SPECIAL COMMISSION OF INQUIRY
INTO ACUTE CARE SERVICES IN NSW PUBLIC HOSPITALS

Before Mr Peter Garling SC, Commissioner

At level 6, 299 Elizabeth Street, Sydney

On Thursday, 12 June 2008, at 2.05pm

Counsel Assisting: Mr Terence Tobin QC,
Ms Georgina Wright

Solicitor to the Inquiry: Ms Catherine Follent

THE COMMISSIONER: This is the resumption of the Special Commission of Inquiry.

<ANDREW EDWARD DIX, affirmed: [2.11pm]

<EXAMINATION BY MR TOBIN:

MR TOBIN: Q. Mr Dix, would you give the Commission your full name and your occupation?
A. My name is Andrew Edward Dix. I'm the registrar or CEO of the New South Wales Medical Board.

Q. Can you tell us in brief the functions of the Medical Board and your functions as the registrar?
A. The Medical Board's role is to protect the public of New South Wales by administering the Medical Practice Act, to ensure that doctors who are registered are appropriately qualified and experienced to be registered and, once they are registered, to ensure that they continue to maintain appropriate professional standards.

Q. And your particular job?
A. My role as CEO is effectively to run the administration of the board and to ensure that the Act is complied with.

THE COMMISSIONER: Q. What sort of size is the board in terms of employees?
A. Currently about 40, 40 employees, and the board itself has 20 members.

MR TOBIN: Q. Just to bring the picture up to date, what services do you provide to the public hospital system, the area health services, with regard to their recruitment of medical practitioners?
A. I think what you're asking is - we don't directly provide any services. We now have, although at the time when all this occurred we didn't have, the Register of Medical Practitioners available on line. So a doctor's registration status is --

Q. Well, that's a service?
A. -- and that's currently available. Prior to that the register has always been a public document and we would provide information. Many hospitals would come to us with a list and say, "Could you please confirm the following doctors are registered," and so on, and we would answer

1 questions relating to the registration of doctors. But,
2 generally speaking, we wouldn't put information out to
3 people; we respond to queries.
4
5 Q. Would you be able to inform and let us begin with
6 members of the public back in the mid-1990s of conditions
7 attaching to a practitioner's registration?
8 A. The Act makes it clear, and I'd have to think which
9 particular versions of the Act as it has been amended a
10 substantial number of times over the relevant period. The
11 Act, firstly, doesn't specify what constitutes the register
12 but it has provisions saying that it shall be available.
13 We have always treated the register as a public document
14 and the conditions on registration that have been imposed
15 through proceedings under the Act are publicly able to the
16 public.
17
18 Q. So that's --
19 A. Sorry, can I just finesse that slightly?
20
21 Q. Yes.
22 A. Section 135A provides that we don't have to provide
23 details of conditions relating to impairment. I think
24 those provisions came in in about 1992, from memory.
25
26 THE COMMISSIONER: Q. Was that 135A?
27 A. Yes.
28
29 MR TOBIN: Q. Perhaps I'm jumping ahead a little bit, but
30 135A is information to be made available to the public?
31 A. Yes.
32
33 Q. Is an area health service within or without the
34 definition of "public"?
35 A. We haven't differentiated. We don't believe we have
36 any higher responsibilities towards government
37 instrumentalities than we do towards the public generally.
38
39 Q. Then the prospective employers are, if there's not a
40 special provision, just members of the public?
41 A. That's correct.
42
43 Q. The next question is this: it would appear during the
44 period from 1997, when the PSC made a determination about
45 Dr Reeves and 2002 when he was employed by the area health
46 service, he was made part of the impairment proposal.
47 A. Right.

1
2 Q. You refer to this section which has a limitation upon
3 provision to the public or a disclosure of what's called
4 physical or mental capacity of a person to practise
5 medicine; is that a reference to the impairment program as
6 you would understand it?
7 A. Yes, that's it, yes.
8
9 Q. What would have been the position in 2002 where
10 Dr Reeves turns up as an applicant for the position and the
11 area health service, let us say, contacted the board to
12 find out if there were any conditions attaching to his
13 practice, and those conditions, or rather the doctor came
14 under the professional impairment program, would the board
15 have been able to disclose those conditions?
16 A. It's a bit more complicated than that. The fact that
17 somebody has conditions relating to impairment doesn't
18 necessarily mean that all those conditions are relating to
19 impairment. For example, if he had conditions saying that
20 he was only able to work in an approved place or something
21 like that, we will freely disclose conditions other than
22 impairment conditions. And we have to make an arbitrary
23 decision on that; when I say "arbitrary," we make our own
24 decision as to what goes into the impairment bundle or what
25 are the other conditions.
26
27 THE COMMISSIONER: Q. So, if you had a drug-addicted
28 doctor, a classic condition that you might make public to a
29 prospective employer might be he is restricted from
30 prescribing schedule 8 drugs, as an example?
31 A. That's correct, but not --
32
33 Q. But you wouldn't make public a condition saying the
34 doctor is to have random urine tests, consult with a
35 specialist in addiction medicine every three months, obtain
36 a report every six months, et cetera?
37 A. That's correct. Yes, that's right, that's the
38 distinction.
39
40 Q. So you have to try to make some decision as to which
41 of the conditions are disclosable and which aren't?
42 A. That's right.
43
44 Q. Can you tell me what underlay that theory? You have
45 been in this job for sometime, haven't you?
46 A. Twenty years, or more than 20 years, 20 and a bit.
47

1 Q. What underlay that theory? How did that come about?
2 A. I think the impairment program, which was first
3 formalised in 1992, although we had a version of it running
4 prior to that time, but the impairment provisions came into
5 the legislation. Then, I suppose, in the political leading
6 up to that, it was sold to the profession on the basis that
7 this would be a confidential process that would enable
8 doctors to be looked after, to be helped in getting well
9 again, where possible. It was made quite clear at that
10 time that its proceedings would be confidential and that it
11 would be not be made publicly available.
12
13 I guess section 135A - unfortunately, I don't remember
14 when it was brought in, I'm not sure that it came in in
15 1992; it might have been a little later - was, we believe,
16 designed to reflect that. However, we as a matter of
17 policy, took the view that because the Act didn't specify,
18 I believe, that we had to make these conditions public, so
19 prior to that we indicated that because the proceedings
20 were not public and the whole nature of the impairment
21 program was such that we could divulge, as we do now, that
22 the doctor has conditions relating to impairment, we
23 wouldn't go beyond that and that it was a matter for the
24 doctor to disclose if he or she chose to do so.
25
26 MR TOBIN: Q. The letter of 27 December 2001 is behind
27 tab 13, basically in the middle of the set of application
28 papers. Do you have that one, 27 December?
29 A. Yes, the letter from the board which is behind tab 13,
30 yes.
31
32 Q. That is signed by Evan Rawstron; is that right?
33 A. Yes.
34
35 Q. I wonder if you could just indicate for the assistance
36 of the Commission what conditions would have come, as you
37 see it, now under the heading of, "Matters relating solely
38 or principally to the physical or mental ability of a
39 person to practise medicine." I'm reading from 135A(2) of
40 the Act?
41 A. We would have viewed 1 through to 6 as all related .
42 Monitoring is monitoring of health conditions basically,
43 although it has merged into monitoring of other conditions
44 as well since that time. At that time when we were setting
45 up a monitoring arrangement that would have - so the
46 health-related conditions 1, 2 and 3, about treating
47 psychiatrists, and so on, and then the review by the board.

1
2 If I can just perhaps expand on the distinction, just
3 looking at these, the health-related conditions were about
4 him being treated, and we try not to get involved in
5 treatment other than to make sure that treatment continues,
6 but also authorising the treating practitioner if there's
7 any dramatic change.
8
9 Then monitoring is where we require the doctor on our
10 behalf to attend - a doctor like Dr Samuels in this case -
11 at the board's expense so that we get the report back from
12 that doctor. So health-related are about their own
13 personal health, and the second part is about our ability
14 to monitor their health. Then the 7 and 8 obviously those
15 are not within that group.
16
17 Q. Let us go back then to 2002, as best you can
18 reconstruct things, what would happen in this hypothetical
19 situation where the area health service had not been given
20 by Dr Reeves this letter, but he applied for the job and
21 the medical director, the director of medical services,
22 made contact with the Medical Board about conditions
23 attaching to his registration? What would the board have
24 been able to disclose there?
25 A. Well, firstly, I don't have the conditions in front of
26 me, if these are the totality of them or were at that time.
27 We would be able to say he has employment-related
28 conditions relating to - saying whatever 7 and 8 are. He
29 has a range of health-related conditions. I guess - and
30 this is where I think this is the key letter - and I would
31 like to think, but I could not guarantee, that whoever was
32 asked that question would have said, "And there is an order
33 that he not undertake obstetric practice." If I can just
34 expand on that a little bit --
35
36 Q. Just before you do, though, could you just focus for
37 the moment on what the practice would have been. This is a
38 hypothetical question, of course, because these events
39 didn't occur this way, but if you could focus on the
40 practice in implementing 135A of the Act, if there's a
41 request that comes in at that time and you have these
42 conditions 1 to 8, I think you have indicated that 1 to 6
43 you wouldn't have cause to disclose, although you may --
44 A. We may disclose their existence.
45
46 Q. The existence of health-related issues?
47 A. Yes, and saying that that's up to the employer to ask

1 the doctor themselves.
2
3 Q. To get that from the doctor?
4 A. Yes.
5
6 Q. But the employment-related ones would be available, 7
7 and 8?
8 A. Yes, yes.
9
10 Q. The next question, which I think you have anticipated:
11 again in the hypothetical situation that an area health
12 service made an inquiry, it would be likely to be, would it
13 not, based on this scenario, the registration of the doctor
14 can be reflected on a card, a registration card; is that
15 right?
16 A. That's right.
17
18 Q. And if there are conditions attaching to the
19 registration, the word "conditions" or
20 "conditional" appears?
21 A. Yes.
22
23 Q. In those circumstances were the area health service to
24 follow up and say, "Well, we've been given the applicant a
25 card. It's conditional. There is a condition on
26 registration - what is it?", again would you expect the
27 answer to be 1 to 6 summarised by health matters?
28 A. Yes.
29
30 Q. And 7 and 8 stipulated as in here?
31 A. Yes.
32
33 Q. The nub of the question really is this: in addition to
34 conditions, you had orders?
35 A. Yes.
36
37 Q. How would either the area health service or, for that
38 matter, the person at the Medical Board answering the
39 query, understand to go beyond the conditions that we see
40 here?
41 A. The order would have been visible on our screen, on
42 our computer, and also it would be clear on the file. I
43 can say confidently that everyone was very well aware of
44 the fact that there was this order on Dr Reeves and there'd
45 been endless discussions, as you've seen from the file, and
46 I'd say --
47

1 Q. Generated by him, changing the conditions?
2 A. By him trying to, you know, push around the edge of
3 what constituted obstetric practice. So that was very well
4 known to everybody at the board.
5
6 THE COMMISSIONER: Q. Was there a designated employee or
7 group of employees to whom queries of this kind were put
8 through by the board's telephone answering machine/person?
9 A. What we would have done was that there would be
10 someone who would take primary responsibility depending on
11 whether it was largely a conduct matter or a health matter,
12 so Evan Rawstron would have been the one. Unfortunately
13 the nature of many of these doctors is generally when they
14 get in a mess like this, they touch a number of bases and
15 sometimes there would be something - we have a regular
16 weekly meeting of the staff involved in this area where we
17 try to do our best to make sure that if something is
18 happening here that everybody knows about it.
19
20 With the monitoring section, which has been now
21 formalised I think since this time and now has about four
22 staff, that section's job solely is to look at these
23 things. The general rule would have been that it would go
24 to the person in charge of the major issue and he or she,
25 if necessary, would touch base with other people who seem
26 to be --
27
28 Q. How would the telephonist - if that's the correct
29 description and it may not be - or your receptionist, how
30 would the person who answers the telephone who has Dr X,
31 the director of medical services or the area health service
32 wanting to make an inquiry about Dr Reeves, know who to put
33 the call through to?
34 A. Look, I guess it's fair to say that we are small
35 enough so most people know. It would go up to someone in
36 conduct or health and they would say, "Oh, that's Evan's
37 matter," and they'd pass it over to him. It's perhaps a
38 bit informal but that's how it works in reality.
39
40 MR TOBIN: Q. Evan, he's called not conduct, but health
41 and performance?
42 A. Yes.
43
44 Q. What side does that fall on?
45 A. There's conduct, health and performance, so we were
46 trying to draw this line. At the time performance didn't
47 exist when the Reeves matters first arose, but we had these

1 two other pathways which were there at the time this letter
2 was written, and he was very much on the performance and
3 health side, but the conduct people would have known that
4 that's a matter that would go to Evan.
5
6 Q. He had gone into the impairment program by this stage.
7
8 THE COMMISSIONER: Q. It started off as a conduct matter?
9 A. I think that's an important question. There are
10 people who will be in the impairment program who also have
11 conduct issues and they may have registration issues as
12 well. Nobody fits neatly into any particular box. What we
13 have to try and do is to ensure that if they are in one
14 box, people who are outside the box, but nevertheless have
15 peripheral dealings with them, know about that and keep
16 ensuring that people aren't operating in isolation.
17 I think it's fair to say about Reeves, if I may digress a
18 little bit, in the Professional Standards Committee the
19 issue of his impairment had been raised once prior to the
20 Professional Standards Committee. We had him assessed and
21 I think the decision of the assessing psychiatrist was that
22 he had personality traits, I think was the term that was
23 used, which is down the other end of the spectrum from a
24 personality disorder, so basically he didn't enter the
25 program. At the Professional Standards Committee, he
26 raised as a defence, I think, that the reason he had done
27 the things that had led to the Professional Standards
28 Committee was that he was depressed. My reading of the PSC
29 decision and my recollection, which is somewhat vague, at
30 the time was that there was some scepticism about that, but
31 saying that's what he has offered, and we will monitor to
32 make sure that if he is depressed, then he should be
33 monitored. So the monitoring was put in place, but he was
34 largely seen, so in that sense he became part of the
35 impairment program because he was having his health
36 monitored. But we have lots of people who are in the
37 impairment program who are there because impairment is
38 their sole problem, not doing anything wrong other than
39 they are taking drugs or they have got a psychiatric
40 disorder or something. So he had come to us really in the
41 sense in a conduct pathway, you might call it a performance
42 pathway now. But nevertheless impairment issues had arisen
43 so he was part of the impairment program. It's difficult
44 to categorise because often people are in three different
45 programs at the same time.
46
47 MR TOBIN: Q. There is a document in the bundle where he

1 is enrolled in the impaired registrants panel?
2 A. Program, yes.
3
4 Q. Sorry, in the program. There was a document where he
5 signed up to have him receive the handbook, tab 5, I think,
6 Mr Dix. This is August of 1999?
7 A. Yes.
8
9 Q. So it's two years after the PSC decision?
10 A. Yes.
11
12 Q. As you point out in that first paragraph of the
13 background, in the first document here, there was both a
14 finding of unsatisfactory professional conduct and of
15 impairment?
16 A. Yes.
17
18 Q. Then on the second page, the panel have conducted an
19 interview, that's the review interview report we are
20 looking at, and you will see that under the present
21 interview in the first paragraph, it ends by saying:
22
23 Dr Reeves was therefore not strictly in the
24 impaired registrants program and his
25 conditions were thus not by agreement but
26 by imposition by the PSC.
27
28 When you were giving evidence a few moments ago you used
29 the word he offered, he offered evidence of impairment?
30 A. Yes.
31
32 Q. But did you also mean by offered that, as I understand
33 it, consensual orders were made?
34 A. The distinction I think we making there, and I wasn't
35 consciously saying that, but you could draw that
36 conclusion, the normal way into the impaired registrants
37 program is via what is called an impaired registrants
38 panel, which is actually a panel set up under the
39 legislation, which again was introduced in 1992, that was
40 when the impairment program was formalised. That is a
41 different process whereby we get a notification of possible
42 impairment. We get the doctor assessed and then that
43 doctor will appear before a panel of two medical
44 practitioners, and this goes back to what I was saying
45 before, about how the program was introduced. They form a
46 view as to what would be appropriate conditions to place on
47 the doctor's registration. But it's a rather perverse sort

1 of provision, I think, the doctor has to voluntarily agree
2 to those conditions being placed on their registration.
3 But once voluntary agreement has been given, then as far as
4 I am concerned, and I think as far as legislation goes,
5 those conditions are there and they stay there and the
6 doctor can't say, "I have actually changed my mind," and
7 walk away from it. So they are voluntary in a sense that
8 we have to make sure that he hasn't had his arm twisted.
9 But once he's there, they are the conditions, as distinct
10 from conditions relating to impairment which could be
11 handed down by a Medical Tribunal or, in this case, a
12 Professional Standards Committee. So I think that's the
13 distinction they are making there. The language, I think,
14 is a bit loose because my view is the impaired program,
15 anybody who has impairment conditions who is being
16 monitored is in the program, regardless of where they have
17 come from. But this is not defined anywhere, that's just a
18 taxonomy issue, I guess.
19
20 Q. One aspect of this in the second paragraph of the
21 section on the present interview says that the two members
22 advised Dr Reeves that the orders on his practice were
23 accepted as being able to be reviewed only by the Medical
24 Tribunal, while the conditions on his registration were
25 able to be reviewed by the board. Is that an accurate
26 statement, as you would understand it, of the position?
27 A. I would have to review the Professional Standards
28 Committee decision. I'm taking it that they said the
29 review body for the order was the tribunal.
30
31 Q. Could I take you to tab 1, which is the decision, the
32 reasons, of course, in the first 40 pages, and then page 41
33 is the determination.
34
35 THE COMMISSIONER: Q. Page 42.
36 A. Yes, that's correct. I think that's what they are
37 referring to.
38
39 MR TOBIN: Q. The position would be that any review would
40 not be through the impaired registrants program, his
41 consent for a variation would be irrelevant, in effect. Is
42 that correct?
43 A. I think that's right, yes.
44
45 Q. So strictly speaking, these conditions which are, let
46 us call it, orders 1 to 3 and conditions 1 to 8, were in
47 two categories. The orders could be reviewed only by the

1 Medical Tribunal and the conditions might be reviewed
2 without the need to go to the tribunal, but to go to the
3 Medical Board. Is that roughly the distinction?
4 A. I'm reading and trying to see that.
5
6 Q. Page 42.
7 A. Yes. I'm reading paragraph 11 order 3 and it is
8 essentially saying that both of them are reviewable by the
9 Medical Tribunal only.
10
11 Q. On the orders or conditions?
12 A. Yes.
13
14 THE COMMISSIONER: Q. The other thing I think we should
15 draw your attention to, Mr Dix, if you go back one page, to
16 page 41, under the heading Determination, the first
17 paragraph determines that Dr Reeves has been guilty of
18 unsatisfactory professional conduct. The next paragraph
19 seems to determine that he does suffer from an impairment?
20 A. Yes.
21
22 Q. Within the meaning of the Act?
23 A. Yes.
24
25 Q. In that he suffers from, et cetera?
26 A. Yes.
27
28 Q. Then there's some discussion about that. That leads
29 ultimately to the orders and conditions. That seems to be
30 how it arose?
31 A. Yes.
32
33 MR TOBIN: Q. You mentioned that by 2002, the staff would
34 have available on the computer system for Reeves the orders
35 and conditions, and I imagine something like page 42 would
36 come up on the screen. Is that right?
37 A. I think that would be correct.
38
39 Q. Would this be amplified in any way by reference to the
40 series of attendances he had under number 8, the review
41 interviews, would they be added? If you look at number 8,
42 would his record available on the screen include
43 attendances at the review interviews and the dates of
44 those?
45 A. The database that you call the screen is something
46 that is constantly being developed. I couldn't say exactly
47 what it was, but we have systems that are designed to bring

1 up and you can enter when people have attended for things,
2 that you can check at the beginning of the week who is
3 supposed to be doing something that week and so on. So,
4 yes, that's part of the system. I couldn't say exactly
5 what it looked like back at this time.
6
7 Q. You will see 12 is publication of the orders and a
8 number of patients are identified who were affected, or
9 their families. Then over the page, a copy of the
10 committee's orders should be made available to Hills
11 Private Hospital, Hornsby and Kur-Ring-Gai Hospital and
12 Sydney Adventist?
13 A. Yes.
14
15 Q. Then:
16
17 A copy of the findings in relation to the
18 particulars should be provided to Doctors
19 Benness and Hyslop and a full copy should
20 be provided to the RACO and G.
21
22 A. Yes.
23
24 Q. Would that be the limit of publication to whom these
25 orders might be sent?
26 A. There are also some statutory provisions about making
27 available a copy, I think, to the nominal complainant, who
28 would have been the Health Care Complaints Commission, the
29 doctor, and so on.
30
31 Q. But not necessarily to prospective employers?
32 A. No. The Act also provides that the board, I think,
33 may make available a copy as it sees fit and from time to
34 time we get a request from someone after a decision has
35 been handed down, "Can I have a copy," and then the board
36 has to look at that. But it would not, unless it is
37 specified there, have been made available to prospective
38 employers.
39
40 THE COMMISSIONER: Q. Again, can I ask you what was the
41 thinking underlying that, as it was then or as you would
42 see it now?
43 A. I think possibly because often we don't know, once
44 somebody has been through our system, we don't necessarily
45 know where they are going and what they are going to be
46 working at. It also is based on an assumption that when
47 somebody comes to apply for a job, a prerequisite of their

1 job is that they are a registered medical practitioner, one
2 assumes, and that the employer will check to make sure they
3 are registered and to see if there are any conditions on
4 their registration. I guess this case has indicated that
5 possibly didn't occur as much as it should have, but
6 I think that that was - I am surmising here - the fact that
7 we wouldn't necessarily know, and in fact we generally
8 won't know, what people did for X number of years after a
9 decision has been handed down.
10
11 Q. I understand all of that, and I'm just thinking out
12 aloud in one respect. The decision is appropriately sent
13 off to the current employer, Hornsby and Kur-Ring-Gai Area
14 Health Service, or whatever it was, Hornsby Area Health
15 Service?
16 A. Yes.
17
18 Q. If one just takes Royal North Shore as an example, you
19 have a public hospital where an obstetrician can deliver
20 children, you have the private hospital 50 metres away from
21 the front door where equally they can deliver children?
22 A. Yes.
23
24 Q. Run by two totally different organisations.
25 Conceivably one could have the example of the doctor
26 walking across from one to the other?
27 A. Yes.
28
29 Q. Getting this decision, resigning from the public
30 hospital, walking across and getting registration at the
31 private hospital, or accreditation at the private hospital,
32 or vice versa, and that employer not being armed with the
33 same detail, unless the prospective employee says, "Here it
34 is," or, "By the way, you should ring the Medical Board"?
35 A. Yes.
36
37 Q. Et cetera. Is there a way around that? One can see
38 in the extreme example I have given - and it is an extreme
39 example - how that could work adversely to the interests of
40 the public?
41 A. Yes, I understand that and in fact what happened - and
42 I won't say Reeves was the sole reason for it, but
43 nevertheless I think Reeves was one of the major triggers
44 for us doing that - we sought specific amendment of the
45 legislation which, by 2002 or thereabouts, I think it was
46 2000 that it came in, saying that we were required to
47 notify current employers. At the time of the PSC, I don't

1 think there was mandatory notification in relation to any
2 employers. In 2000 it said, "You are to notify current
3 employers." We, as a result of this, and possibly there
4 were other cases at the time, sought a specific amendment
5 to enable us, or to require us, to notify prospective
6 employers as well. So we actively took steps recognising
7 that that could be a problem, we actively took steps to
8 address that.
9
10 MR TOBIN: Q. The section is 191B and it begins in
11 subsection (1):
12
13 The board is required to give notice of any
14 order or the imposition of conditions.
15
16 A. Yes.
17
18 Q. I will just put the dot points:
19
20 On the registration of a registered medical
21 practitioner to the following persons.
22
23 Then (a) is the employer, if any, of the practitioner
24 concerned. Then subsection (4) says:
25
26 A reference in this section to the employer
27 of the practitioner (a) is a reference to
28 the employer at the time of the relevant
29 conduct and (b) includes a reference to any
30 subsequent employer of the practitioner
31 that the Board considers appropriate.
32
33 So there is a requirement on the one hand, but a discretion
34 on the other, with regard to future employers, and we were
35 just tracking the dating of those amendments. The notes to
36 the statute suggest October 2000, but is it your
37 recollection --
38 A. My recollection is that subsection (4) was much later.
39
40 Q. Was a later one?
41 A. I think that's 2005.
42
43 THE COMMISSIONER: We will check that. There's no point
44 having a debate about it. We can track the history
45 through.
46
47 MR TOBIN: Q. But the question really is that when it's

1 mandatory with regard to present employers, but as
2 appropriate for subsequent employers, it's not such a
3 compelling section, is it, because you then have to make a
4 decision case by case as to whether this employer ought to
5 receive or not receive --
6
7 THE COMMISSIONER: Mr Tobin, there's another point, isn't
8 there? As I heard the section that you read out, the
9 mandatory notification is to the employer at the time of
10 the conduct.
11
12 MR TOBIN: Yes.
13
14 THE COMMISSIONER: It may not be the employer at the time
15 of the hearing or the decision, rather.
16
17 MR TOBIN: Yes, that's right.
18
19 THE COMMISSIONER: Q. There is then a discretion with
20 respect to the employer at the time of the hearing?
21 A. Yes.
22
23 Q. One can envisage, even with this provision, conduct
24 being referred. It of course takes some time for that
25 conduct to be heard. I'm not suggesting that's
26 inappropriate, but it takes some time to constitute a
27 committee and get the preparations going and to have the
28 matter heard. One could imagine that the doctor resigned
29 prior to the hearing. At the time of the hearing, he's
30 unemployed. The board, not knowing where the doctor ends
31 up, other than by imposition of a condition later or by the
32 ordinary notification provisions of, "Where are you now
33 working?" The doctor takes up employment after the
34 decision is handed down and it would then only be if the
35 registration team who collects details of doctors'
36 practices are notified that the doctor is now practising
37 from location A?
38 A. I should make that clear. A doctor can be at post
39 office box something or other for their entire career, and
40 that is legally quite satisfactory. We don't have practice
41 addresses. I think one of the things - sorry, I
42 interrupted you.
43
44 Q. No, that's important. But you can see my thinking.
45 You can in fact end up with a finding like this PSC of
46 unsatisfactory professional conduct never being revealed?
47 A. Yes.

1
2 MR TOBIN: Q. It would appear, would it not, that in the
3 context of the present legislation - let's move to 2008 -
4 unless there is an obligation upon the prospective employer
5 to go on to the internet and call up the Medical Board's
6 orders and conditions, unless that is a requirement from
7 the prospective employer, the Medical Board would be very
8 hard-pressed to make that information available case by
9 case for all employers?
10 A. Absolutely.
11
12 THE COMMISSIONER: Q. It's an impossible task?
13 A. I was going to say that, but I think that one of the
14 things that ought to come out of this is it ought to be
15 mandatory, and I don't know how one does it in the private
16 sector, and one would have thought, as I said before, that
17 any employer, if you're employing a professional person,
18 one would think you would check that they are actually the
19 professional person they say they are, because there is a
20 very simple way of doing it, you can go online and see it
21 straightaway and it's up to date and it's refreshed every
22 day. We have to rely upon organisation, and unfortunately
23 the sort of doctors who get into this kind of situations
24 that he was in, and we are talking several hundred,
25 disorganisation is often one of their characteristics,
26 disorganisation or actual sort of thumbing their nose at us
27 and just not getting around to it or not remembering.
28
29 Q. Putting their head in the sand?
30 A. Exactly.
31
32 Q. That's often the behaviour one associates with people
33 who are impaired?
34 A. Yes, it all goes with the territory, exactly. I could
35 not guarantee we could maintain a system where we were
36 confident that everybody - people do locums, they just pick
37 up a bit of work here and there, they do all sorts of
38 things, and we don't necessarily know about it. As I say,
39 there are several hundred doctors in that sort of situation
40 and it would be an impossible task for us to be --
41
42 Q. How many are on your register, approximately?
43 A. There are 30,000 doctors registered in
44 New South Wales.
45
46 Q. There's clearly not 30,000 practising in
47 New South Wales, though?

1 A. Our estimate is probably low 20s, but we don't know.
2 Again, we don't have that information.
3
4 Q. I'm thinking, for example, you might have a doctor who
5 lives and works and is based in Melbourne, but occasionally
6 comes up here to do a clinic and is therefore registered in
7 New South Wales?
8 A. Absolutely.
9
10 Q. But in fact may practice here for a very limited time,
11 if at all?
12 A. And there are quite a substantial number who are
13 residing outside the jurisdiction, overseas or interstate,
14 who do just that, or who never come here, never come to
15 New South Wales, but for whatever reason they maintain
16 their registration.
17
18 Q. I just want to understand this because I'm approaching
19 this a little from the background of the legal profession,
20 where one is put on the roll of legal practitioners, which
21 certifies in effect that you have had the necessary
22 education and qualifications and at the time of entry on
23 the roll that you were at that time of good fame and
24 character. That, however, doesn't permit you to practise.
25 To then practise law you have to apply annually for a
26 practising certificate, pay the requisite fees, certify
27 that you have insurance, and then answer a series of
28 questions about (a) where you practice (b) whether there's
29 any facts or circumstances that have arisen that would call
30 your fame and character or behaviour into question, and a
31 number of other like questions. That's not quite the same
32 as with the medical profession?
33 A. We effectively combine both those functions.
34
35 Q. On an annual basis?
36 A. Yes. Once you are registered, renewal is annual and
37 again there's a form you fill out which has your
38 professional indemnity insurance status, declarations about
39 criminal conviction, about impairment. It's all based on a
40 self-declaration system, essentially, but that happens
41 annually.
42
43 Q. Is there then any auditing of that to test whether the
44 declarations you are being given are correct?
45 A. We have taken to doing what we call a targeted random
46 audit - if that's not a contradiction in terms. The one
47 that we have been, I guess, most concerned about is

1 professional indemnity insurance because it has been
2 mandatory in New South Wales since 2003, I think. The form
3 is purely you say, "I hold professional indemnity
4 insurance, my reference number is such and such." On the
5 basis of anybody who comes to our attention where we are
6 taking proceedings of some sort, whether health,
7 performance or conduct, we ask to see further evidence of
8 their PI.
9
10 We have unearthed a couple of cases where people
11 haven't had it, and the legislation that has just gone
12 through Parliament will actually tighten that up. But as
13 far as auditing whether someone is impaired or whether they
14 have had a criminal conviction, we haven't done any sort of
15 structured audit of that sort of thing. Quite often when
16 something comes to our attention we will look back and see
17 was there anything said about this in their declaration. I
18 guess impairment is the most common one, we get a number of
19 notifications about that in annual returns. But we haven't
20 got a structured audit of it, no.
21
22 MR TOBIN: Q. Could I just go back to this letter of
23 27 December 2001, tab 7. You have explained that at this
24 time on the database, if there was a query about a doctor
25 who had "Condition" or "Conditional" written on his
26 registration card, the orders and the conditions would come
27 up?
28 A. Yes.
29
30 Q. On the screen?
31 A. Yes.
32
33 Q. That said, would there be an element of human judgment
34 that may come in for the person answering the query as to
35 whether they deal only with the conditions or with the
36 conditions plus the orders?
37 A. I suppose there's human judgment in anything that
38 someone does. This has been a problem that has troubled me
39 for a long time. I have always felt uncomfortable with
40 having orders and conditions, and I have urged professional
41 standards committees and people sitting on tribunals,
42 "Please don't make orders unless you have to. You can
43 always make a condition that you are not to practise
44 obstetrics, which is just as effective and doesn't have the
45 potential for confusion," which clearly arose in this case,
46 and that's been my view long before this case arose.
47

1 Q. Does that demonstrate that there were instances where
2 that confusion or lack of disclosure perhaps by the medical
3 practitioner led to problems?
4 A. I don't recall it ever actually happening, but it's
5 caused problems for us internally to work out how we record
6 things, it's an administrative issue. But I have seen the
7 potential for it, and clearly this case highlighted it. To
8 be honest, I couldn't say exactly what it would have looked
9 like on the screen at the time, but we now really don't
10 distinguish between orders and conditions, we will just put
11 them on.
12
13 Q. I think that leads to this question: on the premise,
14 which you may accept for purpose of the answer, that
15 Dr Reeves misled the prospective employer, the area health
16 service, and he misled them by not disclosing the obstetric
17 bar and he misled them by holding himself out as able to do
18 obstetrics, if called upon, in that context what do you
19 think could have been the procedure, was there one
20 available that would have prevented him from succeeding in
21 the deception? Do you follow the question?
22 A. I think what you're asking is if the administrators
23 said, "Thanks very much for tendering that letter," part of
24 our procedure is we check with the Medical Board to verify
25 your registration status. That would have been the step,
26 yes, if they had have come to the board. In fact, I think
27 it's apparent from the file that the way in which this all
28 came to our attention was someone rang about an impaired -
29 they had a question, an anonymous question, about an
30 impaired doctor, they rang from Bega, and someone in our
31 office put two and two together and said, "That sounds like
32 Reeves and it sounds like he is doing obstetrics," and that
33 is what got us getting the ball rolling.
34
35 The way to address it would have been for the hospital
36 to have, notwithstanding the fact that he presented and
37 looking at the documentation he put forward, quite a
38 comprehensive deceptive application, if you like, but they
39 should have cross-checked it as well, rather than just
40 accepting that. I think that's how I would see it.
41
42 But, look, the other thing which I'd say and, as a
43 consequence of this, we determined that we should not be
44 issuing letters which relate to a particular aspect of
45 someone's dealings with the board. As I said before, they
46 are often in two or three different areas and you either
47 say: the conditions in relation to your impairment are as

1 follows. Please note that there are a range of other
2 conditions, a range of other things; or else you say: the
3 totality of your conditions are as follows. So a letter
4 should not leave our office now which could be misconstrued
5 as this clearly was.
6
7 Q. If you look at the heading for items 7 and 8,
8 "Employment-Related Conditions," I think that would
9 highlight, would it not, the difficulty that the area might
10 have, that the area health service might have, in not
11 putting or not apprehending that that might be only some of
12 the employment-related conditions?
13 A. Yes, yes.
14
15 THE COMMISSIONER: Q. Quite frankly, when I read
16 condition 8, I thought that it meant that the only
17 restriction on his right to practise was that related to
18 his health?
19 A. Yes, I can see that.
20
21 Q. I think that's an available interpretation of it?
22 A. Yes, yes. For what it's worth, my view is that the
23 area acted - I don't think that they did any more or less
24 than anybody would have done in the circumstances. I
25 think, with the benefit of hindsight, that that letter of
26 ours was a mistake.
27
28 Q. Hindsight is the most fantastic tool in this Inquiry,
29 but in the position of the area health service at the time,
30 which was January/February 2002 - here is a letter written
31 at the end of December; so a very current letter - I think
32 they were entitled to take the view that it was an
33 up-to-date letter. We are not dealing with something tat
34 is 12 months old or anything like that.
35 A. No, I --
36
37 Q. And the question is should they have done something
38 more, and I can well see the argument that says they did
39 what many employers would have done.
40 A. That certainly is my view and that's what I told the
41 O'Connor inquiry as well. I think that they did in the
42 circumstances - although things have emerged subsequently
43 in the press which suggest that they might have known
44 something about the other issue, but we were unaware of
45 that.
46
47 MR TOBIN: Q. In Tab 2, the second document is a

1 19 August 1997 letter that Dr Reeves has written to the
2 Medical Board. You will see, Mr Dix, in the second-last
3 paragraph, he says that he plans to make himself available
4 as:
5 ... a surgical assistant, including
6 assisting at Caesarean Section [he claims]
7 as was discussed at the committee hearing.
8
9 Then the next document on 24 September is from
10 Sherayn Payne, with copies to the employers, you'll see on
11 the second page, where she says in the first of the two dot
12 points under number 1:
13
14 As from the date you received the decision
15 (July 1997) you are not to be involved in
16 the care of obstetric patients as the
17 primary clinician or in the capacity of an
18 assistant. This includes assisting another
19 practitioner during Caesarean Sections.
20
21 And then 2 was that ordinary obstetric patients were to be
22 notified that he was no longer able to be their
23 obstetrician. This seems to raise, does it not, the
24 question of what you do with a practitioner who chooses to
25 ignore, not just the order but a clear exposition of the
26 order from the Medical Board. Have you turned your mind to
27 that? It may be that the simple answer is you're not a
28 police force, but it is a difficulty, isn't it?
29 A. Look, it is a difficulty. As I said before, it goes
30 with the territory a bit, that not infrequently doctors who
31 are in this position, it's in the nature of their
32 personalities or their illness or whatever it is, that they
33 are constantly pushing and testing and engaging in what
34 could be seen as breach, sometimes it's minor, sometimes
35 it's more significant. We spend an enormous amount of our
36 time dealing with this sort of situation where someone is
37 just always pushing the limits.
38
39 Another example comes up when the issue of him
40 attending to an emergency arises. I think he quoted
41 that somewhere in the discussions with the area, where
42 Professor Glover and Dr Amos told him that he could.
43 Again he is interpreting things his way. What I believe
44 they said, I'm not sure, but one assumes they said, "If you
45 were walking down a road and a woman suddenly starts going
46 into labour, you could do something there." But that
47 doesn't mean that you could put yourself on the emergency,

1 and that is the nature of --
2
3 Q. On the emergency roster?
4 A. Yes, putting yourself up on the emergency roster is
5 setting yourself up to ensure that the conditions are
6 breached if something happens; whereas, if you are on an
7 aeroplane, it's probably legitimate that you assist and
8 this sort of thing. I suppose it's fair to say - again
9 this is from reading the file but also from my recollection
10 of it - that Reeves was one of the more difficult, always
11 misinterpreting or interpreting things differently and so
12 on.
13
14 You said should we be a police force? Most doctors
15 are compliant and there is always a number who are not.
16 One of the aspects of our job, I suppose, is to try to
17 establish how much leeway you give them and how much a part
18 of their non-compliance is part of their impairment or
19 whatever and at what point you draw down the boom and say,
20 "That's enough now. We are sending you off to the Medical
21 Tribunal."
22
23 The recent legislation, which has introduced this idea
24 of a critical compliance condition whereby a tribunal might
25 order that any breach of this condition results in
26 automatic suspension, will assist us in deciding. But
27 particularly in impairment cases, it is to be expected
28 often that where somebody has a drug-induced problem, they
29 will breach once or twice before they get back on the
30 straight and narrow and we have to make a judgment call.
31 That's what our committees do, to say: is this one that
32 warrants immediate off with the head or do we show a bit
33 of - you know, we draw a line in the sand, but we are
34 prepared to have some tolerance with it. It is a very
35 difficult enforcement question and one we wrestle with a
36 lot.
37
38 Q. You dealt with the Reeves file, I take it, many times
39 over the years from 1997 to 2003?
40 A. Not personally, but I obviously --
41
42 Q. Were you aware of --
43 A. No, I was very well aware.
44
45 Q. -- the pressure that he was putting on to get
46 caesarean section practice?
47 A. As I said, we were a small office. At this time we

1 would have had half the staff numbers and I was very aware
2 of all of this going on. I remember it quite clearly.
3
4 Q. Did you ever come to the view that his interpretations
5 of what the Medical Board wrote to him and restrictions
6 that were placed on him, his interpretations were innocent
7 misunderstandings, or did you think that they were
8 something different from that?
9 A. No, I don't think I thought that they were innocent
10 misunderstandings. I think that sometimes he got the
11 benefit of the doubt. It is difficult to say how much of
12 this is hindsight, but I can remember thinking at the
13 time, "He's a difficult, unpleasant man"; but, as I say,
14 he's not alone. I suppose what we were trying - the
15 decision we always have to make or try to make is: does
16 this have a bearing on the protection of the public and so
17 on? The sort of fudging that he was doing and his
18 argumentative nature about this, I guess the various
19 committees, and so on, formed the view that he didn't cross
20 that line at that point.
21
22 Q. There's a document, Mr Dix, in tab 4, which is called
23 a discussion document, 21 November 1997, and it seems to be
24 part of the electronic file, I take it?
25 A. Yeah.
26
27 Q. Are you familiar with that one?
28 A. Look, I'd have to read it again. I'm not --
29
30 Q. Basically, I wanted to take you to the third page.
31 That's from the Medical Board file, is it?
32 A. Yes, yes, that's right.
33
34 Q. You'll see it makes the point I think that you've just
35 referred to, the dot point at the top of the page:
36
37 Dr Reeves continues to "push the
38 boundaries" in terms of compliance with his
39 conditions. [For example] slow in ceasing
40 obstetric practice, assisting at
41 caesareans, failing to notify patients ...
42
43 et cetera. The next dot point refers to Dr Borody's view
44 of his clinical judgment.
45 A. Yes.
46
47 Q. There's a document on the file about that issue, and

1 then his failure to attend - that was Dr Samuels, was it,
2 the board-nominated psychiatrist?
3 A. It might have been Dr Woodforde at that point, I'm not
4 sure. He went from Woodforde to Samuels at some point.
5
6 Q. And the last one says:
7
8 Appears to be supervising Registrars. He
9 may also be assisting with Caesarean
10 Sections.
11
12 You will see those options that are spelled out there. Who
13 was the decision-maker as to what options should be
14 pursued?
15 A. I'd have to see the file to see what happened to that
16 particular discussion document. I would assume that went
17 to a Conduct Committee meeting, which is the committee of
18 the board, and that they formed whatever view they did.
19 I'm guessing that they went for the third option, but --
20
21 Q. I think you'll find two sheets on, on 10 September -
22 it's a year later, or 10 months later - 10 September 1998,
23 again he is requesting permission to perform or to assist
24 at caesarean sections?
25 A. Yes.
26
27 Q. It says that his correspondence had been considered by
28 the Conduct Committee on 18 August?
29 A. Yes.
30
31 Q. And it says that there appeared to have been
32 outstanding complaints still and they were not prepared to
33 vary that?
34 A. Yes.
35
36 Q. In any event, the variation would have to have gone to
37 the tribunal, would it not?
38 A. To the tribunal, yes, yes.
39
40 Q. I won't take you to each of those documents. If you
41 could go to tab 6 which is 28 September 2001, which is not
42 long before?
43 A. Sorry, I've got 26 September.
44
45 Q. 26 September, did I misstate the date?
46 A. I think you said 28.
47

1 Q. Oh, did I? I'm sorry.
2 A. No, it's the same one.
3
4 Q. You will see this letter in the third paragraph - it
5 is from Evan Rawstron again - refers to the board's Health
6 Committee. I presume that was one of the committees
7 monitoring his progress for the impairment side; is that
8 correct?
9 A. Yes.
10
11 Q. It says:
12
13 The Committee resolved that your current
14 conditions of registration are no longer
15 suitable due to the change in the nature of
16 your practice in medicine. To accommodate
17 this the Committee resolved that you be
18 required to attend an Impaired Registrants
19 Panel to review your conditions and make
20 any changes necessary to ensure the
21 protection of the public.
22
23 That seems a little strange, doesn't it, against the
24 background of the Professional Standards Committee
25 decision.
26 A. Yes,
27
28 Q. How did they match up then this letter of original
29 decision?
30 A. I don't think, they do. I think that that's - I can
31 see exactly the point you're making.
32
33 Q. Well, it would appear that he's moving, as it were,
34 out of the conduct area into the impairment area by dint of
35 a decision by the review panel or the board's Health
36 Committee?
37 A. Yes.
38
39 Q. But that appears to be ignoring, if you like, the
40 express terms of the original order?
41 A. Yes, I can see that, yes.
42
43 THE COMMISSIONER: Q. Is Mr Rawstron still with the
44 board?
45 A. No, no.
46
47 MR TOBIN: Q. I think we can move forward then to tab

1 number 13. You will see that in 13, you have the covering
2 letter with the attached application that is made by
3 Dr Reeves. Do you have that one?
4 A. Yes.
5
6 Q. If I could ask you to look at the third page of this,
7 do you see where he talks, at the top of the page, about a
8 review, he calls it, in 1997 by the Medical Board --
9 A. Yes.
10
11 Q. -- and a finding of impairment, a condition placed
12 upon his registration and the last review by the board.
13 Then he says:
14
15 In December 2001 a sub committee of the
16 Board conducted an Impairment Hearing
17 Review and have indicated that my
18 conditions remain largely unchanged
19 summarised -"
20
21 And then he summarised what he says are the conditions?
22 A. Yes.
23
24 Q. Do you have a view as to the likely impact of a
25 statement of that kind upon a prospective employer in the
26 medical area, the health area, in 2001/2002?
27 A. Do you mean would someone look at that and think, "Do
28 we want to employ this person?" Is that what you --
29
30 A. No, the question really is he seems to have left out a
31 few salient points?
32 A. Oh, yes, yes.
33
34 Q. In the climate at the time, would you expect the
35 prospective employer to be alerted by the fact that he had
36 an impairment finding, if you like, against him or, on the
37 contrary, be likely to take that as a frank disclosure that
38 was reassuring?
39 A. I would have thought they would have taken it as a
40 frank disclosure, and I think the letter which is a couple
41 of pages on, the 27 December letter, which I think is
42 attached to that, isn't it?
43
44 Q. Yes.
45 A. So I would have thought, as I said before, that he has
46 quite skillfully and comprehensively deceived them by just
47 failing to make any reference to the order itself. I think

1 at the time, and my impression, I don't think things have
2 changed much, is that the desire of places like Bega to get
3 somebody with the skills that this guy seemed to have would
4 have been such that they were - the fact that he was
5 impaired, other places they might say, "We don't want
6 someone who seems to have..." But part of the philosophy
7 is that as long as they are being treated, they should be
8 okay.
9
10 Q. Well, if we look to a system failure, is it still the
11 case that it is difficult to catch practitioners in the
12 position of a Dr Reeves, who are, let us say, setting out
13 to deceive the prospective employer?
14 A. Not if the prospective employer actually checks their
15 registration on the Internet.
16
17 Q. Which is the situation now?
18 A. Yes.
19
20 Q. But back then, I'm just --
21 A. I'm sorry, I thought you meant now.
22
23 Q. I did put it that way, but what would say then about
24 the position in 2001/2002? Did the system assume that you
25 would get a modicum of honesty from whatever professional
26 person was making an application?
27 A. Perhaps I'm naive, but I think that's right. I think
28 that most people assume professional people are being frank
29 and honest with them and they do take things on trust to a
30 certain extent. That's my impression. I obviously can't
31 speak for everyone about that, but I would have thought so,
32 yes.
33
34 Q. At tab 15, you'll see, Mr Dix, the file note that you
35 may have seen reproduced in one of the papers, I think?
36 A. Yes.
37
38 Q. This is a record of a telephone conversation that took
39 place on 11 April 2002 and the third last line says:
40
41 Last heard not meant to do obstetrics. Was
42 holding forth at Hornsby. Dispensed with
43 service. OK as long as treatment has been
44 successful.
45
46 Did you want to make any observation with regard to this
47 point: would it be unusual in the impaired practitioner's

1 program for, let us say, an obstetrician for a period to
2 have an order against him practising or her practising
3 obstetrics? In other words, did the impaired program
4 include certain areas of practice that should not be used?
5 A. No, and I think that --
6
7 THE COMMISSIONER: Q. Well, it did, didn't it, Mr Dix, in
8 this respect, at least: with some doctors who are addicted
9 to drugs, it was often a condition of their impaired
10 register program that they agree not to prescribe certain
11 drugs?
12 A. Or not do anaesthetics.
13
14 Q. Or not do anaesthetics as an example?
15 A. Yes, yes.
16
17 Q. If they were a GP who was appropriately qualified to
18 deliver anaesthetics. It may not be so with obstetrics, I
19 accept, but there must be some areas where the Impaired
20 Registrants program conditions relating to health directly
21 impacted on what they could or couldn't do?
22 A. I suppose it's possible. I mean, I was thinking
23 specifically about obstetrics and remembering again that he
24 came into the program via the conduct pathway --
25
26 Q. Via the conduct route, yes.
27 A. -- rather than the impairment pathway.
28
29 MR TOBIN: Q. But from the point of view of the writer of
30 the note, you can assume that that's not known to him, do
31 you follow that all he knows is that there is the
32 application --
33
34 THE COMMISSIONER: Q. All he knows is what's written on
35 the 27 December 2001 letter?
36 A. Yes, I can assume --
37
38 MR TOBIN: Q. I wondered if you could comment on that
39 because it has been put: "Well, yes, 'last heard not meant
40 to do obstetrics,' but in light of the correspondence and
41 what Dr Reeves specifically told us, we understood that the
42 impairment program must have progressed to the stage where
43 that would not be a barrier anymore, that would not be a
44 condition anymore applying to his practice." Was that a
45 reasonable thing, do you think, to have - a view to have
46 come to at that stage?
47 A. I have to say that never crossed my mind before. I've

1 only seen this when it appeared in the paper. I suppose my
2 view is that something like that would have warranted a
3 phone call or a check with the board. I think to just
4 assume that that must have happened - but I can see the
5 letter of December could have given them some comfort in
6 the other direction too. I don't think I'm answering the
7 question for you.
8
9 Q. No, I think what you say is that it's difficult to put
10 yourself in the shoes of the writer of this?
11 A. Yes.
12
13 Q. But you may have not erred on the side of having made
14 the inquiry rather than accepting, if you like, the letter
15 and what Reeves had said as disposing of the question?
16 A. I suppose, if I try and put myself in someone's shoes,
17 if I had those two bits of information, there seems to be
18 an inconsistency here. We should just clarify this, work
19 out, you know, is this letter a statement of the totality
20 now or is there something else? I don't know; that's just
21 how I look at it.
22
23 Q. If I could move to April 2002, and this again goes to
24 the question of compliance and disclosure by Reeves. In
25 tab 22, you'll see on 12 April 2002 he has contacted
26 Evan Rawstron and told him is he no longer a GP. He has
27 gone to Pambula. He is going to resume gynaecological
28 practice.
29 A. Yes.
30
31 Q. And he wants to be excluded from the performance
32 assessment program --
33 A. Yes.
34
35 Q. -- which related to activities when he was at the GP
36 clinic in Richmond?
37 A. Yes, that's right.
38
39 Q. Would this prompt any particular action at the Medical
40 Board, do you think, at the time? There is a letter, an
41 earlier letter on 18 March, and this is about the
42 performance assessment program?
43 A. Yes.
44
45 Q. The letter from Dr Reeves, the phone call is in
46 response to that?
47 A. Yes. Sorry, the question was what the response --

1
2 Q. Well, perhaps it's easier if I take you to the next
3 tab, which is 23.
4 A. My recollection is we said we were going to go ahead
5 with the performance assessment, anyway. In fact it was
6 quite a good thing. The performance program was newly
7 introduced legislation in 2000 that had given us those
8 powers and it was seen that his communication skills, which
9 were the issues that had brought him to our attention,
10 warranted that.
11
12 Q. If you look at this 14 April letter to the board, do
13 you see it states in the second last paragraph:
14
15 I will not be doing Obstetrics, further, my
16 Indemnity is for Gynaecology only ...
17
18 Do you see that?
19 A. Mmm-hmm.
20
21 Q. Just to put this in context, he had been appointed a
22 temporary VMO as a locum obstetrician for one of the GP
23 obstetricians down in Bega. He had that appointment from
24 10 to 13 April. It included clinical privileges for the
25 purpose of performing emergency caesarean sections, if
26 required. It appears that it was not necessary, but that
27 was what the clinical privileges were for, and yet the
28 letter informs the board expressly that he would not be
29 doing obstetrics?
30 A. Yes.
31
32 Q. The further context you should understand is that,
33 three days later, he'd received a letter that he would be
34 appointed a VMO/obstetrician/gynaecologist, not as a
35 temporary but as a permanent appointee. The question I
36 want to put to you is this: whereas, as you point out, your
37 judgment was that perhaps it was Dr Mortimer who made the
38 call to the referee and got information that he'd
39 previously been barred from obstetric work or he's not
40 meant to do obstetrics and what he may have done, would
41 this letter have sent off any alarm signals at the Medical
42 Board, do you think, as to his compliance, and if no
43 alarms, why not?
44 A. He says he is appointed as a specialist gynaecologist,
45 so that's fair enough from our point of view. Then he goes
46 on, "I've explained I will not be doing obstetrics." I
47 don't see it, but I might be missing something. To me

1 actually, perhaps he is protesting too much might be the
2 only thing I'd say but that's --
3
4 Q. I'm just referring really to the third paragraph:
5
6 In Both My written application and
7 Interviews, I have fully explained My
8 Impaired status and Conditions ...
9
10 That doesn't refer to the orders. Would that have any
11 impact at all, do you think, in the --
12 A. No, I wouldn't have thought so in the sense --
13
14 Q. -- in the processing of this?
15 A. No, I wouldn't have thought so in that the distinction
16 between orders and conditions in the mind of the
17 practitioner, and probably also in the mind of the staff
18 and so on, it's kind of arbitrary. I don't think anyone
19 would have read that as a legal statement.
20
21 Q. Well, in any event, if in fact he was conducting
22 himself so as to be available on the emergency caesarean
23 roster at this time or shortly after, the reader of this
24 document, I take it, would have assumed that this was not
25 an obstetric practice or didn't involve any obstetric
26 practice; do you agree with that?
27 A. Sorry?
28
29 Q. The reader at the time would have understood that he
30 was expressly disavowing conducting any obstetric practice
31 at all?
32 A. Assuming that the reader didn't know that he was on
33 the emergency roster for caesareans.
34
35 Q. Yes.
36 A. Yes, that's how I would take it, yes.
37
38 Q. It would follow, would it not, that certainly the
39 understanding that would exist at the Medical Board would
40 have been based upon this letter from Reeves as to the
41 nature of his practice in the area health service?
42 A. That's right.
43
44 Q. He had an obligation, didn't he, to inform the board
45 of changes in practice and where he was practising?
46 A. Yes. Although I seem to remember, consistent with
47 everything else, I think this was one where he got the job

1 and then told us about it. I can't remember whether he was
2 actually required to tell us in advance, but he did.
3
4 Q. I think he was formally appointed by the board in May?
5 A. Yes.
6
7 Q. However, by the end of April, he had signed the
8 contracts?
9 A. Yes.
10
11 THE COMMISSIONER: Q. Have you still got tab 23 open?
12 A. Yes.
13
14 Q. Would you go to the last two pages, which is a letter
15 of 20 September 2002. I wonder if you could just explain
16 to me the difference between the impaired registrants
17 program and the performance assessment program?
18 A. Yes. The performance program, which came in with
19 legislation in 2000 and actually formally commenced,
20 I think, in July 2002, over the preceding decade really we
21 formed the view that we had three groups of doctors: there
22 were the bad doctors, the naughty doctors, the impaired
23 doctors, and then there was a third group.
24
25 Q. Just hopeless?
26 A. Just hopeless - well, "hopeless" is putting it too
27 highly. Some of them were hopeless and some of them were
28 just not good enough. We did research on international
29 work in this area and developed this performance program,
30 which essentially enables us to go and conduct an audit of
31 the doctor's practice, where we send out two doctors, they
32 spend a day with them, they watch them operate or interact
33 with patients, they review records, they do a (inaudible)
34 and so on. It seemed to us at the time that a lot of the
35 issues that we were aware of at that time were about him
36 being a difficult person in his communication skills, and
37 we formed the view that communication could be an integral
38 part of performance. So that's why when I think a couple
39 of complaints came in, they said this would be most
40 effectively dealt with through performance, as often the
41 sort of complaints that go to performance don't reach the
42 threshold that would warrant the Health Care Complaints
43 Commission undertaking an investigation, and we can do it
44 much more quickly than the commission, an investigation.
45 But this was very much in the early days of the program, so
46 it would have been one of the first.
47

1 Q. I understand.
2
3 MR TOBIN: Q. Mr Dix, I should correct something I put to
4 you a few moment ago. With regard to the letter of
5 14 April 2002, it actually postdates his appointment. The
6 board adopted the recommendation to appoint him on 12 April
7 2002?
8 A. He seems to be saying that he verbally told us on the
9 11th, so I'm not sure how. Again, that would be consistent
10 with how this fellow operated.
11
12 Q. In tab 27, if we could move then to the events towards
13 the end of 2002, there's a file note on the Medical Board
14 file of a call from Dr Arthurson, Director of Medical
15 Services of Southern Area Health Service, seeking advice on
16 how to approach a potentially impaired doctor. The
17 background of that, which you are probably familiar with,
18 is that there was an incident in the operating theatre and
19 I think there had been some previous rumblings that caused
20 some alarm to Dr Arthurson as well as to other staff at the
21 hospital, and he contacted the board:
22
23 He told me the doctor's name -
24
25 you will see -
26
27 and I advised him that the doctor had
28 conditional registration and of the
29 employment-related conditions.
30 Dr Arthurson made some comment regarding
31 the board giving him the name of the
32 supervisor that Reeves was required to
33 report to, or something to that effect, but
34 I told him I was unable to discuss anything
35 further with him without the doctor's
36 consent. He made some comment at the end
37 of the conversation to the effect that he
38 was hoping that his concerns were
39 unfounded.
40
41 What would have been the constraint upon the writer of this
42 note, Kym Worth, in disclosing anything further than is
43 pointed to there?
44 A. I would assume she was talking about the impairment,
45 whether the impairment condition was something that we
46 could disclose in detail.
47

1 THE COMMISSIONER: Q. It appears, Mr Dix, that here is an
2 example of how one tests the hypothetical: what would have
3 happened if someone had rung up?
4 A. I can see that, yes.
5
6 Q. It strikes me that one reading of this note is that
7 Ms Worth has followed what one might expect, namely, "Yes,
8 we have got a doctor by that name, the doctor has got
9 conditions, here are conditions 7 and 8," which are the
10 employment-related conditions, and perhaps she said, "And
11 he has some health-related conditions." She doesn't seem
12 to have gone on to find the orders or identify them or to
13 disclose them?
14 A. Yes.
15
16 Q. At least as I read that note?
17 A. I read it the same way, yes.
18
19 MR TOBIN: Q. Is it likely then that the database didn't
20 throw up the orders when this query was made?
21 A. I would have to take that on notice. As I say, I
22 don't exactly know what it looked like then.
23
24 Q. Could you find that out? It may not be possible to
25 reconstruct it?
26 A. I don't know technically that I can, but I can try.
27
28 THE COMMISSIONER: Q. It's now five and a half years ago?
29 A. Yes. I can do what I can to find that out.
30
31 MR TOBIN: Q. It does seem, though, that if one
32 interprets the file note against the background that we
33 have, it may well be that a query of the same kind back in
34 2001-2002 may not have thrown up the orders?
35 A. Yes.
36
37 Q. Is that a reasonable hypothesis at this stage?
38 A. I think that is. Look, I honestly couldn't say.
39 I can try and find out. I suspect it would have been - no,
40 I don't know.
41
42 Q. The next file note, 14 November 2002, is a follow-up
43 by Dr Reid, medical director?
44 A. Yes.
45
46 Q. On 14 November, and she has picked up on that query
47 that went to Kym Worth and I think you have said that,

1 given the size of the office, that was the sort of thing
2 that might be expected to happen?
3 A. Yes, Kym worked directly for Dr Reid, too. Dr Reid
4 runs the health program and Kym Worth was working in that
5 area.
6
7 THE COMMISSIONER: Q. Reading this note through, I get
8 the impression that Dr Reid is a very careful person who
9 has made a good note of what happened?
10 A. Yes.
11
12 Q. It does appear that even when she rang Dr Arthurson,
13 or caught up with Dr Arthurson, I should say - she seems to
14 have telephoned him and then he rings back - it makes it
15 plain that he was doing caesarean sections at least in the
16 third paragraph, "In the course of the conversation, I
17 asked what sort of surgery Dr Reeves was doing. He" -
18 that's Dr Arthurson - "indicated gynaecology, caesareans,
19 et cetera." She then knows that Dr Reeves is prohibited by
20 the order of the PSC. She asks Dr Arthurson to clarify his
21 employment status, and then that goes through and obviously
22 the conversation finishes. She looks through the file,
23 speaks with you, sends a letter to Dr Reeves, gets a
24 response, and then rings Dr Arthurson back?
25 A. Yes.
26
27 Q. Then seems to discuss, when she gets to the larger
28 paragraph, "I clarify with Dr Arthurson as follows:
29 Dr Reeves may not provide obstetric services," et cetera.
30 It does appear, at least in the first conversation of
31 13 November 2002, that Dr Reid didn't say anything about
32 the order that he not practise obstetrics. I'm not asking
33 to you speak for Dr Reid, I'm just giving my interpretation
34 of that note.
35 A. I certainly think that's an interpretation you could
36 place on it, yes.
37
38 Q. Is that she was getting information in that first call
39 rather than disclosing information. This is not a
40 criticism, I immediately say, of Dr Reid, I'm not
41 suggesting it is, but it throws up this question, when you
42 combine Ms Worth's note and this note, of just how freely
43 information was available from the board to people they
44 were talking to who had an obvious interest, because by
45 this stage, on any view, Dr Arthurson, on behalf of the
46 area, has a real interest in knowing what the position is
47 about Dr Reeves?

1 A. Yes. Obviously I can't speak for Dr Reid. I can
2 speculate as to what she might have been thinking at the
3 time, but I really couldn't respond.
4
5 MR TOBIN: Q. Mr Dix, I want to ask whether there was a
6 change, in either the legislative or policy context,
7 between 97 and this date in 2002. I think I can do this by
8 reading from the file note. "MAH," who would that be in
9 1997?
10 A. That's the legal officer, Anne Harvey. She was the
11 legal officer who I think assisted the PSC.
12
13 Q. This is 27 August 1997, it's at tab 2. Tab 2 seems to
14 be what has been told by Ms Harvey and by Ms Payne in,
15 respectively, 27 August 1997 and 11 September 1997?
16 A. Yes.
17
18 Q. About the ban, if I could use that term, on
19 obstetrics. Is the first one Shane Payne?
20 A. Sherayn Payne, yes.
21
22 Q. Sherayn Payne. You will see three lines from the
23 bottom:
24
25 I told Mr [redacted] that Dr Reeves is no
26 longer entitled to practise obstetrics.
27
28 A. Yes.
29
30 Q. Then the next document, it's about halfway down:
31
32 He did not inform her at all about any
33 restrictions on his right to practise.
34
35 A. Yes.
36
37 Q. And:
38
39 She has not been informed at any stage by
40 Dr Reeves about the restriction.
41
42 Higher up, the fourth line:
43
44 I informed her that Dr Reeves has recently
45 been given conditional registration and
46 that one of these conditions is that he not
47 do clinical obstetrics.

1
2 That's much more forthcoming, isn't it, in answer to a
3 member of the public who is querying either her own or his
4 wife's treatment by Dr Reeves?
5 A. Yes.
6
7 Q. Was there a change in either the policy or the
8 legislation?
9 A. No, certainly not. As I say, I suspect - again, I can
10 only surmise, but I imagine what Dr Reid was doing, when
11 she had that call from Dr Arthurson, was probably going
12 away to check what the situation was. I would have thought
13 she would have known that there hadn't been a change in
14 condition, but I can only surmise that she thought, "I
15 should go and check that."
16
17 Q. But Kym Worth was the first person, not dissimilar, is
18 that fair, from Sherayn Payne?
19 A. Yes.
20
21 Q. And Ms Harvey?
22 A. That's right.
23
24 Q. So by the time she's dealing with it, she may have
25 been affected by changes in privacy legislation?
26 A. If so, just by subtle sort of changes, the way these
27 things occur. I mean, there certainly wasn't any overt
28 policy or legislative change that I can think of that would
29 have meant that we would have been more guarded about
30 saying things.
31
32 Q. Of course, the orders required Reeves to disclose to
33 patients back in 97 that he could no longer do obstetrics?
34 A. Yes.
35
36 Q. So there was a different, perhaps, climate at that
37 stage with regard to Dr Reeves?
38 A. One possibility is this was all very fresh in
39 everyone's mind at the time, that might have been it, but
40 I'm speculating.
41
42 Q. Mr Dix, you will see at tab 29 your letter to
43 Dr Reeves?
44 A. Yes.
45
46 Q. Which deals with, in effect, the breach of that order?
47 A. Yes.

1
2 Q. I won't go into the detail of the correspondence from
3 Dr Reeves, I don't think that's necessary. Then there's a
4 further letter the next day, on 14 November, tab 31. It's
5 the next folder. You will see that you reiterate the fact
6 that the order has not been changed?
7 A. Yes.
8
9 THE COMMISSIONER: Q. Just stopping there, I am right in
10 thinking, am I not, Mr Dix, that the conditions were in
11 fact changed in the period 1997 to 2002?
12 A. I believe that --
13
14 Q. Because of at least the increase in the amount of time
15 between reviews?
16 A. Yes.
17
18 Q. If nothing else?
19 A. Yes.
20
21 Q. Can you suggest any reason why that was being done by
22 the relevant panel as opposed to going back to the
23 tribunal, which was what the original PSC seemed to
24 require?
25 A. I can't, and I have been thinking about it as we have
26 been talking today.
27
28 Q. The only thing that seems to me is that I had a look
29 at the act while you were giving some earlier answers and
30 of course the act provides with respect to Division 5
31 Section 66 suspensions that conditions can be imposed in
32 lieu of a suspension and that the board can change or amend
33 those conditions. So there's at least some room,
34 I suspect, for confusion about who gets to change which
35 conditions?
36 A. Yes, that has been an issue where somebody has
37 conditions imposed in one set of proceedings and then
38 something comes up subsequently, and does that body have
39 the - but if there hasn't been that subsequent set of
40 proceedings --
41
42 Q. Yes, it's a difficult issue, isn't it?
43 A. It is indeed, yes.
44
45 Q. That would seem to suggest, wouldn't it, leave aside
46 for a moment proceedings that go to the Medical Tribunal,
47 it would seem to be that the better practice of the PSC

1 would be only to make conditions and to make the board the
2 authority which has the right to change those conditions?
3 A. That condition there, which was the one that the
4 tribunal is the review body of, I actually can't think of
5 another one in probably hundreds of Professional Standards
6 Committee where that has been there. It's invariably the
7 orders, the review body, so that the nature of these
8 things, particularly impairment conditions - as people get
9 better, which one hopes they do, that they get varied. I'm
10 thinking, and I make no apology for this because I think it
11 appears to me the fact that the tribunal was named as the
12 appropriate review body somewhere or other got lost and he
13 just got into the normal process of being reviewed and
14 saying at what point it might be appropriate to vary the
15 conditions, I would like to go back and review it, but
16 certainly that's my only explanation I can offer.
17
18 Q. That's the sense I have, that the earlier conditions
19 and orders were effectively overtaken by the impaired
20 registrants process?
21 A. Whether rightly or not.
22
23 Q. Whether correctly or not, that's practically what has
24 happened?
25 A. It got into that pathway and was treated and reference
26 was not made back to that particular order, people were
27 focusing on the conditions.
28
29 Q. On the conditions, yes, I think that seems to be
30 right, doesn't it?
31 A. Yes, I think that's correct.
32
33 MR TOBIN: Q. Tab 32, there's a fax that has gone to
34 Dr Arthurson, and your letter of 14 November 2002 with it.
35 You have that?
36 A. Yes.
37
38 Q. This would appear to be the letter where you marry up
39 the order, which is in the first paragraph?
40 A. Yes.
41
42 Q. And the conditions in the balance of the letter?
43 A. Yes.
44
45 Q. I think if you look at tab number 34, you have then on
46 22 November 2002, in this letter from Dr Reeves, the last
47 paragraph --

1
2 THE COMMISSIONER: What tab is that, Mr Tobin?
3
4 MR TOBIN: Tab 34. There's a letter before it, so it's
5 the third sheet in.
6
7 THE COMMISSIONER: I see.
8
9 MR TOBIN: Q. You will see at the end of it he makes a
10 request for a, "Variation to my conditions," it says "is":
11
12 so as to allow me to provide the same
13 services as the consultant surgeons do in
14 the region by being on emergency roster
15 for caesarean sections. Patients remain
16 always under the care of their GP
17 obstetrician.
18
19 This was a theme from Dr Reeves from 1997 to late 2002, was
20 it not, that he be allowed to do caesarean sections?
21 A. Yes.
22
23 Q. You have, I think, replied to him - sorry, there's a
24 later letter. I'll just clarify this. You will see in the
25 letter of 29 November 2002, tab 37, Anne Harvey is the
26 writer of this, she sets out the orders and conditions and
27 then she says under Section 92 Review of Orders:
28
29 The committee nominated the Medical
30 Tribunal as the appropriate body for any
31 review of its decision.
32
33 That was to indicate to Dr Reeves that it wasn't within the
34 power of the Medical Board to vary it?
35 A. Can I go back to the point we were making just a
36 moment ago. I'm just wondering, and I apologise that I
37 probably should know this, but I'm wondering whether in
38 fact the things that happened to the conditions over the
39 period 97 through to 2002 were in fact consistent with the
40 conditions, in that many of the conditions say, "Until
41 reviewed by the board" or --
42
43 THE COMMISSIONER: Q. Well, there's a bit of a mixture?
44 A. Anne Harvey, who has written this letter we are
45 looking at now under tab 37, she was the legal officer who
46 handled the Professional Standards Committee, and I think
47 it gets a bit almost contradictory, whether in fact

1 conditions were in effect dropped or changed because the
2 board determined that the frequency of review was whatever
3 it might be. So that was not inconsistent because it
4 wasn't actually changing the condition, the condition
5 actually built in a review mechanism. I'm offering that, I
6 suppose, by way of an explanation.
7
8 Q. I think there's something in that.
9 A. It's a point that just occurred to me, because I was
10 taken aback by the other issue.
11
12 Q. I think that may be right.
13
14 MR TOBIN: Q. Numbers 7 and 8 are postulated upon
15 variations, are they not?
16 A. Yes. Just to complete that, 7 and 8 are postulated on
17 variations. 4, 5 and 6 are really in Reeves' hands
18 himself, in the sense that he has to continue psychiatric
19 treatment at a frequency determined by his treating
20 psychiatrist. So again that's something we didn't have the
21 clinical supervision of, the intervals to be reviewed by
22 the board. I think that 1, 2 and 3 could be seen - and I
23 would like to think that was actually the logic that
24 applied, although I do think the other issue about the
25 nature of impairment conditions generally would have been
26 that people probably viewed them as just being conditions
27 to be varied. But I think they actually do have within
28 them the ability to, I suppose, loosen them up or slacken
29 them off without necessarily going back to the tribunal.
30
31 THE COMMISSIONER: Q. Interestingly, as we pause over
32 this letter, something emerges which I haven't picked up
33 before. If you turn back to the letter of 27 December,
34 which is behind tab 7, and then go to what the PSC has
35 ordered, as recorded by Ms Harvey - and I have no reason to
36 think it's not an accurate recounting of what the PSC
37 said - they are not actually the same?
38 A. No.
39
40 Q. There are some additional ones in the impaired
41 registrants program and some additional ones in the PSC
42 orders that don't appear in the letter of 27 December?
43 A. I think that I could work through an explanation of
44 that in that issue I raised a moment ago, or a few minutes
45 ago, about the ability of a subsequent proceeding, such as
46 an impaired registrants panel, to impose conditions.
47 I think, for example, the conditions relating to clinical

1 supervision and monitoring, at some stage in the 90s my
2 recollection from the file is that the intervals, until
3 reviewed by the board at some point, the board said, "We
4 think you have done enough of that," so effectively --
5
6 Q. They have disappeared?
7 A. They have disappeared. Also another feature of this,
8 which I have just seen, looking at the letters myself, is
9 that the distinction between health and monitoring
10 conditions doesn't appear in the PSC. That, as I think I
11 said before, was an administrative thing we did to try and
12 assist us in working out which conditions should appear
13 when the register went online so that we didn't find that
14 we were inadvertently putting up health conditions which
15 shouldn't have been there. So even though a tribunal
16 wouldn't normally hand down conditions broken up into those
17 categories, we try and do it ourselves, and perhaps taking
18 a liberty.
19
20 Q. If you look at health-related condition 1, which is
21 attend at treatment by a GP, that doesn't appear in the PSC
22 at all?
23 A. Yes.
24
25 Q. As an example, but no doubt was imposed by the
26 relevant panel?
27 A. I think that that's what - yes.
28
29 MR TOBIN: Q. On 20 December 2002, tab 39, Kym Worth has
30 written to Dr Reeves and in the third paragraph advises him
31 that there would be an interview convened by the Health
32 Committee scheduled for 27 February 2003. Do you see that?
33 A. Mmm-hmm.
34
35 Q. It says:
36
37 The interviewers have no adjudicatory
38 powers and cannot impose conditions on your
39 registration.
40
41 It was to obtain information. Was that a complete
42 description of the powers of that Health Committee or was
43 it an adequate description?
44 A. I think so. My recollection is that the matters, when
45 he was found to be breaching the order, would be taken
46 before the Health Committee probably. They saw the
47 correspondence, what steps had been taken and they

1 said, "What are we going to do?" We do this not
2 infrequently, we have no formal power to do it, but we call
3 them in to read the riot act, I suppose, is the way to
4 describe it.
5
6 Q. Have a chat, I suppose, is the preferred description.
7 A. Professor McCaughan might see it differently, but,
8 yes.
9
10 Q. 7 January 2003 at tab 41, you will see that there's
11 another file note by Kym Worth of a communication from
12 Dr Mortimer seeking to clarify the orders about the
13 practice of obstetrics. You had set out, hadn't you, in
14 your letter, the orders that were made by the PSC, and it
15 would appear that, perhaps at Dr Reeves' instance,
16 according to the file note, Dr Mortimer was being told that
17 he wasn't practising obstetrics and they were not
18 communicating on the same wavelength: do you see that?
19 A. Sorry, let me just read it. Yes.
20
21 Q. I think you said earlier in your evidence that
22 arguments like that from Dr Reeves had been, to your
23 knowledge, common over the years?
24 A. Yes.
25
26 Q. And they didn't actually bear a relationship to the
27 reality but were more in the nature of a contrived
28 argument, as it were, to push the boundaries of what he may
29 be allowed to do; is that the right --
30 A. I couldn't go so far as to say they didn't reflect
31 reality because I didn't know exactly what he was doing,
32 but certainly this kind of argument and trying to define
33 and categorise things was pretty commonplace for him.
34
35 Q. To re-categorise them so that it was permissive for
36 him to do things that he may not otherwise have been
37 allowed to do?
38 A. Yes.
39
40 Q. Now, I don't think I need to take you to the
41 communications from the area health service because they
42 simply canvassed discussions that were being had with
43 Dr Reeves by Dr Mortimer at the time. The next step seems
44 to be at tab 46, dated 22 January 2003. The deputy
45 registrar, Anne Scahill, writes to Dr Reeves, and she says.
46
47 ... it appears that you are continuing to

1 work in breach of the Order of the
2 Professional Standards Committee [of]
3 21 July 1997 ...
4
5 The context of this would appear to be that, on two
6 occasions prior to this in January, the area health service
7 said that he had engaged in obstetric health practice and
8 that presumably had come to the notice of the board; is
9 that as you would understand it?
10 A. Yes.
11
12 Q. I suppose that leads to the question: at what point
13 would you stop writing the letters and take a more drastic
14 step?
15 A. I would have to check the chronology, but I think it
16 was shortly after this that we convened the section 66
17 inquiry. I'm not sure what the time frame is.
18
19 Q. Perhaps if we could go to tab 51, which is the
20 section 66 inquiry transcript or summary of proceedings,
21 and that was on 18 February 2003. You may not know this,
22 but did that replace the Health Committee meeting or was
23 it --
24 A. If I can perhaps explain a little bit about the
25 section 66 inquiry.
26
27 Q. Yes.
28 A. It is a power that we have. Effectively it's a bit
29 like an injunction. It's something we do in an emergency
30 situation where we have reason to believe that a
31 practitioner may pose a threat to the physical health or
32 safety of any person, I think it is, and we act very
33 quickly, or as quickly as we can, on the information we
34 have available to us. We don't do an investigation other
35 than getting together whatever documentation is available.
36 We generally convene it within a week or so, and we have
37 the power at that hearing to suspend someone or place
38 conditions on their registration without more formal
39 proceedings.
40
41 So that was where he crossed the line. I think the
42 22 January letter was saying, "We've heard more about you
43 now." I suppose it's possible that we could have said on
44 22 January, "We are going to convene a section 66 inquiry,"
45 but we gave him an opportunity to put his position first,
46 I believe.
47

1 Q. Are there criminal sanction applying to breaches of
2 section 66 orders?
3 A. No, it's a provision of - I can't remember the number
4 now - section 65, I think it is, where we can refer to a
5 matter to the Medical Tribunal. Generally speaking, breach
6 of orders can be seen as unsatisfactory professional
7 conduct but it has to go through all the investigation and
8 prosecution process and then it ends up as professional
9 conduct rather than a criminal matter.
10
11 Q. Then the orders are set out at page 15 which amplify,
12 do they not, the existing order against obstetric work?
13 A. Yes.
14
15 Q. So what additional teeth did this have? Was it
16 capable of triggering an immediate application to the
17 tribunal or --
18 A. By virtue of the section 66 inquiry being held, a
19 complaint is required to be made to be referred to the
20 tribunal or it can go to an Impaired Registrants Panel as
21 well. The power is used more frequently these days but it
22 tends to be used where somebody has been locked up in a
23 psychiatric institution, or something like that, or there
24 is some very serious evidence of sexual misconduct or
25 drug - whatever it might be.
26
27 One of the issues that we have raised with the
28 O'Connor inquiry was we had been slapped over the wrist by
29 the Supreme Court when we exercised this power, in the
30 early 1990s I think it was. We suspended someone and we
31 were told fairly and firmly, and we got advice to make sure
32 we got this right, that we had to do the bare minimum to
33 protect the public and it didn't mean we could suspend
34 because someone had done something bad. It was whether
35 they posed an immediate threat to anyone's physical health
36 and safety.
37
38 My reading of this is that the section 66 inquiry was
39 satisfied that he got it now, and one can form opinions
40 whether, particularly with the benefit of hindsight, they
41 were right or wrong. I guess one can say there's no
42 evidence he attempted to do obstetrics after this, so maybe
43 they were right, but I know there's a sense of: why didn't
44 the board suspend him because he has been so bad? Our view
45 has been that section 66 is not something where, when
46 someone has done something very bad they have done
47 something very bad and that's a matter for the tribunal,

1 but it's where they have done something --
2
3 Q. They threaten to do something?
4 A. No; so that the public is threatened; so someone who
5 has done - yes, I don't need to say it again, yes.
6
7 Q. Can you remember the name of the case in the 1990s?
8 A. It was X v New South Wales Medical Board. I do
9 remember his name. It was [redacted]. We got an opinion
10 from John Basten about it subsequently because we had to
11 change our whole - there were aspects about whether we had
12 given him adequate notice, but we had very convincing
13 evidence of --
14
15 Q. Did that go to the Court of Appeal or was it dealt
16 with by a single judge?
17 A. I couldn't say.
18
19 Q. We'll look it up.
20 A. I've got the reference if you want to chase me up for
21 that.
22
23 Q. Thank you, we might chase the reference up from you,
24 if we could, just to assist in the background.
25 A. Yes.
26
27 MR TOBIN: Q. Because, of course, the area health
28 services may have the same problem in the context of
29 employment law in summarily suspending an employed VMO, as
30 in Dr Reeves' case, on the strength of a breach of the
31 orders of the Professional Standards Committee?
32 A. Again the legislation that has just gone through
33 Parliament purports to address this in a couple of ways.
34 Firstly, the jurisdiction of the section 66 now extends to
35 enable it to suspend as well as if it poses a threat,
36 et cetera, but also if it's in the public interest to do
37 so. I'm not entirely sure what that means. It remains to
38 be seen how we will actually exercise that power, but that
39 came out of the first O'Connor inquiry, which was a couple
40 of years ago now.
41
42 Also I think I mentioned before this idea of a
43 critical compliance condition where - I think they might
44 have envisaged that the order about obstetrics would say
45 that this is a critical compliance condition or a critical
46 non-compliance order, the fact that it has been breached of
47 itself leads to a section 66 which must suspend. So I

1 think they have been addressed through the legislation,
2 although there still would be that judgment as to whether
3 one describes something as a critical compliance order, and
4 that will be something for PSCs and tribunals to work out.
5
6 Q. The last document I wanted to draw to your attention
7 was the complaint under the Medical Practice Act which I
8 think you will find was at tab 54. There was the subject,
9 of course, of the proceedings later in 2003 --
10
11 THE COMMISSIONER: 2004 and about the events of January
12 2003.
13
14 MR TOBIN: Yes, in 2004, sorry and about the January 2003
15 events. Commissioner, I think that's the totality of the
16 documentary material unless Mr Dix wanted to assist in some
17 other way with regard to the activities of the Medical
18 Board.
19
20 THE COMMISSIONER: Q. Mr Dix, I will give you the
21 opportunity of raising anything that you think you haven't
22 had the chance of fully explaining. If there's something
23 that you think that you would like to add, this is an
24 opportunity for you to do so, and we'd welcome any
25 information you want to add. When you have done that,
26 there are just two things I want to raise with you, but
27 they are quite separate.
28 A. Okay, I would like to make a few points if I could.
29
30 Q. Certainly.
31 A. I don't want to prolong this too much, but obviously
32 we have done an enormous amount of soul-searching about
33 this. We are still in a very difficult situation where we
34 are reading and being told about allegations about conduct
35 that we still don't know anything about. There are things
36 that one reads in the press, but they still haven't come to
37 our attention - the 500 cases, or whatever it is, of which
38 we know very few.
39
40 I think there is no doubt that that letter, the
41 27 December 2001 letter, with the benefit of hindsight,
42 should have listed both the conditions and the orders. As
43 I said before, we have instituted processes to ensure that
44 that doesn't happen again. My view from that is that what
45 the board did in various times in what was one of the most
46 difficult - we have a lot of difficult cases, but this was
47 a particularly difficult one because it was spread over a

1 long period dealing with a difficult person who has a
2 number of different problems.
3
4 I feel that the board acted appropriately on the
5 available evidence at the time. There were times when
6 judgment calls were made where they could have gone either
7 way and, with the benefit of hindsight, it probably would
8 have been better if they'd gone the other way, but the fact
9 of the matter was at the time decisions were made, I think
10 the decisions that were made by the various bodies, and so
11 on, were open to them and not unreasonable decisions.
12
13 I think that while not all the bodies - for example,
14 the Professional Standards Committee is an independent
15 body. The board doesn't tell it what to do, it has to make
16 its own decisions; nevertheless looking at that, perhaps it
17 would have been better if it decided differently. But they
18 did what they did, and I don't think that on the evidence
19 before them what they did was perverse or anything like
20 that.
21
22 Q. Just so I understand, it was open to them to refer it
23 to the tribunal?
24 A. Exactly, yes. They could have.
25
26 Q. But that's a judgment they had to make at the time?
27 A. Yes, but the way the process works - just going back a
28 little bit before that, as you would be aware, the Health
29 Care Complaints Commission conducts the investigation so
30 the board really doesn't have any role in that. We are
31 presented at the end of the commission's investigation with
32 an investigation report and a recommendation that this
33 matter go to the tribunal or a PSC or no further action, or
34 whatever it is. We concurred with their view at the time
35 that it went to the PSC. Then the commission conducted the
36 prosecution, if you like. The board's role in the PSC is
37 that we appoint the members of the PSC and we provide a
38 legal officer who assists the PSC if they need assistance
39 in answering any legal issues, and so on, but essentially
40 the PSC is an independent body. As I say, it's not my role
41 to defend them but, looking at it, obviously, it's very
42 much part of what we do.
43
44 A point that I have made, but I'll just emphasise, is
45 that there has been an enormous amount of change, most of
46 it evolutionary change, since all this occurred. I suppose
47 the most important one is just the fact that the register

1 is on line and that information is available.
2
3 Q. Is that Australia-wide?
4 A. No, no.
5
6 Q. Sorry, is your online register matched by all other
7 States? That is perhaps the better question.
8 A. No, I think two or three jurisdictions still don't
9 have it. Also you might be aware the medical profession
10 will become a national profession in two years time. The
11 New South Wales Medical Board will cease to exist and then
12 obviously there will be a national register.
13
14 Q. There will be an Australian Medical Board?
15 A. That's right.
16
17 Q. Presumably with a New South Wales branch?
18 A. That's correct - well, something along those lines,
19 yes. The point that I'd like to make is that --
20
21 Q. Sorry, as I understand the Commonwealth proposals, and
22 I appreciate that the detail may not yet be fully advanced,
23 but is it proposed that it will be anything more than just
24 a national register; that is to say, all of these things
25 that you do with performance assessment and impaired
26 registrants and so on, would be done nationally?
27 A. Well, it's not entirely clear. One of the points that
28 we have been making and urging the State Government to make
29 is that the things that we do, like impairment and
30 performance, don't get dropped. I think there is a view at
31 the Commonwealth level that getting a medical registration
32 is a bit like getting a fishing licence - pay your money
33 and you get your ticket. Our view is that what we do is
34 much broader than that. Regulation is much more than
35 registration - you have to have both. The idea, on our
36 understanding, is that there will be a national system
37 which will have rules that will cover impairment
38 performance, conduct, et cetera, but the details are really
39 unclear.
40
41 One of the points that I think a lot was made of was
42 his impairment and with someone who was obviously so
43 psychiatrically ill, how could the board let him go for so
44 long? I think on a reading of the tribunal decision in
45 particular, which is where everything came together - in a
46 sense the evidence that was prepared for the tribunal - he
47 crossed the line from being the diagnosis of personality

1 traits to personality disorder.
2
3 Dr Samuels, in the evidence he gave in the tribunal -
4 I think there was a bit of an error in his evidence - said
5 some of the material he hadn't seen before, but I believe
6 he had actually seen it all but he had seen it over a
7 period. When it was all brought together, it, combined
8 with the most recent events which led to the tribunal, were
9 the straw that broke the camel's back, if you like. I
10 think that's important. He was a difficult doctor; but, as
11 I said before, there are a lot of difficult doctors and
12 some of them are quite successful, and there are difficult
13 lawyers and difficult people in all walks of life.
14
15 Q. The community has also invested a very large sum of
16 money in training doctors. To simply dismiss it where they
17 are capable of practising under rational supervision or
18 conditions would, in fact, be contrary to the public
19 interest?
20 A. That is certainly our view, but it is very heavy
21 burden on us to make sure that we know when enough is
22 enough and we have to draw the line. We trust that we get
23 it right most of the time, and I believe we do. I think we
24 have a good track record with problem doctors, but there
25 will be some who will slip through the net. As I say, with
26 the benefit of hindsight, there are things we could have
27 done differently with Dr Reeves but on the evidence that is
28 still available, I don't know that much would have been
29 done differently. I think that's what I want to say in
30 general terms.
31
32 Q. I understand. One of the submissions we received in
33 the course of this has suggested a criticism of the Medical
34 Board, and I want to put it to you and invite your
35 response. I think it goes something along this way: you
36 start with the proposition that, in the Medical Practice
37 Act, the object of the Act is to protect the health and
38 safety of the public, albeit by providing mechanisms to
39 ensure doctors are fit and students are appropriate, but
40 the overall object of the Act is to protect the public and
41 provide for the safety and health of the public. The
42 Medical Board is really doctor-centred. It's run by
43 doctors. I don't diminish your role and your staff's role
44 at all, Mr Dix, but the board consists essentially of
45 doctors. It is run by doctors, the arms of it, be it the
46 PSC or the Impaired Registrants Panel, et cetera, are
47 doctors, and that there's an underlying assumption that all

1 doctors are good and competent and conscientious and
2 truthful and reliable and trustworthy unless something
3 comes to your attention, and you then say, "Ah, we found
4 the bad apple in the barrel," and you then deal with the
5 single case.
6
7 It is suggested that that process doesn't really focus
8 on public expectation and doesn't really look at the
9 process from the public's point of view. It looks at it
10 from the doctor's point of view. It provides procedural
11 fairness to the doctors. It bends over backwards to make
12 sure they are notified of all sorts of things that
13 concessions are extended to them and so on. Is there any
14 validity in that criticism, in your view?
15 A. I'm very well aware of that criticism. Firstly, the
16 point about the board being doctors, well, that's true. I
17 think 14 of the members are medical. There are lay
18 members. I don't know the exact number, but there are a
19 number of people who are not doctors on it.
20
21 I think one of the things that the board has been very
22 good at is recognising that it is there to protect the
23 public, and even though people are nominated by the
24 college, or there are a couple of people from the AMA, with
25 a couple of exceptions, by and large, they are very clear
26 about what hat they are wearing when they attend board
27 things. There are people, obviously, with a spectrum of
28 views. I guess I see one of my roles, and it is a
29 difficult role, that when we were selecting people to sit
30 on panels there are some people of whom we say, "This
31 person takes everything that the doctor says is right," or
32 "They say everything that the patient says is right." We
33 have to exercise some judgment about whether we keep using
34 people, and we try to do our best to ensure that we have
35 people who are fair and balanced, who don't bend over
36 backwards one way or the other, but who try to be judicial
37 in what they do.
38
39 One of the problems is that this idea that we sit back
40 and when things come to us, we deal with them and then
41 think we are dealing with the bad apples, I recognise
42 that --
43
44 Q. And it picks up something you said earlier, and again
45 I don't put this at all critically of you, where you said,
46 "We hold the records. We can be a central reference point,
47 but to notify the world is very difficult," and that in

1 part is a reactive approach, isn't it?
2 A. I was going to say the problem is the nature of what
3 we do is reactive. We have a certain amount of getting
4 people to tell us things, like in their annual
5 declarations. A number of jurisdictions have tried systems
6 generally about maintenance of competence, so requiring
7 that people be recertified every five years and so on, but
8 all the international experience is that that tends to
9 become just a sort of mechanical thing, that you really
10 can't do anything in depth.
11
12 I think that we touched a little bit on the
13 performance program and although again it is reactive,
14 I think that is one of the really positive things, as the
15 impairment program was when it first came in, but it has
16 been in for long time now. The performance program enables
17 us, instead of looking through a keyhole at a complaint, we
18 are able to go, on the basis of having received a complaint
19 or whatever it might be, whatever notification, we can go
20 and actually spend time looking at a doctor's whole
21 practice. I think it's a more effective way of protecting
22 the public, but it is still subject to that problem that it
23 only gets what we know about it. One can say that about
24 Reeves and the situation about Reeves at the moment, that
25 we can only deal with what we know about it. There is an
26 awful lot we hear about, but we don't actually know about
27 it at the moment with Reeves, too.
28
29 I don't know that anybody has got the answer to how a
30 regulatory body can be proactive, in the sense of going
31 out, unless one does random audits and so on, and that's a
32 possibility, but that obviously has pretty major
33 implications with resourcing and so on. I would very
34 happily place on record my view, not as a medico, that I
35 believe the board has done a very good job most of the
36 time.
37
38 There have been times when I thought, "That wasn't a
39 particularly good decision," as one would expect with any
40 body. But to put the public interest ahead of any kind of
41 sectional or the doctor's always right, I'm not quite
42 comfortable in saying that, having been there for a
43 substantial period and having been sort of critical of that
44 club mentality which I think does pervade, and it does
45 pervade the professions, but I think the Medical Board is
46 actually quite distinct from the medical profession. It is
47 clearly not the AMA, and we make that point very strongly.

1 The AMA doesn't like us very much because they think we are
2 too much on the other side. I don't know if that answers
3 all the points there, but that's my perspective on it.
4
5 Q. There were similar suggestions made about the conduct
6 of the General Medical Council in England in the Shipley
7 report. No doubt you have come across that?
8 A. Yes.
9
10 Q. There was a very extensive inquiry arising out of
11 Dr Shipley?
12 A. Yes.
13
14 Q. Who is a doctor who managed to kill a large number of
15 patients.
16 A. Yes.
17
18 Q. There was a very long inquiry and I think it produced
19 six reports ultimately, one of which was directed to the
20 performance of the General Medical Council and its reforms.
21 I wonder if the board has ever looked at what the GMC did
22 to reform itself to cope with that perception?
23 A. We did, and we have followed the --
24
25 Q. I'm not suggesting the GMC has necessarily got it
26 right, but it is at least an interesting report to have
27 been considered, and I was hoping to hear that the board
28 had considered it?
29 A. We did, we formed a committee to look into it, to
30 examine it, and one of the things that emerged from it,
31 which we had known - I went and visited the GMC fairly
32 early in my role at the board and was astonished at how
33 complaisant they were, they were so reactive and the
34 hurdles were so high. I was talking about, "What about so
35 and so?" and they said, "We don't do it that way here," and
36 it was a real eye-opener for me, and I wrote some articles
37 about it when I came back.
38
39 The GMC, I think, was incredibly complaisant for a
40 long time. We had our Chelmsford, and I wasn't involved
41 with the board in the Chelmsford times, but I think the
42 whole sort of stirring up of the things here in the 1980s
43 with Chelmsford set our board off on a different
44 trajectory. The GMC has done a lot, but they came from an
45 awful long way behind, I think. As I say, we looked at
46 that and tried to identify if there were any particular
47 aspects of it that we could learn from. Again, I think our

1 performance program is one of the bright stars in our
2 firmament at the moment, but it's under threat.
3
4 Q. How would you rate the board as against its interstate
5 counterparts?
6 A. It's difficult. We are substantially bigger than any
7 of the others. I think we are the national leader in most
8 respects. I think every now and then another jurisdiction
9 does something, they have a new take on something. We were
10 the first ones to bring in an impairment program, we were
11 the first ones to bring in the performance program.
12
13 The principles of our disciplinary structure are much
14 more jurisprudentially sound, although there are some
15 issues with our disciplinary structure that cause us
16 difficulty. I believe, and I'm sure everyone says this,
17 but I think we are recognised as being the preeminent
18 board, and not just because we're the biggest.
19
20 Q. One thing that has been occurring to me as you have
21 been discussing your performance program is that from time
22 to time, particularly in private session, as this
23 Commission has gone around the state listening to people
24 and taking evidence, a number of witnesses have touched,
25 either directly or indirectly, on this proposition, namely,
26 "I am involved, because I assist or I observe or I'm
27 present at treatment being delivered by a doctor, Dr X or
28 Dr Y. I also am present, involved, assist in treatment
29 being delivered by doctors A, B and C. I can tell that
30 Dr X is not nearly as good as doctors A, B and C at what
31 they do"?
32 A. Yes.
33
34 Q. Whether it be medical treatment or particular surgery
35 being performed, it doesn't matter. "I am very worried
36 that the patients that see Dr X are getting less than an
37 appropriate standard of care, and it's just a matter of
38 luck as to whether Dr X is on duty or doctors A, B and C
39 are on duty." As one expects in a public hospital, it
40 would depend on the roster?
41 A. Yes.
42
43 Q. "And I feel helpless to do anything about it." Does
44 the Medical Board's performance program enable a person
45 like the assistant, the helper, the observer to telephone
46 the board and say, "I have this concern"?
47 A. Yes.

1
2 Q. Do you do that by, what, an 1800 number with anonymous
3 reporting?
4 A. No.
5
6 Q. I mean, how does that happen?
7 A. It's fair to say most complaints or concerns go to the
8 Health Care Complaints Commission, which has a higher
9 profile, I think they probably get about four to one the
10 ratio of matters that come to us, although impairment and
11 performance things, which tend to come from colleagues, I
12 suppose that's probably the divide.
13
14 Members of the public tend to go to the Commission
15 whereas I think - and this is just my impression - I think
16 members of the profession are more likely to come to us.
17 We will say they have to have something in writing, we
18 can't just bail a doctor up on the basis of a phone call.
19 But quite often what will happen is if you get a call from
20 someone and you've heard gossip, because there's a lot of
21 that around, as you know, it gives us something to go on.
22 Whether it can be made simpler, an 1-800 number, there are
23 certainly ways one can do it, but I guess we always have to
24 remember that we have to reach a threshold, we can't just
25 deal with everything that comes in because people are
26 anxious about it, we have to be satisfied that there's
27 enough material there to justify taking action.
28
29 Looking at the broader complaints situation, which no
30 doubt you've seen the statistics about, 1200 or 1300
31 complaints about doctors are received a year, of which 10
32 to 15 per cent are actually investigated and the rest are
33 dealt with through a whole range of other means, and over
34 50 per cent are no further action.
35
36 You mentioned before public expectation, and I think
37 that is one of the really difficult things we deal with,
38 that public expectation and professional conduct and
39 professional standards are not always the same thing. You
40 can have a terrible outcome, but nobody did anything wrong,
41 and that's one of the things we are dealing with all the
42 time, to try and handle the situation where a baby has died
43 or the case that brought this inquiry into being, a
44 terrible clinical situation. But whether there was
45 professional misconduct or unsatisfactory professional
46 conduct or lack of standards at a level that would warrant
47 serious disciplinary or other action is another issue, and

1 that is one of the things we are dealing with all the time.
2
3 Q. I'm trying to separate out of my mind the sort of
4 thing that would give rise to a serious complaint which the
5 HCCC would look at and investigate, I'm really just trying
6 to understand the standards question, just simple
7 competence?
8 A. Yes.
9
10 Q. I accept, before you send someone down the
11 disciplinary path, there has to be a proper investigation
12 and have it peer reviewed and all of the things that the
13 HCCC does, and I don't want to engage in a debate about
14 that. One of the things that the Police Integrity
15 Commission does, and indeed the ICAC does, albeit in a
16 slightly different context, is to publicly have inquiries
17 or tests of police officers or inquiries about corruption,
18 to say, "We got a complaint, we looked into it, and there
19 is no corruption here." In other words, "Here is a body
20 that is doing the right thing," and they see that as being
21 as valuable an anti-corruption or anti-fraud tool as
22 actually finding one?
23 A. Yes.
24
25 Q. In other words, "Even if you are doing the right
26 thing, someone may just pop up and check you"?
27 A. Yes.
28
29 Q. "So don't even think of doing the wrong thing." Do
30 you follow what I mean?
31 A. Yes.
32
33 Q. Is there room in competence terms - and I'm not
34 suggesting serious discipline or anything of that kind -
35 but is there room in competence terms for the board
36 literally to get a phone call from a colleague saying, "I'm
37 really worried about Dr X's performance, I think he or she
38 is losing it," to just send someone out there on the basis
39 of that, to have a look?
40 A. As things presently stand, that wouldn't happen, we
41 would need more than that. We take calls, and I don't know
42 whether this sounds reasonable or not, but a call from a
43 colleague is something we take very seriously.
44
45 Q. Sure.
46 A. We will find out as much detail as we can in the
47 course of that conversation and then it might be we will

1 say, "We are going to need something in writing," or it
2 might be we are able to take some other action. We can do
3 it and we do do it, but to send somebody out is not
4 something that we have the wherewithal to do, as things
5 currently stand. To actually go out and do the performance
6 assessment I have talked about, where we have the two
7 doctors, or two or three doctors, go and spend a day in
8 someone's practice, that's a major logistical exercise
9 which involves a whole lot of preparation; you saw in the
10 correspondence, you send out questionnaires and so on.
11
12 To send somebody out on spec because we have had a
13 call saying, "I'm worried about so and so," apart from all
14 the legal issues, I imagine if we tried to do it, people
15 would be jumping all over us saying, "What power have you
16 got," because they wouldn't be very happy with us doing
17 that, I suspect.
18
19 Under current circumstances, I would have difficulty
20 thinking how we could do it in any way other than where we
21 have the cooperation and the agreement of the doctor
22 concerned. But I think it's fair to say we are not seen as
23 a friend by the profession. I think the profession, if
24 they get a call from the Medical Board, that's something
25 that they are not very happy about it and they are not just
26 going to say, "Yes, come and have a look at what I'm
27 doing," in the absence of specific legal powers to have a
28 lower level assessment. But that might be something that
29 could be contemplated because at the moment a performance
30 assessment is a major exercise.
31
32 We have just got some data from the UK, who are trying
33 to do something similar, and I think the cost of each
34 performance assessment they are doing is something like
35 35,000 pounds, or something like that. We do it on the
36 smell of an oily rag compared with that. They have tried
37 this approach but it has become so hidebound with whatever
38 it is, technicalities and so on, that it's really
39 unworkable, I think. Still, we conduct about probably 20
40 or 30 of these a year, I think, but it is a major exercise.
41
42 MR TOBIN: Q. Can I raise one question that Ms Wright
43 reminds me of, and that is the relationship with, in this
44 case, the Royal Australian College of Obstetricians and
45 Gynaecologists?
46 A. Yes.
47

1 Q. Dr Reeves was recertified - if that's the correct
2 term - by the college in the years from 97 on?
3 A. Yes.
4
5 Q. Do they have any role, in your view, to play in
6 maintaining the protection of the public?
7 A. I think their role is difficult because they are
8 essentially a club, they have no legal authority, although
9 certain things that they confer on people, like for example
10 the fellowship, entitlements flow from that, access to
11 Medicare benefits at a higher rate and so on, and they also
12 have the ability to expel members from the club if they
13 don't participate in their continuing professional
14 development activities or, I think, for serious misconduct.
15 But my impression is that the colleges, when they have
16 tried to deal with matters of discipline, have found
17 themselves in great difficulty and they just can't, for a
18 whole lot of legal reasons, that they don't actually have
19 any legal authority over people, they tend to refer them to
20 us. Sorry, I think I have lost track of the question.
21
22 Q. No, it was simply to note the fact that the committee
23 made a finding in 1997, that didn't ruffle the surface of
24 Reeves' relationship with the college at all?
25 A. No. If somebody is deregistered, they will have their
26 college fellowship removed. Our philosophical view, I
27 suppose, and we notify the colleges of actions taken
28 against practitioners, there has been a policy --
29
30 Q. As in this case?
31 A. Yes. We are trying to develop a national policy just
32 to make it clear exactly in what circumstances they will be
33 told. I think one of the difficulties is that the colleges
34 don't have any particular standing from a legislative point
35 of view, or from our perspective, and it is not entirely
36 clear to us what the college can do. If they receive a
37 decision like this, are they going to punish him some more
38 or are they going to mandate. Maybe they might mandate
39 some kind of additional training, but they haven't got the
40 power to do so, so it's all very much - as I say, they are
41 a club essentially, which has this funny ability to confer
42 qualifications in a sense.
43
44 Q. And to place members of the club in particular public
45 hospitals throughout the system, for training purposes?
46 A. Yes, that's right.
47

1 Q. Could I follow that up with another question. You
2 mentioned the proposed national profession, I suppose, is a
3 way one can put it, in two years' time. Will that have an
4 impact on the colleges and the way they operate, do you
5 understand, or is it a separate category?
6 A. The colleges are all national already, with state
7 branches. One would like to think it will actually make
8 things a bit more logical. There will only be one body,
9 although the colleges will maintain their state committees.
10 No, I can't see it would have any adverse effect. My view
11 is that national registration, and the board's view is that
12 national registration, is absolutely logical and it ought
13 to happen the sooner the better.
14
15 Q. But there is no program of national certification for
16 specialists?
17 A. Sorry, that's another point. One of the points that
18 the health ministers agreed some three or four years ago,
19 when this was first being bandied about, and we have been
20 pushing this as well, is that there should be mandatory
21 continuing professional development. The view that we have
22 taken in New South Wales, where there is a very soft CPD
23 requirement that basically every practitioner, when
24 renewing, has to declare what they do in the way of CPD and
25 if they declare, "I do nothing," that's a valid response.
26 It's only if they don't tell us what they do that we write
27 them a nasty letter, but we actually don't have any power
28 to do anything about it.
29
30 Our view is that, as with the legal profession, there
31 ought to be some sort of mandatory CPD and the colleges
32 would be in the box seat to administer that. We accept as
33 evidence of CPD, evidence of satisfactory participation in
34 college programs, so --
35
36 THE COMMISSIONER: Q. So there's no mandatory CME at the
37 moment?
38 A. No, that's correct.
39
40 Q. Although the public perception, I think, is that
41 everybody does it. Interestingly, when this first came in,
42 which was five or six years ago, I think, 4 per cent of the
43 profession who returned annual returns said that they were
44 in active practice and they did no CPD, and they were quite
45 prepared to say that. That's dropped down now to I think
46 less than 2 per cent, but it is interesting. There are
47 some people who have an ideological position that they

1 don't think it should be mandatory, although the board's
2 view is that it should be.
3
4 MR TOBIN: Q. Did you spend some time with the GMC in
5 England working?
6 A. No, no, not working.
7
8 Q. You were a visitor?
9 A. I worked there a long, long, long time ago, too long
10 ago to be of any relevance.
11
12 THE COMMISSIONER: Is that it, Mr Tobin?
13
14 MR TOBIN: That's it.
15
16 THE COMMISSIONER: Mr Dix, thank you so much for coming
17 and giving your evidence and thank you for the candid way
18 in which you have answered the questions and helped us as
19 far as you can.
20
21 THE WITNESS: Thank you.
22
23 <THE WITNESS WITHDREW
24
25 AT 4.48PM, THE COMMISSION ADJOURNED ACCORDINGLY
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