

**SUBMISSION
TO THE
STANDING COMMITTEE ON HEALTH AND AGEING
OF THE
COMMONWEALTH HOUSE OF REPRESENTATIVES**

**REGARDING THE STANDING COMMITTEE'S
INQUIRY INTO HEALTH FUNDING**

BY

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1. This submission is provided to the Standing Committee at the request of its Chairman, Hon. Alex Somlyay MP, and a member, Mr Ross Vasta MP.
2. Until 2 September 2005, I was Chairman of the Bundaberg Hospital Commission of Inquiry, set up by the Queensland Government by Order in Council dated 26 April 2005, with the following Terms of Reference:

Under the provisions of the Commissions of Inquiry Act 1950, Her Excellency the Governor, acting by and with the advice of the Executive Council, hereby appoints Mr Anthony John Hunter Morris QC to make full and careful inquiry in an open and independent manner with respect to the following matters:-

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

(2) The circumstances of:

- a. the employment of Dr Patel by Queensland Health; and*
- b. the appointment of Dr Patel to the Bundaberg Base Hospital.*

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

(4) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (3) above, both:

- a. within the Bundaberg Base Hospital; and*

b. outside the Bundaberg Base Hospital.

(5) In relation to (1) to (4) above, whether there is sufficient evidence to justify:

- a. referral of any matter to the Commissioner of the Police Service for investigation or prosecution; or*
- b. referral of any matter to the Crime and Misconduct Commission for investigation or further action; or*
- c. the bringing of disciplinary or other proceedings or the taking of other action against or in respect of Dr Patel or any other person.*

(6) The arrangements between the Federal and State Governments for the allocation of overseas-trained doctors to provide clinical services, with particular reference to the declaration of "areas of need" and "districts of workforce shortages".

AND, as a result of any findings in respect of the above matters, to make recommendations in relation to:

(1) Appropriate improvements to the functions, operations, practices and procedures of the Medical Board of Queensland, in particular in regard to the assessment, registration and monitoring of overseas-trained medical practitioners.

(2) Any necessary changes to the Queensland Health practices and procedures for:

- a. the recruitment and employment of medical practitioners (particularly overseas-trained medical practitioners);*
- b. the appointment of medical practitioners (particularly overseas-trained medical practitioners) to regional and remote hospitals; and*
- c. the supervision of, and maintenance of the standards of professional practice of, medical practitioners, with particular reference to:*
 - i. overseas-trained medical practitioners; and*
 - ii. medical practitioners (particularly overseas-trained medical practitioners) appointed to regional and remote hospitals.*

(3) Mechanisms for receiving, processing, investigating and resolving complaints about clinical practice and procedures at Queensland Health hospitals, particularly where such services result in adverse outcomes, both:

- a. within the hospital concerned; and*
- b. within Queensland Health generally; and*
- c. through other organs and instrumentalities of the Queensland Government, including the State Coroner, the Health Rights Commission, the Medical Board of Queensland, the Queensland Police Service, and the Crime and Misconduct Commission; and*

d. otherwise.

(4) Having regard to any unacceptable situations or incidents revealed in evidence, whether at the Bundaberg Base Hospital or at other Queensland Health hospitals, any systems of accountability necessary or appropriate to prevent the recurrence of such situations or incidents.

(5) In reference to (6) above, measures which could assist in ensuring the availability of medical practitioners to provide clinical services across the State.

(6) Any other action which should be taken properly to respond to the findings of the inquiry.

3. My role as Chairman was terminated following a finding by the Supreme Court of Queensland (constituted by the Honourable Justice Moynihan) that I was "ostensibly biased" in respect of two administrators at the Bundaberg Hospital, Mr Peter Leck (District Manager) and Dr Darren Keating (Director of Medical Services). The Queensland Government chose not to appeal that decision. Instead, another Chairman – the Hon. Geoff Davies QC, a retired Justice of the Queensland Court of Appeal – has been appointed to complete the work of the Commission of Inquiry.

A. DR. JAYANT PATEL

4. For two years, between April 2003 and April 2005, Dr Jayant Patel ("Patel") was Director of Surgery at the Bundaberg Base Hospital ("BBH"). Dr Patel was born, and received his undergraduate education, in India. He later trained and worked in the United States, especially in New York State and Oregon.

Patel's performance at Bundaberg

5. Evidence from highly respected medical specialists, received by the Commission of Inquiry up to the time that I ceased to act as Chairman, identified some 13 cases in which patients died following "sub-optimal" care and treatment on the part of Patel. Significantly, of these 13 deaths, 8 involved operations which Patel had been banned from performing in Oregon.
6. However, it is not just the deaths which cause concern. An eminent general surgeon, Dr Geoffrey de Lacy, has seen about 150 of Patel's former patients. He testified that:

One of the points that I'd like to make if I could was that I'm not certain that the magnitude of his errors, the number of problems that he's had, the number of deaths that

he's had has ever been sort of appropriately compared to what we might have expected him to have, and these things aren't just things that happened to an average, general surgeon, at all. They're not 10 times what you might expect. They're more like 100 times what you might expect.

7. Elsewhere in his evidence, Dr de Lacy said:

... [A]re we talking about, from your observations, Patel being at the low end of an acceptable degree of competence or something worse than that?-- Far worse than that. Far worse. Far worse. I've looked after complications in the last four months that I've never seen before. I've had an opportunity to sort of assess his decision making both pre-operatively, intra-operatively and post-operatively and it was terrible.

8. Specifically, Dr de Lacy identified these issues in relation to Patel's performance as a surgeon:

- 8.1 That there were instances of Patel's having performed unnecessary operations – such as the removal of a patient's bowel on account of a suspected cancer, which was later found to be benign (an outcome which could have been prevented by appropriate pathology testing prior to surgery);
- 8.2 That there were instances of Patel's having removed the wrong organ – such as the excision of a healthy organ instead of one which had been found to be cancerous;
- 8.3 That Patel consistently did not comply with accepted standards and procedures for wound closure, often resulting in burst abdomens and incisional hernias;
- 8.4 That Patel's patients experienced an unacceptable number of wound dehiscences;
- 8.5 That Patel's patients experienced an unacceptable number of anastomotic leakages;
- 8.6 That Patel's operative procedures revealed a lack of up-to-date knowledge in many aspects of medical practice; and
- 8.7 That Patel's medical notes frequently misrepresented the course of the patient's progress, both operatively and post-operatively.

9. Dr de Lacy's evidence was fully supported by other testimony – both the evidence of other medical practitioners, and the evidence of patients.

How the Patel phenomenon came about

10. In his Foreword to *Whistleblowing in the Health Service – Accountability, Law and Professional Practice*, John Hendy QC identifies a malaise in the (British) National Health Service which he described as “a manifestation of structural defects far more profound and at much higher level than the personality of managers.”
11. In considering events at BBH, especially in relation to Patel, one inexorably comes to the irresistible conclusion that structural and systemic factors are at the heart of the problems facing the public health sector. What occurred at Bundaberg is not itself the disease: it is merely an acute symptom of a condition which is chronic, wide-spread, and potentially terminal.
12. Any explanation for the Patel phenomenon must recognise a confluence of factors, each of which was *necessary*, but not *sufficient* in itself, to produce that phenomenon. That such a confluence did not occur sooner, and has not occurred more frequently, may be attributed more to good luck than good management. Most of the factors have been present, at least for several years (perhaps much longer), at most (if not all) hospitals throughout Queensland. Patel, himself, was like a bacillus which, introduced into an unhealthy body, found the body in such a weakened condition – its defensive mechanisms so atrophied – that it could wreak havoc, without detection or resistance, for two years.

I. “Area of Need”

13. Patel was appointed to BBH on the footing that it was an “area of need” within the meaning of section 135 of the *Medical Practitioners Registration Act 2001* (Queensland) (“the Registration Act”), which provides:

135. Practice in area of need

(1) The purpose of registration under this section is to enable a person to practise the profession in an area the Minister has decided, under subsection (3), is an area of need for a medical service.

(2) A person is qualified for special purpose registration to practise the profession in an area of need if the person has a medical qualification and experience the board considers suitable for practising the profession in the area.

(3) The Minister may decide there is an area of need for a medical service if the Minister considers there are insufficient medical practitioners practising in the State,

or a part of the State, to provide the service at a level that meets the needs of people living in the State or the part of the State.

(4) If the Minister decides there is an area of need for a medical service, the Minister must give the board written notice of the decision.

14. The **first** problem regarding Patel's appointment is that no proper or adequate steps were taken by the Minister's delegate to be satisfied that Bundaberg was, in fact, an "area of need". The evidence discloses that:
 - 14.1 An Australian qualified surgeon had previously applied for the position of Director of Surgery, and was placed second by the selection panel when another doctor was offered that position; but he was not offered the position when the selection panel's first choice declined the offer.
 - 14.2 No apparent attempt was made to establish whether other Australian trained doctors, including qualified surgeons, would be prepared to provide surgical services at Bundaberg Hospital as Visiting Medical Officers (VMOs) – although the evidence suggested that there was an abundance of competent Australian qualified surgeons in private practice in Bundaberg, and at least some of them would have been willing to accept VMO appointments, provided that reasonable efforts were made to accommodate their scheduling needs.
 - 14.3 In fact, a highly respected, Australian trained general surgeon (Dr Geoffrey de Lacy) – who had previously been Director of Surgery at Brisbane's Queen Elizabeth II Hospital – moved to Bundaberg to enter private practice shortly after Patel's appointment, and offered his services as a VMO, but was refused.
15. In an interim report dated 10 June 2005, the Commission of Inquiry identified the following areas of concern regarding the processes adopted within Queensland Health in making "areas of need" declarations, at least in relation to vacancies at public hospitals:
 - 15.1 Queensland Health currently worked with a policy issued in July 1996, based on the *Medical Act 1939*, rather than the Registration Act which was enacted in 2001 - in other words, the policy document currently in use by Queensland Health was based on legislation repealed some 4 years earlier.
 - 15.2 Since at least August 2003, Queensland Health has supposedly been working on a new policy, but that was yet to be produced.

- 15.3 Queensland Health had no "protocols to assist" in making a determination under section 135 "with respect to the public sector", because – according to the evidence of one of the Minister's three delegates – "our data is not good enough".
- 15.4 Queensland Health had, in the past, required no proof that a public sector employer was unable to fill a vacancy, merely assuming that the hospital was unable to find a suitable applicant with the appropriate qualifications. When Queensland Health received an application from a public hospital, the delegates "simply accept[ed] each and every application from a regional hospital for an Area of Need position ... under the assumption that they have gone through the correct process"; they "never rejected an application by [a] public hospital".
- 15.5 Queensland Health made no assessment regarding the clinical competence of an applicant for a "area of need" position.
- 15.6 Similarly, Queensland Health undertook no on-going monitoring or assessment of a special purpose registrant.
- 15.7 Nor was it the practice for Queensland Health to enforce the policy requirement that a person should not continue to hold a position as a *special purpose registrant* for more than four years without progressing to general or specialist registration.
16. After the Commission of Inquiry provided the Interim Report of 10 June 2005, the procedural anomalies relating to "area of need" appointments within Queensland Health have been thoroughly addressed. But it remains the case that the practices which existed at the time of Patel's appointment contributed to the situation in which a plainly incompetent person was appointed to the surgical staff at BBH.

II. Patel's Dishonesty

17. It is clear that Patel was willing and able to conceal his chequered disciplinary history in the United States. Had this come to the attention of the appropriate authorities, it would probably have prevented his practising as a surgeon in Queensland, and most certainly would have prevented his being appointed as Director of Surgery at BBH and practising largely without supervision or restriction.

18. That Patel was willing to do so is a feature of his own personality – his duplicity and dishonesty, and his preparedness to take a chance that the truth would not come to light.
19. To procure his registration as a medical practitioner in Queensland, Patel submitted to the Medical Board of Queensland (“**the Board**”) an application form, which specifically asked the following questions which Patel answered in the negative:

*3. Have ... you been registered under a corresponding law applying, or that applied, in ... a foreign country, **and** the registration was affected either by an undertaking, the imposition of a condition, suspension or cancellation, or in any other way ? ...*

*4. Has your registration as a **health practitioner** ever been cancelled or suspended or is your registration currently cancelled or suspended as a result of disciplinary action in ... another country ?*

20. The application was signed by Patel beneath the words:

I declare that the above statements are true and correct ..., and that all documents and supporting material lodged with this application are true and correct.

21. In support of the application, Patel also supplied to the Board a document which purported to be a “Verification of Licensure” certificate issued by the Oregon Board of Medical Examiners in the United States. In fact, the document submitted by Patel was not what it purported to be: it comprised only a part of the certificate issued by the Oregon Board of Medical Examiners, omitting an attachment which would have disclosed that:

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

22. Apart from his concealment of the disciplinary outcome in Oregon, Patel also failed to disclose that:

- 22.1 In 1984, Patel was disciplined by the New York State Board for Professional Medical Conduct (BPMC) for entering patient histories and physicals without examining patients, failing to maintain patient records and harassing a patient for cooperating with the New York board’s investigation, with the BPMC ordering a six-month licence suspension with a stay, three years probation and a fine on each charge.

- 22.2 On 10 May 2001, Patel's New York licence was surrendered due to disciplinary action which he did not contest, arising from the September 2000 proceedings in Oregon, and by consent his name was struck from the roster of physicians for New York State.
23. Accordingly, there can be no doubt that Patel's conduct, in connection with his registration in Queensland as a medical practitioner, was false and fraudulent. It is equally clear that, but for the falsehoods contained in his application to the Board, Patel either:
- 23.1 would not have been registered under the Registration Act; or
- 23.2 if he had been registered, would have been the subject of appropriate conditions, including (potentially) a conditions requiring supervision, and restricting the scope of his surgical practice.
24. However, whilst Patel's dishonesty was a *necessary* pre-requisite to the Patel phenomenon, it was not, alone, *sufficient*. Such dishonesty could have achieved little or nothing for Patel, unless the system – at every stage – was capable of being duped. Reasonably simple investigations and enquiries could have brought Patel's chequered disciplinary history to light, virtually at any stage of the process: before he was registered, without conditions, by the Medical Board; before he was employed by Queensland Health; or before he was appointed as Director of Surgery at Bundaberg. Those systemic flaws are as much a part of the cause for the Patel phenomenon, as the man's own dishonesty.

III. Patel's clinical competence

25. Of course, the critical element was Patel himself: a man of apparently mediocre skill and talent as a surgeon, who was propelled into a position where he could do the most harm with the least control or supervision – as Director of Surgery at a major provincial hospital. Paradoxically, the very fact that Patel was *not* totally incompetent only added to his lethal propensities: a surgeon who was *obviously* incompetent would not have lasted so long, or done so much harm, in the position to which Patel was appointed. The evidence suggests that Patel was proficient at relatively minor surgery, and was (at times) even capable of carrying off more complex surgery within tolerable parameters of success. But this simply meant that he became the most insidious and dangerous type of pathogen – the type which is not immediately fatal to its host, but allows its host to linger in a debilitated condition, whilst the pathogen spreads death and destruction to all but the strongest who come into contact with it.

26. Although Patel's surgical abilities were no better than mediocre, that – alone – is not enough to explain the trouble which he caused. As some of the medical witnesses have commented, he was far from the worst that they have encountered in professional practice. Surgeons – like other professionals, and not only in the medical profession – range in competence, from the very best, to those who are (on the most generous view) only barely competent. It is therefore inevitable that the system must be able to cope – and, generally, is able to cope – with those whose abilities are sub-optimal. What made Patel different ?
27. In attempting to explain what went wrong, after the event, I have the advantage of hindsight. But, as the great British neurologist Lord Brain has observed, a *post mortem* examination seldom reveals the whole truth, just as “there is an obvious limit to what one can learn about normal business transactions from even a daily visit to the bankruptcy court”.
28. Yet it may readily be concluded that four particular features made Patel especially adapted to survive as Director of Surgery at BBH, causing harm of an extent and diversity which is grossly alarming in retrospect, yet without triggering the alarm-bells which ought to have sounded much sooner.

IV. Patel's self-importance

29. Apart from his dishonesty, there were other features of Patel's personality which undoubtedly contributed to the tragedy at Bundaberg. It is apparent that the man was manipulative and ingratiating: that he was capable of winning the trust and confidence of his colleagues and superiors, gaining a reputation as a hard-working and valuable member of the medical staff at BBH, whilst at the same time treating with disdain and contempt anyone (especially junior medical staff and nursing staff) who questioned his judgment or ability. Dr Nydham – the acting Director of Medical Services who appointed him to BBH – described him as having an “alpha male” personality; others characterised his general attitude as “kiss up and kick down”.
30. There can be no other explanation for the fact that many of those with whom he worked most closely at BBH – surgeons like Dr Gaffield; anaesthetists like Dr Carter, Dr Berens, Dr Younis and Dr Joyner; junior medical staff like Dr Boyd, Dr Athanasiov, Dr Kariyawasam and Dr Risson; even the acting Director of Medical Services, Dr Nydham, and later the permanent Director of Medical Services, Dr Keating – accepted him at face value. Dr Miach, a highly-qualified and respected nephrologist, who was the senior physician at BBH, ultimately became one of Patel's most strident critics;

but, for several months at least, he continued to trust Patel to perform surgery on his (Dr Miach's) own patients.

31. The truth about Patel's performance as a surgeon – and perhaps, even now, something less than the whole truth – has only been revealed through the painstaking forensic audit of Patel's patients by Dr Woodruff, and the review of many of Patel's patients by Dr de Lacy and Dr O'Loughlin. He was, undoubtedly, hard working. He undertook a great deal of surgery. Some of it – maybe, in purely numerical terms, the majority of operations which he performed – was carried out with an adequate level of competence. But even routine surgery was performed to a standard which Dr de Lacy considered to be "terrible".
32. Yet Patel's Achilles heel was not his sub-optimal performance of routine surgery; it was his willingness, indeed enthusiasm, to carry out surgery which was beyond his competence. The simple fact is that at least eight patients died at BBH as a result of his performing operations of great complexity – operations like oesophagectomies and Whipple's procedures – which, unknown to his colleagues and superiors, he was banned from performing in Oregon.
33. It would seem that some defect of Patel's personality – something, almost, in the nature of megalomania – drove him to undertake operations for which the necessary skill had been adjudged, by disciplinary authorities in the United States, to be lacking. It may well be the case, as Dr Woodruff speculated, that he needed to vindicate himself – at least to himself, if not to others. Again, it is difficult to credit any other explanation for the fact that he undertook such complex operations at all; let alone the he did so at a hospital which lacked the resources and facilities to enable even the most skilled surgeon – which Patel assuredly was not – to undertake such operations with safety.
34. A need to vindicate himself does not, however, provide the full explanation for Patel's conduct. He needed more than vindication: he needed respect; he needed admiration; he needed to be valued. Those whose opinions did not matter to him, especially amongst the nursing staff, were lucky just to be ignored. Some of the junior medical staff praised his care, enthusiasm and generosity as a teacher – quite conceivably, the image of a respected pedagogue was one which suited Patel's ego – but any who had the temerity to question his judgment or ability were swatted away like insects. Thus he surrounded himself with sycophants and flatterers, when he could find them; and was otherwise content to work with people who had the good sense to keep their opinions to themselves.

35. It has been reported by various witnesses – a sufficient number not to be discounted – that, when challenged, Patel resorted to “big-noting” himself, claiming that he had the unreserved support of management at BBH, and threatening to resign. In truth, it does not follow either that Patel enjoyed the level of support which he claimed to have amongst management, nor that his departure would have been as great a disappointment to management as he himself apparently conceived. But these tactics suggest, at the very least, that Patel earnestly believed that he was important to administrators like Mr Leck (District Manager of the Bundaberg District Health Service) and Dr Keating (Director of Medical Services at BBH).
36. For present purposes, it is largely irrelevant whether Patel’s perception of his standing amongst management was as over-inflated as his perception of his own skill as a surgeon; or whether, perhaps, hospital administrators – being experienced in dealing with medical specialists, who, as a class of humanity, are not widely known for their self-effacing modesty – were prepared to humour Patel’s egoism by allowing him to believe that he was indispensable. The result, in either case, is the same: Patel believed, was permitted to believe, and was almost certainly encouraged to believe, that he was important to the “powers that be” at BBH.
37. The sources of such beliefs are not difficult to identify. It is undoubtedly the fact that Patel was a “money spinner” for BBH. He performed teaching duties for the University of Queensland amongst interns and junior medical staff, which resulted in significant funds being paid directly into BBH’s coffers. He was very active surgeon. The amount of surgery which he performed not only made BBH’s statistical results look good; the “elective” surgery which he undertook also entitled BBH to receive extra funding from Queensland Health. Moreover, based on the system of “weighted separations” used by Queensland Health to assess such entitlements, the pecuniary value of his efforts was increased in proportion to the complexity of the surgery undertaken and the patient’s underlying state of health. It is no exaggeration to say that, for each patient on whom Patel performed an operation which he was banned from performing in Oregon, thousands of dollars flowed to BBH – regardless of whether or not the operation was successful – indeed, regardless of whether the patient lived or died.
38. Even the most rigorous selection process might not have detected these dangerous aspects of Patel’s personality. Nor can Queensland Health – let alone individual administrators – be blamed for allowing an apparently experienced surgeon to feel that he was a valued member of the BBH medical staff. Indeed, one of the criticisms of Queensland Health frequently articulated in evidence and submissions received by the Commission of Inquiry concerns its failure to treat specialist medical practitioners with the respect to which they feel entitled.

39. It is, however, apparent that systemic factors within Queensland Health contributed significantly to this aspect of the Patel phenomenon. The undoubted fact is that the system made Patel financially valuable to BBH. Tragically, his monetary value was unrelated to his competence as a surgeon, the quality of the surgery which he performed, or the outcomes for patients. Patel was directly rewarded for the quantity and complexity of the surgery performed by him, regardless of the good (or harm) done to patients. Whilst his rewards were not monetary, they took a form which was possibly more important to him: he was rewarded with praise, with respect, with admiration. There could have been no more attractive "remuneration package" for a man who came to Bundaberg with the object, not of healing patients, but of healing his own wounded pride.
40. These matters are a direct – albeit unintended, and perhaps unforeseeable – consequence of a public health system which places "elective surgery" waiting lists at the top of the political agenda; which rewards hospitals for the quantity, rather than the quality, of surgery performed; which regards surgical operations, ahead of all other forms of treatment, as the ultimate indicator of success; and which places a premium on the performance of highly complex surgery, especially in the case of seriously ill patients. In short, the Patel phenomenon demonstrates the inherent vice in a system which is not focussed on patient outcomes, but regards patients merely as statistical units in a production-line process, and offers financial incentives for "processing" the maximum number of "units".

V. Patel's lack of self-restraint

41. Patel's belief in his own importance to the administration at BBH – whether that belief was true or false, and whether actively encouraged or merely tacitly tolerated – would not have been problematic in the case of a surgeon whose practice was regulated by the kind of self-restraint which might be expected of any competent medical practitioner. But self-restraint was a feature noticeably lacking from Patel's surgical practice. Even when he occasionally had doubts about his ability to perform very complex operations, he was quick to shrug off such doubts and move on to the next patient.
42. It may be accepted, without hesitation, that the vast majority of medical practitioners can function safely and successfully without systemic restraints on the nature and complexity of the cases which they are permitted to handle. But the need for such restraints cannot be tested by reference to a "best case scenario", where the medical practitioner is conscious of his or her own limitations, and the limitations of the medical facilities and environment in which he or she is functioning. The adequacy of

systemic restraints can only be tested by considering a "worst case scenario" – a scenario in which, free of such restraints, a medical practitioner will feel at liberty to undertake surgical procedures which are beyond his or her competence, and beyond the functional capacity of the medical facilities and environment in which he or she is working. Patel demonstrates that, in a "worst case scenario", the system provided no effective restraints at all.

VI. Appointment of Patel as Director of Surgery

43. The problems began even before Patel drew blood on his first patient in Bundaberg. I leave to one side, for the moment, the fact that, had his disciplinary history in the United States been revealed to or discovered by the Medical Board, he would not have gained registration at all – or, at the very least, would have been registered only on the basis of stringent conditions. Even though it was unaware of his disciplinary history, the Medical Board registered Patel on the footing that he would be employed at BBH as a Staff Medical Officer – an "SMO" – under the supervision of the Director of Surgery. Instead, he was immediately appointed as Director of Surgery; a position in which Patel –
 - 43.1 was not subject to supervision by anyone;
 - 43.2 was not answerable to anyone for his clinical judgments;
 - 43.3 was free to perform any surgery he thought fit; and
 - 43.4 was, to all intents and purposes, at the apex of the clinical hierarchy.
44. The evidence, as to how Patel came to hold the position of Director of Surgery, is far from satisfactory. Dr Nydham admits that, in his then capacity as Acting Director of Medical Services, he appointed Patel to that position. The rôle of Mr Leck is unclear, save that he must have – at least – "rubber stamped" Dr Nydham's decision. It seems that another overseas trained surgeon (it is not clear whether this was Dr Gaffield) was expected to fill the position of Director of Surgery, but Patel appeared to be better qualified. In any event, Patel was immediately appointed to a position for which he had not applied, and which was inconsistent with the terms of the registration which had been granted to him by the Medical Board, without (so it seems) and formal process or procedure of any nature whatsoever.
45. Dr Nydham explains this appointment as being temporary – a kind of "*locum tenans*" – pending the appointment of a permanent Director of Surgery. It is difficult to accept this explanation. Not one piece of paper exists to corroborate the proposition that

Patel was appointed as Director of Surgery on a temporary basis: indeed, as Dr Nydham readily conceded, Patel was invariably referred to as "the Director of Surgery" rather than (for example) "the Acting Director of Surgery".

46. Nor was there any suggestion of a serious attempt – indeed, any attempt at all – to fill the "temporary" position with a permanent Director of Surgery. For example, when Dr de Lacy relocated to Bundaberg and offered his services to BBH as a Visiting Medical Officer ("VMO"), he would have been eminently qualified to become Director of Surgery – there being no objection, in principle, to the position being held by a VMO – especially given that he was fully qualified as a general surgeon in Queensland, a member of the Royal Australian College of Surgeons, and a former Director of Surgery at the Queen Elizabeth II Hospital in Brisbane. But Dr de Lacy was told that it was "not a priority" to add another surgeon to the Hospital's visiting staff.
47. Moreover, it is apparent that even Dr Nydham expected Patel to hold the position of Director of Surgery, at least for the period of his initial 12-month appointment at BBH, and, in all probability, thereafter. In fairness to Dr Nydham, it was his expectation – so he claims – that Patel would take the necessary steps to become a member of the Royal Australian College of Surgeons, and obtain full specialist registration as a surgeon in Queensland. Patel did not do so; and, with the knowledge of information now available to us, it is very likely that Patel refrained from doing so, out of fear that his disciplinary history in the United States would come to light. But, of course, Dr Nydham was not aware of that – and he had no reason to doubt that Patel could and would become registered as a general surgeon, thereby "regularising" the situation with regard to his appointment as Director of Surgery. Even on that footing, however, it is difficult to condone an approach which relied on the ends to justify the means.
48. On the most charitable view, the notion that Patel was appointed as Director of Surgery on a temporary basis may have been present in Dr Nydham's mind at the time when the appointment was made, but was never recorded in writing or communicated to anyone – including, it would seem, Patel himself. However, in all likelihood, this notion is no more than an *ex post facto* rationalization, on the part of Dr Nydham, for an appointment which he now recognises ought never to have been made.

VII. Absence of an appropriate "credentialing and privileging" process

49. The appointment of Patel as Director of Surgery was just another step in the confluence of factors which gave rise to the Patel phenomenon. At least equally significant was the absence of any functional "credentialing and privileging" system at BBH. Such a system had previously existed, under the aegis of Dr Brian Thiele, when he had held the position of Director of Medical Services. It seems that the system established by Dr Thiele was still notionally operational, but it is asserted that Patel "slipped through the cracks" for two reasons: first, because his appointment was only temporary; and secondly, because BBH was unable to obtain a nomination from the Royal Australian College of Surgeons in order to form an appropriate "credentialing and privileging" committee.
50. Both excuses are unacceptable. A proper "credentialing and privileging" process is no less important in the case of a "temporary" as opposed to a permanent appointment. An abbreviated process may be acceptable in the case of a surgeon (or other specialist) appointed on a genuine "*locum tenans*" basis – say, for a period of up to 3 months – but not in the case of a 12-month appointment, and especially where there is an expectation, or even a hope, that the 12-month appointment will be renewed. And even in the case of a genuine "*locum tenans*" appointment, it is appropriate that there be *some* "credentialing and privileging" process, albeit less comprehensive that would ordinarily be the case.
51. Nor is it possible to accept the excuse that BBH was unable to obtain a nomination from the Royal Australian College of Surgeons in order to form an appropriate "credentialing and privileging" committee. In the absence of corroborative evidence, it would seem surprising that the College was unwilling to appoint a nominee, although it is plausible that the College was concerned about indemnity issues. In any event, the absence of such a nomination should not have prevented an appropriate "credentialing and privileging" process: the participation of a nominee from the relevant college is best practice; but BBH's inability to obtain such a nomination is no excuse for abandoning the process altogether.
52. There were more than sufficient general surgeons in private practice at Bundaberg – amongst them Dr Thiele, Dr Anderson, and possibly Dr Kingston – to form an adequate "credentialing and privileging" committee; and, in the unlikely event of each of those surgeons having declined an invitation to participate, it should not have proved insuperably difficult to involve a surgeon from Brisbane or another regional centre, whether in person or by means of a telephone "conference call". Even the involvement of a general surgeon would not have been imperative, if another specialist with surgical experience – such as an orthopaedic surgeon, or an emergency

specialist, or even a gynæcologist and obstetrician – had been available; or, if worst came to worst, a “credentialing and privileging” committee without any surgical specialist would have been better than none at all.

VIII. Absence of appropriate clinical auditing

53. The seven issues identified above explain how Patel came to be in a position to do so much harm, and go some way towards explaining why that harm went (largely) undetected and (totally) unaddressed for the better part of two years. But there must be some further explanation for the fact that Patel could cause so much mayhem without anyone taking official notice.
54. The first is the absence of any appropriate clinical auditing process. This deficiency, I think, speaks for itself.

IX. Dysfunctional Mortality and Morbidity Committee

55. The next relevant factor is that, whilst there was a semblance of a “Mortality and Morbidity Committee” at BBH, it was totally ineffectual. When operating effectively, such a committee provides optimal “peer review” for surgeons and other medical specialists.
56. The “Mortality and Morbidity Committee” failed at BBH for the simple reason that Patel was in charge of it – he selected the cases to be reviewed, and led the discussion. This just contributed to the disaster which was brought about by his appointment as Director of Surgery, whereby he was entirely without supervision, either by superiors or peers.

X. Queensland Health’s “Culture”

57. Many witnesses who testified before the Commission of Inquiry spoke of a “culture” within Queensland Health, whereby:
 - 57.1 Concepts and practices based on a business model – rather than a model of public sector clinical care – inform administrative decision-making. Hence, patients are referred to as “clients”; medical superintendents and other senior clinicians and bureaucrats are called “directors”; clinicians proposing improved procedures and practices are required to present a “business plan”; the Department’s central office in Brisbane calls itself the “coporate” office; and so forth.

- 57.2 The institutional reaction to adverse events and crises is consistently the same: first, you deny the facts; secondly, you bury the evidence; and thirdly, you shoot the messenger.
- 57.3 People who are "trouble-makers" – that is, those (especially clinicians) who raise concerns and identify problems – are subjected to "trumped up" disciplinary complaints and threats of civil and criminal action; have their honesty, their motives, and their clinical competence challenged; are victimised with inconvenient rosters and other workplace impediments; and are otherwise bullied until they are eventually eased (or squeezed) out of the system altogether.
- 57.4 Visiting Medical Officers – that is, medical specialists from the private sector – are actively discouraged, because they tend to highlight inefficiencies in the public sector, and, because they are not dependent on Queensland Health for their regular incomes and are therefore immune to Queensland Health's usual bullying tactics, are the first to become "trouble-makers" as described above.
- 57.5 Meanwhile, Overseas Trained Doctors are much prized, because they are not only financially dependent on Queensland Health – their very right to remain in Australia is dependent on their *not* making waves with their employer.
58. Many witnesses testified to – and many submissions addressed – a perception that such a "culture" exists within Queensland Health. It is claimed to have many adverse consequences; amongst other, that it –
- 58.1 is inimical to efficiency and productivity;
- 58.2 hampers the early detection and resolution of issues, especially clinical issues, throughout the public health system;
- 58.3 creates adversarial tensions between (particularly) clinical and administrative officers; and
- 58.4 contributes to a workplace environment which is less than convivial.
59. Whilst most witnesses and submissions agreed that there are "cultural" problems within Queensland Health, they did not necessarily concur in identifying what the "cultural" problems are, or how they impact on the public health system generally. This is not, in itself, surprising. So-called "cultural" problems are essentially a matter of impression or perception, largely influenced by one's standpoint. To take just one

example: the "front line" clinicians in a particular hospital may perceive that the hospital's administrative officers are too bureaucratic, too obsessed with finances and budgets, and therefore unresponsive to their clinical needs; zonal or departmental administrators may consider that the same hospital administrators are not sufficiently focussed on financial and budgetary imperatives, and too ready to side with clinicians; whilst the hospital's administrative officers, themselves, may feel (with some justification) that they are the "meat in the sandwich".

60. However, from the evidence and submissions received by the Commission of Inquiry, it must be accepted that there are significant "cultural" problems within Queensland Health. It is possible, at least, to identify a number of the "root causes" of this "culture".
61. The first, as previously mentioned, is the adoption of a "business model" rather than a model of public sector clinical care. Queensland Health does not exist to make profits for shareholders, or to improve its market share over its competitors. It exists, at the taxpayer's expense, to provide the best standard of clinical care for the greatest number of patients possible, within the resources available to it. One step towards reinforcing this truism would be to dispense with the business jargon which has become fashionable within Queensland Health: to refer to patients as patients, doctors as doctors, nurses as nurses, and superintendents as superintendents; to speak of "clinical plans" rather than "business plans"; and so forth. Changing the words will not change the substance – but it may go some way towards changing the perceptions which created the existing "culture".
62. Secondly, the feudal hierarchy within Queensland Health is a significant factor. A director of a clinical unit cannot make a decision without consulting the director of medical services; the director of medical services must seek approval from the district manager; the district manager is answerable to the zone manager; and all of them are beholden to the (so-called) "corporate office" in Charlotte Street, Brisbane. Many of the perceived "cultural" problems would disappear if regional and rural hospitals were under local control, with both the community and the clinical professions represented on the managing body.
63. Thirdly, strict enforcement of rigorous "areas of need" policies will prevent bureaucrats from choosing the easy option of employing compliant Overseas Trained Doctors, rather than having to deal with Australian qualified medical practitioners – even when they are "trouble-makers".
64. Fourthly, appropriate protection for whistleblowers – including, in an appropriate case, the right to communicate their concerns to members of State or Federal

Parliament, their unions or professional associations, and the media – will prevent at least some of the “bullying” about which so many witnesses have complained.

65. Fifthly, the existing “culture” is largely contributed to by a “them and us” relationship which exists within Queensland Health, between bureaucrats and clinicians. This is not surprising, when only 20% of the Departments employees (totalling some 64,000) are doctors or nurses: for every clinician who actually deals with patients, there are four other employees who have to justify their existence within Queensland Health. Bureaucrats must learn to understand that they exist to facilitate the provision of health services by clinicians; that clinicians do not exist to make life easier for bureaucrats. And if they cannot (or will not) learn to understand that simple proposition, they must go.
66. Sixthly – and as a consequence of the fifth factor mentioned above – Queensland Health has an extraordinary “budget culture”. This is partly caused by the lavish expenditure on “projects” within Queensland Health’s “corporate office” – “projects” which do not involve the provision of any health services directly to patients, and which are sometimes undertaken even though there is no funding available to implement the outcome of the “project”, if and when the bureaucrats concerned eventually finalise it. It is also contributed to by a so-called “historical funding” model: a model which takes as its premise the proposition that, if a particular hospital has managed to function in the past with inadequate resources, there is no need to provide adequate resources in the future. The Commission of Inquiry received nothing to suggest that Queensland Health has even considered funding regional and rural hospitals on the footing of actual need, using basic “burden of disease” demographic statistics to ensure that the quality of healthcare in (say) Longreach is comparable with that provided in Brisbane.

XI. Information Management by Queensland Health

67. One of the central problems identified by the Patel phenomenon is that there needs to be a fundamental change of mind-set, so that problems within the public health system are openly and frankly addressed, rather than covered up. For instance, the on-going fraud perpetrated by Queensland Health – of publishing purported “waiting list” statistics, whilst denying that there is a “waiting list for the waiting list” – should become a thing of the past.
68. Such a change of mind-set is vital to the health of the public hospital system, as it is essential to:

- 68.1 Prevent members of the general community being given unrealistic expectations as to the services available to them from the public health sector;
 - 68.2 Enable individuals to plan their own health needs and requirements in full knowledge of any limitations or delays existing in the public sector;
 - 68.3 Permit members of the community who are dissatisfied with the level of services available in the public sector to express their concerns, in the appropriate democratic way, through the ballot box;
 - 68.4 Allow administrators and clinical staff sensibly to plan and budget to provide the best healthcare service possible within available funding; and
 - 68.5 Facilitate individual clinicians, both within and outside the public sector, providing meaningful and realistic advice to patients regarding their prospects of receiving appropriate and timely treatment in the public sector.
69. It may be accepted that there is a sharp and genuine philosophical difference between those who advocate openness, and those who urge that information should be strictly controlled. And it may be readily accepted that there are two categories of information which require strict control: where the disclosure is inconsistent with patient privacy and confidentiality; and where the disclosure may involve harm to an "at risk" patient.
70. A patient's entitlement to expect rigorous preservation of his or her privacy, and the confidentiality of his or her medical condition and treatment, is absolutely fundamental to any healthcare system. A patient *must* be able to share the most intimate personal details with a clinician, without fear or suspicion that the information will be inappropriately disclosed or misused.
71. Traditionally, these principles have depended largely on the professional and ethical obligations of individual clinicians. Within Queensland Health, those professional and ethical obligations are bolstered by section 63 of the *Health Services Act*, which – subject to various exceptions – makes it an offence, punishable by a fine of up to 50 penalty units, to "give to any other person ... any information ... if a person who is receiving or has received a public sector health service could be identified from that information".
72. The second category of information which requires the strictest possible control is information which, if released, may result in direct or indirect harm to the patient.

concerned. This category is especially, although not exclusively, relevant to mental health patients.

73. A breach of a patient's privacy or confidentiality may sometimes have ramifications which are potentially harmful to the patient outside the clinical context. Improper disclosure of a patient's diagnosis may cause profound harm to the patient in a wide range of ways. This is most obviously the case if the diagnosis involves a communicable disease, and especially if the disease is sexually transmissible. But serious damage can also be caused by the disclosure of a diagnosis which involves no moral opprobrium: for instance, disclosure of the fact that a patient is suffering from a potentially debilitating illness (such as a terminal cancer, a cardio-vascular condition, multiple sclerosis, or another profound neurological disorder) may lead to both social and employment problems. Inappropriate disclosure of haematology results, especially if they reveal the use of recreational drugs, may have similar consequences. The ethical dilemmas flowing from DNA paternity testing have been discussed in a recent article by Mark Bellis and others from Liverpool John Moores University, UK, in the *Journal of Epidemiology and Community Health*, the authors calling for "clear official guidance for GPs and health professionals on when and whether to disclose such explosive information".
74. In most cases, such problems are adequately addressed by existing rules – both professional and ethical, and also statutory – protecting patients' privacy and confidentiality. But what of the situation where the relevant information is not specific to a particular patient, yet its disclosure may be harmful to one or more patients? As previously noted, this situation is especially, although not exclusively, relevant to mental health patients. This is because mental health patients often dislike their medication and treatment, but may be at serious risk if medication or treatment is terminated abruptly: any disclosure which causes them to lose confidence in their medication and treatment may therefore have significant consequences.
75. A case in point is revealed by the evidence which the Commission received concerning a person named Berg, who was registered and practised at Townsville as a psychiatrist, but whose qualifications have since been called into question. It may be accepted that anyone – clinician, administrator or politician – involved in making a decision whether or not to release that information publicly faced a major dilemma, involving a reconciliation of a number of considerations. On the one hand, considerations favouring controlled public disclosure of the relevant facts included: the patients' right to know that they had been treated by a person whose medical and psychiatric qualifications were, at best, dubious; the risk that hospital records would not reveal the identities of all patients seen and treated by Berg; the risk that some patients seen or treated by Berg (including, possibly, some who could not be

identified from hospital records) had received inappropriate medication or other treatment; the risk that some patients seen by Berg (including, possibly, some who could not be identified from hospital records) had inappropriately been refused medication or other treatment; the risk that, in the absence of controlled public disclosure, a garbled version of events would "leak out", possibly causing patients to lose confidence in other psychiatric staff at the Townsville General Hospital, the Hospital's Department of Psychiatry, and the Hospital generally; the risk that the facts would ultimately emerge, causing psychiatric patients to feel deceived by Queensland Health, and disillusioned with the medical (including psychiatric) services which it provides; the risk that Berg, having (apparently) obtained registration and employment based on fraudulent qualifications, may have taken advantage of the status which that gave him, to the detriment – whether financial, personal, or otherwise – of patients. On the other hand, considerations militating against public disclosure of the relevant facts included: the risk that disclosure would cause patients to lose confidence in the Townsville General Hospital's Department of Psychiatry, or even the Hospital generally; and, in the case of psychiatric patients, the risk that this would lead to an abrupt termination of medication or treatment, to the harm of their mental health.

76. It cannot be accepted that, in the Berg case, the decision to conceal the facts was the correct one. Patients who received treatment at Townsville General Hospital from a person, who had been held out by Queensland Health as a qualified psychiatrist, had an inalienable right to be told the truth as soon as it was discovered. Whilst this may have presented some risk to some patients, who could have been inclined to take it as an excuse to terminate their medication or treatment, this situation could have been handled in the case of patients whose identities were known to health authorities, and who had continued to receive medication or treatment from other staff of the Psychiatry Department after Berg's departure. By far the greater risk involved patients whose identities were unknown to health authorities, and who may have received inappropriate medication or treatment – or who may have been inappropriately refused medication or treatment – by Berg. The only way that Queensland Health could have helped such patients was by prompt, full and frank disclosure through the press and media.
77. Even without the benefit of hindsight, it is perfectly obvious that a charlatan – who was capable of obtaining registration and employment based on falsified qualifications – was a person without any moral, ethical or professional restraints on his behaviour. To conceal such an incident involved the appreciable risk of also concealing any illegal or anti-social behaviour which Berg committed under cover of his status as a qualified psychiatrist employed at Townsville General Hospital. As events have transpired, that is precisely what occurred: it only emerged, following

disclosure of these matters in the course of evidence before the Commission of Inquiry, that Berg has (allegedly):

- 77.1 been convicted in Russia for paedophile offences;
 - 77.2 been convicted in the United States for an offence of dishonesty; and
 - 77.3 sexually molested the young son of a Townsville General Hospital patient, in circumstances where he (inappropriately) visited the patient's home – supposedly in connection with her treatment – and then undertook also to provide psychiatric treatment to the son, convincing both the mother (his original patient) and her partner to leave the son in his care for that purpose.
78. The Berg case is illustrative of a tendency, on the part of Queensland Health, to “cover up” embarrassing information. Any justification for the decision depends in that instance depends on the proposition that it was judged to be in the best interests of patients – a conclusion which is difficult to sustain, for the reasons canvassed above, and especially in circumstances where the *only* documented psychiatric opinion favoured disclosure.
79. The lesson is this: non-disclosure (or concealment) of information may, in some circumstances, be justified as protecting the interests of “at risk” patients; but it is all too easy to use this as a pretext to “cover up” information which could cause embarrassment to Queensland Health. In the absence of compelling reasons to the contrary, information which has the potential to cause embarrassment to Queensland Health should *always* be made public, because its very potential to cause such embarrassment is the clearest indicator that disclosure is in the public interest.
80. The renowned ethicist, Geoffrey Hunt, has observed in relation to the (UK) National Health Service:
- “The very notion of confidentiality, understood in the context of professional ethics, is being challenged by a notion of confidentiality which comes from quite a different environment – the environment of business. ... I think we may be seeing in some controversies a confusion of confidentiality taken from professional ethics, with the purpose of protecting patients and respecting their autonomy, with commercial confidentiality and trade secrecy taken from the context of business, with the purpose of protecting competitiveness and profits.”*
81. Hunt's suspicion in relation to the NHS is readily demonstrated, by the evidence received by the Commission of Inquiry, to be the fact in relation to Queensland

Health. Even those charged with the responsibility for undertaking "ethical awareness" seminars on behalf of Queensland Health seem oblivious to the difference between protecting information which is confidential to a patient, in the interests of the patient, and protecting information which is potentially embarrassing to Queensland Health, in the so-called "corporate" interests of the Department.

82. Indeed, the "corporate" analogy has been specifically invoked as justifying Queensland Health's rigorous policy of preventing unauthorised disclosure of potentially embarrassing information, through its "Code of Conduct" and employment contracts with its staff. This is an utterly bizarre notion – and an absolute perversion of basic public ethics – in the case of a self-styled "corporate" entity which exists for one reason only: to provide services to the public at the public expense.
83. In my respectful opinion, notwithstanding the (no doubt) genuine desire of the current Minister and Director-General to change a "culture" which has existed for years, if not decades, Queensland Health – as presently constituted – simply cannot be trusted to tell the truth about itself. The only viable solution is to treat Queensland Health for what it is – Queensland's largest provider of healthcare services – and subject it to the same rigorous external regulation and controls that apply to other providers of healthcare services.

XII. The Coroners Act

84. The twelfth and final factor which may be identified as contributing to the Patel phenomenon is a "loophole" in the Queensland *Coroners Act 2003*, section 8(3)(d) of which deems that a death is "reportable" if it "was not reasonably expected to be the outcome of a health procedure".
85. As the Patel experience shows, this statutory provision is clearly not working. It allows a rogue surgeon (or other health practitioner) too much latitude in determining whether to report a death to the Coroner. In fact, of the 13 deaths identified as having a connection with sub-optimal care on the part of Patel, only one was reported to the Coroner.
86. Significantly, none of the remaining 12 deaths resulted from emergency treatment – they were all "elective" operations, in the sense in which that term is used by Queensland Health: in other words, they were operations where the patient's survival did *not* depend upon urgent surgery. Without the benefit of the Patel experience, one might have thought that any death resulting from "elective" surgery would be regarded as unexpected.

87. Had the Commission of Inquiry proceeded, I would certainly have been offering recommendations as to appropriate amendments to this provision of the *Coroners Act*. I would not have suggested a return to the situation which previously existed, where *all* deaths in the operating theatre had to be reported. For example, where a person undergoes emergency life-saving surgery, which is sadly unsuccessful, there would not normally be any need to report the matter to the coroner. However, where death results from "elective" surgery – and especially in cases where the patient is not clearly informed that death is an "expected" outcome of the surgery – the matter should be reported to the Coroner's office.
88. Evidence received by the Commission of Inquiry highlights another anomaly, in that it seems to have been Patel's practice (and, apparently, the practice of some other surgeons) to get the most junior doctor in the operating theatre to sign the death certificate. At the very least, I firmly believe that the person in charge of an operation should take the responsibility for signing the death certificate, and thereby certifying to the appropriate authorities that the circumstances of the death do not require further investigation.

B. SYSTEMIC PROBLEMS WITHIN QUEENSLAND HEALTH

89. The Patel phenomenon, and the evidence received by the Commission of Inquiry, reveal, directly and indirectly, a plethora of systemic problems within Queensland Health.
90. Following my removal as Chairman of the Commission of Inquiry, I wrote to the Director-General of Queensland Health – with a copy to the Premier, Mr Beattie – attempting to summarise the most important issues which would have been addressed in the final reports of the Commission of Inquiry if it had continued under my chairmanship. I advised that some of the more important issues, based on the evidence received to date, would appear to include the following:
91. First, the need for Overseas Trained Doctors either to work under supervision, or, where that is not feasible, to work in a tertiary hospital for a probationary period before being sent to a location where the doctor will be working without supervision.
92. Secondly, the need to improve orientation facilities for Overseas Trained Doctors, including:
- 92.1 Medical issues which may differ from the doctor's country of origin (to take one extreme example, we received a report about a doctor at Caboolture

treating a pregnant woman who was the subject of a dog bite, and insisting that she receive rabies inoculation, although this is of course unnecessary in Australia, and might have harmed her pregnancy);

- 92.2 Medical technology in use in Queensland hospitals;
 - 92.3 The Australian healthcare system, including Medicare, private hospital and medical insurance, the relationship between Federal and State funding of healthcare, and the relationship between public and private practice;
 - 92.4 Cultural issues generally; and
 - 92.5 Language issues, including knowledge of Australian slang which may be used by patients in reporting their symptoms.
93. Thirdly, added protection for "whistleblowers" in the public health system, including provisions enabling such people to report their concerns (in an appropriate case) to:
- 93.1 Members of Parliament;
 - 93.2 Unions;
 - 93.3 Professional associations;
 - 93.4 The media.
94. Fourthly, the need for a central bureau (a "health sector ombudsman") to:
- 94.1 Receive complaints, both from the public and from people working within the public health sector;
 - 94.2 Ensure that such complaints are directed to the appropriate body (such as the administration at the relevant hospital, the Department, the Medical Board, or the Health Rights Commission) for investigation;
 - 94.3 Ensure that such investigations are conducted in a timely fashion;
 - 94.4 Ensure that the complainant receives appropriate "feedback".
95. Fifthly, the need to address the reputation of Queensland Health for "bullying" staff, and for adopting a "shoot the messenger" attitude. For this purpose, it is totally

irrelevant whether that reputation is justified or not, although the existence of such a reputation is hard to understand unless there is at least some truth to it. But, so long as that reputation exists – whether fairly or not – staff, and especially clinical staff, will be discouraged from highlighting matters of concern.

96. Sixthly, the need, within every hospital, to have a clinical “chief of staff” – a person who is a practising (or possibly retired) clinician, and whether or not a member of the hospital’s full-time staff, who can function as:
 - 96.1 A mentor and source of advice to other clinicians;
 - 96.2 A “court of appeal” in relation to clinical issues;
 - 96.3 A mediator in respect of disputes between clinical staff; and
 - 96.4 A liaison between clinical staff and administrators.
97. Seventhly, the need to ensure that every hospital in Queensland, public and private, has a functional and effective credentialing and privileging process.
98. Eighthly, the need for a “rapid response team”, either within Queensland Health or as part of a separate regulatory body, to urgently investigate serious clinical problems which may arise anywhere in the State.
99. Ninthly, the need to reform the current “waiting list” system, so that:
 - 99.1 Non-surgical procedures, such as diagnostic and prophylactic procedures, are recorded; and
 - 99.2 Statistics provide a true and accurate reflection of the real situation, measured in terms of the length of time between a patient’s referral to a public hospital by the patient’s general practitioner, and the patient’s receiving appropriate clinical advice and/or treatment.
100. Tenthly, the need to change the current funding priorities, by which:
 - 100.1 Hospitals are rewarded for conducting surgery, but not diagnostic or prophylactic procedures such as endoscopies and colonoscopies; and

- 100.2 The reward is based solely on the complexity of the operation, and the patient's state of health, without regard to whether the operation was either necessary or successful.
101. Eleventhly, the need to formalise indemnity arrangements, so that experienced clinicians from outside the public hospital system can (as necessary) provide voluntary assistance at public hospitals, either:
- 101.1 In emergency situations; or
 - 101.2 For non-clinical purposes, such as participating in audit and review processes, or credentialing and privileging processes.
102. Twelfthly, the need to ensure that clinical auditing and review practices, throughout Queensland Health, are consistent with "World's best practice".
103. Thirteenthly, the need to review remuneration arrangements for clinicians (both doctors and nurses, and both full-time and part-time or visiting) in regional and remote areas, to ensure that the best people are attracted and retained, including:
- 103.1 Providing genuine compensation for the real costs and hardships associated with living in a regional or remote area; and
 - 103.2 Allowing to local management some measure of flexibility, such as permitting "salary sacrificing" arrangements, to make remuneration packages more attractive.
104. Fourteenthly, the need to ensure that funding for regional and remote hospitals is based on genuine demographic data, and a proper clinical analysis of the "burden of disease", rather than the "historical" funding model which merely perpetuates inequities and anomalies.
105. Fifteenthly, the need to re-educate administrative and managerial staff, particularly at District and hospital level, to be an effective part of the clinical team, rather than remote and aloof from the day-to-day clinical activities undertaken within a hospital.
106. Sixteenthly, the need to plan, urgently, to provide appropriate training for the significant numbers of medical graduates who will be produced by Queensland universities over the next few years.

107. Seventeenthly, the need to review and enhance the existing system of rural scholarships for Queensland medical graduates, to provide greater opportunities and incentives for young doctors to work in regional and rural parts of the State.
108. Eighteenthly, the need to create both the appearance and reality of genuine independence between the provision of public sector health services in Queensland, and the regulation of the healthcare sector, by removing from Queensland Health, and investing in a separate commission or organisation, responsibility for matters such as:
 - 108.1 Registration, credentialing and accreditation of health practitioners and health facilities;
 - 108.2 Dealing with both internal and external complaints (a "Health Sector Ombudsman");
 - 108.3 An "inspectorate", to oversee clinical audits and reviews, and to operate a "rapid response team" as canvassed above;
 - 108.4 An authority for maintaining research and collating statistics, independently of Queensland Health;
 - 108.5 A body (not unlike the existing Health Rights Commission) responsible for mediation and resolution of disputes;
 - 108.6 Responsibility for maintenance of institutional standards across all Queensland Hospitals and healthcare institutions, as the Chief Health Officer currently does for the private sector; and
 - 108.7 Oversight of professional standards and disciplinary issues.
109. Nineteenthly, the need to ensure that clinical auditing and review processes can function freely from legal constraints, including:
 - 109.1 Exemption from Freedom of Information legislation;
 - 109.2 Indemnity from civil liability;
 - 109.3 Privilege against use as evidence in criminal proceedings;
 - 109.4 Whistleblower protection; and

109.5 Compulsive powers.

110. Twentiethly, a need to give local communities, particularly outside Brisbane, "ownership" of their own hospitals, and a genuine role in the decision-making process.
111. Twenty-firstly, a need to ensure that practising clinicians – doctors and nurses, and allied healthcare professionals – have genuine representation in hospital management.
112. Twenty-secondly, an urgent need to ensure that "projects" undertaken at Departmental level, which do not involve the provision of actual clinical services to patients, are:
 - 112.1 Justifiable as having a greater priority than the provision of clinical services;
 - 112.2 Focussed on enhancing Queensland Health's capacity to deliver quality healthcare services, rather than "pie in the sky" projects which have no grounding in practical clinical application;
 - 112.3 Undertaken only in circumstances where resources exist to implement any conclusions or recommendations which may be forthcoming (as compared with the scandalous situation, exemplified in the evidence of Dr. Waters, where money has been spent on "projects" which cannot be implemented due to lack of funding); and
 - 112.4 Are not merely a pretext to "sideline" Departmental staff whose services cannot usefully be taken advantage of elsewhere in the Department.
113. Finally, but most fundamentally, a need to change the culture within the Department's administration, so that clinical problems are addressed in an open, frank and honest way, so that:
 - 113.1 Members of the general community are not given unrealistic expectations as to the services available to them from the public health sector;
 - 113.2 Individuals can plan their own health needs and requirements in full knowledge of any limitations or delays existing in the public sector;

- 113.3 Members of the community who are dissatisfied with the level of services available in the public sector can express their concerns, in the appropriate democratic way, through the ballot box;
- 113.4 Administrators and clinical staff can sensibly plan and budget to provide the best healthcare service possible within available funding; and
- 113.5 Individual clinicians, both within and outside the public sector, can provide meaningful and realistic advice to patients regarding their prospects of receiving appropriate and timely treatment in the public sector.
114. I should be very pleased to address these – and any other issues which are of interest to the Standing Committee on Health and Ageing – in oral testimony.

Anthony J H Morris QC
07 September 2005