Second, the comment with which the Commission is concerned is responsive to Dr Aroney's use of the media, not his writing to the Premier. So much is accepted in the potential finding notified – see the first underlined part of the passage above. For this reason we will not direct the Commission specifically to the evidence about this, unless we hear further from the Commission. However, we note that the assumption in the first underlined part of the passage above accords with the evidence of both Dr Aroney and Dr Scott, for instance see t 6261 l30: *"I was very taken aback when Dr Scott launched into me at the meeting to intimidate me and shut me up. Obviously angry about the public disclosures and seeking to keep me solely from then onwards."* [sic]

1.3 The comment made by Dr Scott was, as is assumed in the second underlined part of the passage above, about Dr Aroney's use of the media. Dr Scott says at paragraph 19.12 of his statement, ex 317, (attachment B), *"What I intended to convey was that if Dr Aroney continued to criticise QH in the media, that we would respond to any allegations he made."* This is the natural meaning of the words in the context which Dr Aroney has them in his notes of the meeting, see "CA6" (attachment C) where the comment follows directly upon Dr Aroney's saying that he will continue to report deaths, the very thing which has provoked the meeting. Again, unless we hear otherwise from the Commission, we will assume that, in accordance with the second underlined part of the passage above, the Commission takes this view of the meaning of the comment with which it is concerned.

1.4 It would therefore be wrong to find that a comment which is to the effect that, *"If you want to debate these matters in the media then we will too"* is a threat or a threat of reprisal. Dr Aroney says he was frustrated by a lack of response to his using more conventional channels to put his points of view. There are things that might be said about that, but accepting that view for the

purpose of these submissions, Dr Aroney has decided to *"up the ante"* and go to the media. He is told that if he wishes to debate matters that way, QH will too.

1.5 If the Commission is concerned that the exchange on 8 January 2004 is an illustration of difficulties in communication between clinicians and QH administrators, then, subject to what is said at 1.6 -1.11 below, so be it. However, it would be would be wrong to make any finding as regards that in terms of *"threat"* or *"reprisal"* because these words have specific legal meanings, particularly in the context of the *Whistleblower's Protection Act 1994*, and the factual circumstances here do not amount to conduct which falls within the terms of that Act – what Dr Aroney was doing in terms of his use of the media does not amount to conduct which is protected under that Act, indeed the Act concerns itself with ensuring that disclosure takes place in a balanced and responsible way and forum (ss 7(2) and 10 of that Act).

1.6 On 8 January 2004 two senior medical men lost their tempers with each other and had an argument – see Mr Bergin tt 6059-6060 (attachment D). Dr Aroney made a note after the meeting and it records the comment with which the Commission is concerned. Dr Aroney made angry comments too - t 6261 ll1-11. Dr Scott did not bother to record them. Personality factors no doubt intruded. Dr Aroney is prepared to make scandalous allegations on the basis of extremely flimsy evidence – see paragraph 8 of our previous submissions. He is also, as he illustrated both in his statement, and his evidence, prepared to make allegations that most people find very offensive – eg., that people – variously Mr Bergin, Ms Wallace and Dr Scott – didn't care about people dying on waiting lists –tt 6257 l 50; 6259. He was, and still is, of the view that senior administrators, like Dr Scott, didn't *"stand up"* and ensure the health system operated in a better way –t 6252. He is incapable of seeing these matters in anything but an extreme way – see the last transcript reference – if to stand up meant that you were sacked then that was just too bad, and compare his evidence that clinicians who did not have a private practice to fall back on could not afford to stand up in the hospitals – tt 3951-2.

1.7 The other side of this personality equation is that Dr Scott was undoubtedly a sincere man dedicated to the improvement of public health – see ex 436 (attachment E). In fact, he was *"standing up"* in a system which had many faults – see the evidence as to the use of the Measured Quality Reports – tt 5247-8, and see Mr Nuttall's evidence at tt 5365-5369 and exs 322-324 which show that Dr Scott was trying to have the government consider the cost of addressing the problems in QH. It is a small but illustrative point, that Dr Aroney volunteered that he was so impressed by the Courier Mail's championing of anti-smoking legislation that he wrote to congratulate the editor – t 6251. In fact, unknown to Dr Aroney, it was Dr Scott who had been the moving force behind this – see ex 436 p7. The point is that Dr Aroney simply had no understanding of who Dr Scott was; what he was doing, or the reality of funding within the health system – time and time again he said in his evidence that he did not care to concern himself with budgets.

1.8 Dr Scott says, *"Before the meeting Dr Aroney chose to go to the media, and to proclaim that Queensland Health administrators did not care if people died but was driven by budgets. He had not taken the time to meet with me to discuss his issues and concerns. I found the claim personally deeply offensive having worked in direct patient care and being at least as ethically and morally motivated as Dr Aroney."* At paragraph 1 of Dr Scott's statement he explains that his work as a GP in particular has been in rural and remote areas, and that as an administrator he took a strong interest in the better provision of services to these areas. He is obviously well aware of the problems rural Queenslanders face in accessing tertiary institutions like TPCH. The same part of his statement also explains that he was a Censor, not only of the Queensland faculty, but also a member of the Board of Censors of the Royal College of General Practitioners at a national level. A Censor is a keeper of standards; the position is elected, an indication that he had the respect of his peers.

1.9 Perhaps if Dr Scott had been the type of person who was not so sincere about his work there would have been no argument at the meeting because

he would not have been so offended by Dr Aroney's comments. Perhaps if Dr Aroney had been more temperate in his views expressed before the meeting, or had some understanding that the senior bureaucracy was not able to deliver everything they thought sensible and desirable, there would not have been an argument.

1.10 In the end, the Commission has evidence that two senior men who were both working in their different ways to improve health in Queensland had an argument. No doubt intemperate comments were made by both. One is recorded. It may not have been a constructive thing to say, but it does not amount to a threat or a threat of reprisal. Look at the substance of the matter –patient care: TPCH and the very cardiac centre where Dr Aroney worked was given funding well above its base line budget before and after the meeting of 8 January 2004 – see paragraph 4 of our earlier submissions. It was Dr Scott who gave out this extra funding, the second tranche of which was given even without a formal request – see the documents referenced at 4(g) of our previous submission, which are attached as attachment F.

1.11 No adverse finding should be made about the comment made at the meeting of 8 January, 2004. There is no evidence that Dr Scott was a bully or was part of what the media and others have labelled the bullying culture of QH. In fact the evidence about Dr Scott's work, demeanour and character is that he is sincere, dedicated and respected – see attachment E; see the evidence of Ms Edmond – t 4969-4971, and Mr Nuttal - t 5361-2 (together attachment G). It would be a grave and unjustifiable thing to make a finding attributing blame for one angry comment in the course of such a career in the Commission's public report in circumstances which are detailed above.

(b) On 15 October 2004 during an interview on the Australian Broadcasting Corporation's television show "Stateline" you made statements to the effect that:

(i) Queensland was not behind other States in terms of the number of cardiologists per head of population.

2.1 The formulation of the above sub-paragraph is inaccurate. The transcript of

the interview is "CA13" to ex 263 (attachment H). In response to a question about *"international standards"*, and the *"number of cardiologists* [QH] *should have"* Dr Scott said, *"We certainly would be prepared to accept that we have issues to address with staffing but really that's an issue for Australia generally. So we don't see that we are behind any other States in Australia."*

(ii) Queensland Health had sufficient cardiologists to meet clinical need.

2.2 Dr Scott did not say that Queensland Health had sufficient cardiologists to meet clinical need. To the contrary, he said that there were issues with staffing, that QH was behind internationally, and that Dr Aroney's view that QH had one-third of the cardiologists needed was not true to the level he [Dr Aroney] was describing it.

(iii) patients were not at risk whilst awaiting cardiac treatment by Queensland Health.

2.3 Again the formulation of the above sub-paragraph is inaccurate. Dr Scott said, *"I suppose we would say that we are behind but we really feel that the services that we are delivering at the moment are not putting any Queensland lives in jeopardy."*

(iv) there had not been a reduction in cardiology services provided by the Prince Charles Hospital.

2.4 Again the formulation of the above sub-paragraph is inaccurate. Dr Scott was asked: *"Have you reduced the number of services cardiology procedures at the Prince Charles Hospital from 80 to 57?"* He replied, *"No, What we've done is we've said let's go ahead and enhance services and that was happening in fact we've put something in the order of $ 5 million extra dollars into cardiac services in Queensland this year. And that $ 5 Million will be there each year from here on. But what has happened is there has been an increase budget will allow situation and we've asked the cardiologists to review the situation with a view to at least staying within the resources that are available to us but we have not in any way respects reduced services."* [sic].

2.5 This is in the context of the comment immediately above in the transcript: *"What we are doing is looking to increase services across Queensland and of course what that means is that services and resources are going to hospitals other than Prince Charles..."*.

(c) The statements above were false and misleading, and the inference that may be drawn by the Commission is that the statements were intended to:

i. create a positive media response to prior comments by Dr Con Aroney who had claimed that Queensland Health had cut cardiology services at the Prince Charles Hospital; or

ii. suggest that Dr Aroney's comments were alarmist or untrue; or

iii. both of the above;

3.1 A fair reading of the transcript of the Stateline broadcast as a whole makes it clear that Dr Scott was attempting to explain the situation in Queensland in relation to cardiology services. Dr Scott is not a lawyer and he was not making some formal written submission; he was responding orally to questions on a television interview. Of course it is a legitimate enquiry to see if the sense of what he was conveying was false or misleading, but this should not be done in an unreal context where individual sentences or words are parsed over minutely in isolation from the context of the interview overall.

3.2 As to (b)(i) above, Dr Scott is asked whether it is true that by international standards Queensland has only one third of the cardiologists it should have. The substance of his answer is to concede that Queensland needs more cardiologists by international standards, but not to the extent Dr Aroney thinks. He points out that Queensland is not the only state in Australia to have too few cardiologists by international standards. If the last sentence read to the effect - *"So the problem is Australia- wide"*, no-one would have any quarrel with any of the answer. Instead, Dr Scott used the words, *"So we don't see that we are behind any other States in Australia"*. Had he said, *"So we don't see that we are substantially behind any other States in Australia"*, no-one would have any quarrel with any of the answer. The one sentence

which is impugned is in a context where appropriate concessions have been made immediately before and after the statement that Queensland has issues to address with staffing, and that it is behind with respect to international standards. The response of Dr Scott when cross-examined about these matters is exactly to this effect – see tt 5266-5275(attachment I).

3.3 As to (b)(iii) above, the first thing is that the statement is an expression of opinion. The second thing is that it is not strictly responsive to the question asked but is responsive in terms of the allegations made by Dr Aroney in the public debate which led to the interview. And that second point is important to bear in mind in judging the statements made by Dr Scott generally, they are in a context of a wider debate where Dr Aroney has made allegations which are not all put to Dr Scott in the interview. The allegations Dr Aroney was making in the media prior to this interview have not proved to be correct. He made the allegations that 3 patients died waiting in the press in January 2004. He made those allegations without first hand knowledge of the circumstances of the deaths - "MIC9" to 301C - and without making that clear in the press. The investigation – "MIC14" to ex 301C - considered that 1 of the deaths (patient 3) was caused by a wait – there may have been fault involved in the deaths of patients 1 and 2 but their deaths were not caused by a wait.

3.4 By 4 March 2005, ex 301C paragraph 65, after this interview, an investigation had found 1 more death attributable to a wait. The deaths of patients A , B, D and E appear from ex 439 not to be caused by a wait. The others in that document cannot, on the information available to the Commission, be said to be due to a wait, rather than disease, or other fault. It is not even clear that anything could have been done for these patients to prevent their deaths. The Commission cannot conclude much from the notes in this document which are scant, unexplained and untested. Findings about serious matters should not be made when the evidence is minute compared to, say, what might be led even in a civil trial.

3.5 As to (b) (iv) above, the alleged reduction in cardiology procedures at the

Prince Charles Hospital from 80 to 57 is explained by Dr Scott as a return to baseline funding after extra one-off funding provided after the election of early 2004 had been spent – Ex.317, para.19.8 and 19.9 (attachment B) and in response to cross-examination as to this point – t 5273.

3.6 Out of any context at all, it is true that to bring back procedures from 80 to 57 is a reduction. The point is, that what happened did not happen out of any context, it happened in a context where procedures were only at 80 because of a temporary increase in funding. This is not just semantic. A is paid at $570 per week but is asked to act in higher duties for 3 months while B is on long service leave. For that time A is paid $800 per week. When B comes back from leave, A is no longer on higher duties and reverts to a pay rate of $570. A cannot complain that his pay has been reduced, a temporary increase has been taken away.

3.7 To say, as Dr Aroney did, that there had been a reduction is a half-truth, it is a statement which is literally true, but not in substance true, because it only tells part of the story. The truth is that there was funding for 57 procedures; a temporary increase, and then a reversion to base levels. This might be undesirable in terms of health policy and health funding, but Dr Scott was not telling untruths about what was happening. He was correcting a half-truth told by Dr Aroney. And it is not irrelevant to note, turning to the substance of the matter – patient care - that there was never a time when procedures reached 57 per week – that was because Dr Cleary complained to Dr Scott about it, and Dr Scott increased base line funding so that the baseline could be increased from 57 - see paragraphs 4 (f)-(g) of our previous submission and attachment F.

3.8 No finding should be made as proposed.

(d) **In conducting yourself as a senior public service officer, namely the General Manager of Health Services, you chose to act as an advocate for the Minister and the Government <u>instead</u> of maintaining impartiality and integrity in informing, advising and assisting the Government. You therefore failed to comply with the principles of public service management contained in s.23 of**

the ***Public Service Act 1996.*** (original emphasis)

4.1 First, see the introductory paragraph as to Dr Scott's employment at p1, above.

4.2 Second, Dr Scott's appointment as SEDHS was under s.24 of the *Health Services Act 1991.* (see attachment J) As such he was a *"health service employee"* as that term is defined in that Act. While acting as GMHS and SEDHS it would appear that Dr Scott was employed as a health service employee under s24(3)(c) of the *Health Services Act.* The position of SEDHS was a contract position under this Act and so, we believe, was the position of GMHS, this could be checked with QH. Section 25 of the *Health Services Act* provides that a health service employee is not a public service employee. Thus the *Public Service Act* does not apply to Dr Scott.

4.3 Third, even if Dr Scott were a public service employee, s23 of the *Public Service Act* sets out a number of principles introduced by the words, *"Public service management is to be directed towards:".* It is meaningless in legal terms to say that Dr Scott failed to comply with that section. It is meaningless in factual terms to say that he failed to comply with the section in the abstract as the passage above does. There are no facts or allegations put as to this supposed non-compliance.

4.4 This proposed finding appears to be based on the response to a question by counsel for Dr Aroney:

> *"Do you identify any deficits in your own performance as a senior bureaucrat?-- I'm sure I did, I'm sure we all do.*
>
> *And what are they?-- I think probably if I look back in retrospect, I would say that I probably was more of an activist for the Government and the Minister than perhaps I should have been. I think that there are issues that need to be addressed which sometimes aren't attractive politically, but I think that in terms of how hard I've worked, how hard I've tried to support people, I don't have any deficits from that point of view that I can see."– t5287, l 41.*

4.5 This response did not relate to any specific incident. It was made in response to a very general question which required Dr Scott to critically analyse his performance throughout the entirety of his tenure as a senior bureaucrat. To say that if he had his time again he would act less as an activist for the minister and government does not imply that Dr Scott acted partially or without integrity in his time with QH, in general, or in relation to any specific matter. No doubt there is a range of legitimate conduct in relation to any particular matter; nothing said by or about Dr Scott would suggest that he acted outside this legitimate range. Indeed, there are instances like the Measured Quality reports and the cabinet submissions put up in June 2005, see paragraph 1.8 above, where, despite his reflection above, Dr Scott was clearly acting, within that legitimate range, as an activist for public health. Indeed, he has been recognised nationally for so doing – attachment E, look at the achievements listed:

4.5.1 Protect and Promote Public Health Within Australia
4.5.2 Increased Investment in Public Health
4.5.3 Promotion of Multi-disciplinary approaches to Designing Public Health Solutions and Solving Public Health Problems
4.5.4 Advance Community Awareness of Public Health Measures and Outcomes and the Real Cost of Inadequate Public Health responses
4.5.5 Advance the Ideals and Practice of Equity in the Provision of Health care,

These are the achievements of someone who worked with integrity and impartiality to better public health.

4.6 Note that if it did apply to him, there are several principles espoused by the *Public Service Act* which obviously must be balanced against each other, s25 (c) for instance, provides that a public service employee's work performance and personal conduct must be directed towards giving effect to Government policies and priorities.

4.7 There is simply no basis in fact or law for the finding mooted. It is quite contrary to all the evidence about Dr Scott's work.

Dated this 25th day of October 2005.

JH Dalton SC

C S Harding