Queensland public hospitals

Commission of Inquiry – *never a dull moment!*

By RJ Douglas SC

On 30 November 2005 the Honourable Geoffrey Davies AO, Commissioner, delivered his report on the Queensland Public Hospitals Commission of Inquiry. The report catalogued a litany of failures in Queensland Health, not just at Bundaberg Hospital with respect to Dr Jayant Patel, but also at senior levels of stewardship of health services up to cabinet level. However, Mr Davies' report did not simply criticise. It created a template for improving state and territory health systems generally. The author, who was senior counsel assisting the inquiry, provides some insight into the report and the claim process it spawned.

COMMISSIONER DAVIES

Commissioner Geoff Davies AO deserves all the plaudits he received for the task he performed in 2005.

His Commission of Inquiry, appointed under the *Commissions of Inquiry Act* 1950 (Qld), started on 6 September 2005. His report, a 538-page, readable tome, was delivered on 30 November 2005.

The report catalogued the litany of failures on the part of Dr Jayant Patel, an 'area-of-need' appointed surgeon at Bundaberg Hospital, and in Queensland Health as a whole. The Commissioner exposed deficiencies in management practices, including the management of complaints and incidents, and a culture of concealment.

Importantly, the report went on to catalogue remedial measures in a raft of areas. These embraced registration of foreign doctors, the credentialing and privileging of such doctors, 'whistleblower' protection and reform of coronial practice.

Commissioner Davies, a highly regarded retired Queensland Court of Appeal judge, accepted appointment following the abrupt termination of the Bundaberg Hospital Commission of Inquiry. That Inquiry was headed by Tony Morris QC, who sat with Deputy Commissioners the Honourable Sir Llewellyn Edwards AC and Margaret Vider RN.

In the decision of *Keating v Morris & Ors; Leck v Morris & Ors* [2005] QSC 243, judicial review was successfully sought against Commissioner Morris and his deputies on the grounds of apprehended bias. The inquiry was then terminated.

It would be remiss not to acknowledge that, leaving aside the apprehended bias decision, Mr Morris engendered much confidence in the community, in particular in Bundaberg, that his Inquiry's investigations would be undertaken without fear or favour.

Commissioner Davies picked up the pieces. He adopted the exhibits and transcript of the Morris Inquiry. Some witnesses were recalled. The former directors-general of Queensland Health, the Bundaberg Hospital administrators (fresh from their successful judicial review against Commissioner Morris) and many others gave evidence.

In the first few days of his inquiry, the Commissioner dismissed – furnishing detailed and compelling reasons – an application by the Medical Board of Queensland and others to exclude counsel assisting the Morris Inquiry (except for the writer who had joined that inquiry only in its last weeks) on the basis of being, in effect, tainted by the same apprehended bias that had undermined the integrity of the Morris Inquiry.

Commissioner Morris had been flamboyant. Commissioner Davies, a very different personality, seasoned by a long career as a barrister, solicitor-general and Court of Appeal judge, was cool and clinical.

The media and public lapped it up.

REPORT CONCLUSIONS[1]

Several salient matters dealt with in the report reinforce the benefits of fearlessly independent commissions of inquiry.

Medical shortages

Queensland, like the other states and territories, suffers from medical staff shortages. However, the position in Queensland, Australia's most decentralised state, is worst.

> '2.21 Whatever the causes, there are, in fact, fewer doctors per head in Queensland than in any other state or territory, and the statistics for nurses are similar. It is also clear that the state's needs are not nearly satisfied by the local graduates, or even from interstate sources because other states or territories suffer from similar – but mostly, less critical – shortages and because doctors are inclined to make their career where they trained. Concurrently, it has become much more difficult to recruit from countries with comparable medical systems because those countries are experiencing shortages, because some countries have introduced measures to ensure that they retain their graduates, and because such doctors can command better remuneration elsewhere.
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> 2.22 In consequence, Queensland has become highly dependent for a number of years on doctors from >>

developing countries. This state employs well more overseas-trained doctors than any other Australian state and, at least by 2003, the proportion of Resident Medical Officers who were overseas-trained doctors across the state was approaching 50%. Whereas in 1997-98, the UK and Ireland accounted for 70%of the temporary working visas issued to overseas-trained doctors (known as the subclass 422), by 2002-03 that share had fallen to 4%. Over the same period, the proportion of doctors originating from India, Pakistan, Sri Lanka, Malaysia, the Philippines, Bangladesh and 'other' increased from 9.6%to 37.%. Queensland authorities often know little about the training standards at particular medical schools in those countries and, in any case, the training may address quite different conditions from those operating in this state. The practice is also problematic from a moral point of view: it deprives developing countries of doctors in circumstances where those countries may have paid for their education and are likely to have at least an equal need for their services.'[2]

It was on the back of such staff shortages that Dr Patel came to be appointed.

Dr Jayant Patel

The Queensland medical registration system allowed, and continues to allow, overseas doctors to be appointed on an 'area-of-need' basis.

In late 2002, the Bundaberg Hospital advertised for the position of director of surgery. The position was ultimately offered to Dr Patel, a Indian-trained surgeon resident in the US.

Dr Patel secured registration on the basis of false or misleading credentials, found Commissioner Davies. Dr Patel had previously been the subject of disciplinary proceeding in the US for errant surgical practice. This was not disclosed to the registering authority. Any 'google' search would have disclosed as much, as it did in 2005 when complaints reached a crescendo.

The rest is history.

The evidence found at the inquiry, as to the devastating outcome of Dr Patel's surgery (he being otherwise found to be an industrious surgeon, albeit one lacking in clinical skills and judgment), was summarised in the report:

'3.418 Dr Woodruff noted that:

- There were 13 deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome;
- There were a further 4 deaths in which an unacceptable level of care on the part of Dr Patel may have contributed to the outcome;
- There were, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to, or may have contributed, to an adverse outcome;
- Of the 31 patients identified, there were 23 patients who suffered major technical complications;
- In all, there were 48 patients where Dr Patel contributed, or may have contributed, to an adverse outcome.

Dr Woodruff concluded:

I have no hesitation in saying that [Dr Patel's] performance was incompetent and that his performance is far worse than average or what one might expect by chance.

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When the figures are considered carefully, however, it leads to a harsher judgment of Dr Patel. Many patients were *in extremis* or suffering terminal pathology. Those deaths (which are not attributable to Dr Patel) "spuriously" show Dr Patel in a better light. Dr Woodruff believed that they should not be considered when arriving at a "denominator". When one reduces the sample accordingly, one finds there is a high proportion of operations that went wrong. Dr Woodruff said, in particular, that of the 13 deaths, there were 7 or 8 where the treatment was just "outlandish" and involved "absolutely non-defendable processes".'

A culture of concealment

Commissioner Davies took no prisoners on the issue of concealment from the public of information regarding elective surgery waiting lists and reports regarding surgical and health quality at Queensland hospitals.

His conclusions were as follows:

'6.717 Successive governments followed a practice of concealment and suppression of relevant information with respect to elective surgery waiting lists and measured quality reports. This, in turn, encouraged a similar practice by Queensland Health staff.

6.718 Queensland Health itself, by its principal officers Dr Buckland and Dr FitzGerald, implemented a policy of concealment and suppression of events, the exposure of which were potentially harmful to the reputation of Queensland Health and the government.

6.719 The conduct of officers of Queensland Health, together with its strict approach to surgical budget targets enforced by penalties, led to similar practices in hospitals, especially with respect to complaints about quality of service and it also led to threats of reprisal in some cases. These caused suppression of complaints which ought to have been exposed earlier.

6.720 In my view it is an irresistible conclusion that there is a history of a culture of concealment within and pertaining to Queensland Health.'

Commissioner Davies was scathing in his criticism of successive governments, of each political hue, and in particular of former Health Ministers Wendy Edmond and Gordon Nuttall.

Evidence was led before the Inquiry of potentially embarrassing material pertaining to both hospital waiting lists and hospital quality reports being wheeled on 'fridge trolleys' into the cabinet room so as to invoke the disclosure exemption provisions in the *Freedom of Information Act* 1992 (Qld).

In this matter, the Commissioner was unforgiving in his findings:

'6.559 The conduct of cabinet, in successive governments, in the above respect, was inexcusable and an abuse of the *Freedom of Information Act*. It involved a blatant exercise

of secreting information from public gaze for no reason other than that the disclosure of the information might be embarrassing to government. In the case of the Measured Quality Service policy, cabinet's decision was undertaken in the teeth of a contrary view expressed by Queensland Health and, had anyone outside the ranks of Queensland Health bothered to enquire, contemporaneous literature.

6.560 On 28 September 2005 I gave an intimation in respect of findings in relation to elective surgery waiting lists and Measured Quality Service reports. On that occasion I indicated in open hearing the following:

I have given this intimation at this stage to give to any person the opportunity to consider whether to give or tender further evidence upon either of these issues and to permit that consideration to be given before the close of evidence which will possibility occur at the end of next week.

6.561 Apart from the submissions received from relevant participating parties, namely former Minister Nuttall and former Minister Edmond, no politician (past or present) took up this opportunity.

6.562 I received a letter from Premier Beattie on 30 September 2005.

6.583 That spoke prospectively of the current government's intentions in respect to waiting lists and Measured Quality reports. It said:

> I am prepared to act to continue my government's record of openness and accountability. Therefore, my government now commits to legislating to ensure that all relevant data about waiting lists and all Measured Quality Reports about individual hospitals will be reported in an annual State of Health Report. That information will be available to be accessed by all Queenslanders.

6.563 The opening sentence of this extract is inconsistent with the facts as I have related them pertaining to elective surgery waiting lists and Measured Quality hospital reports.'

Bundaberg Hospital claims

As regards the disposition of claims against the state of Queensland arising from the errant clinical practice of Dr Patel, my informant, in this regard, is Gerry Mullins, of counsel. Together with Justin Harper, of counsel, Mr Mullins appeared for the Bundaberg Patients Group for the duration of each inquiry.

The essential information is as follows:

- 300 claims were brought against the state by Bundaberg hospital patients and their privies.
- A scheme for resolution of these claims by mediation was put in place by the state.
- As at 3 October 2006, 125 of these claims were resolved by compromise under the scheme.
- The scheme is likely to be concluded by mid-2007.
- The state is paying the costs of mediation (most mediations have been before Ian Hanger QC) and all medico-legal investigation costs.
- Any compromises are on a 'plus costs' basis.
- The restrictions on general damages initiated by the *Civil Liability Act* 2003 (Qld) are only being paid lip service.

CONCLUSION

Hopefully this article provides some insight into the central pillars and results of the Queensland Public Hospitals Commission of Inquiry.

Those seeking to campaign for practical, and cost-efficient change in any health system would do well to consider the recommendations of Commissioner Davies. It is hoped that his report will not simply gather dust.

Dr Jayant Patel, unfortunately, has slipped through the net, misrepresenting his disciplinary history. His malpractice, however, exposed a raft of deficiencies in the health system in Queensland, and the inimical results of medical and nursing staff shortages.

A culture of concealment, extending to cabinet level, has no place in modern government, nor in mainstream public services such as health. The public is entitled to know what is, and is not available through the public health system, and within what timeframe, so effective choices can be made about health service provision and insurance.

Where a mainstream public service system fails, governments ought put in place an extra-curial system of compensation to expeditiously address losses. The Queensland Government, to its credit, has done this. ■

Notes: **1** The interested reader will find the report at http://www.qphci.qld.gov.au/. The salient conclusions from the report are to be found in the appendix to this article. **2** Footnotes omitted.

APPENDIX

8.1 It would be a pity if the impression gained from this Report was that there were few capable, industrious and caring doctors still working within public hospitals. On the contrary, there are many, some of whom gave impressive evidence before this Commission.

8.2 But many capable, industrious and caring doctors have left the public system, particularly from provincial hospitals. The causes of this have been excessive and unsafe working hours caused by inadequate numbers of capable doctors, inadequate salaries and conditions, and a failure to involve them in decision making in areas in which there is tension between, on the one hand, patient care and safety, and on the other, budget integrity. The provision of inadequate funds to provide the services promised, is a root cause of all of these.

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8.5 These constraints and their strict enforcement have been the main cause of conflict between administrators, whose main concern has been budget integrity, and clinicians, whose main concern has been patient care and safety. Unfortunately, the conflict seems too often to have been resolved in favour of an economic rationalist view of budget management, sometimes with harmful effects on patient health and safety. The view, which seems to be that of Queensland Health, that substantial adverse publicity is as serious a consequence as multiple deaths, is shocking.

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8.7 Because there are so many cases in which patient care and safety will conflict with budget integrity, it is essential to have clinicians involved in decisions about what is needed to provide adequate, reasonably safe clinical care, and, consequently, how much needs to be spent to provide that.

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