SPEECH – MEDIA CLUB

THE BLACK DEATH IN QUEENSLAND HEALTH

The O'Rourke Family has made an exceptional contribution to surgery in this State. Recently, Dr Michael O'Rourke was "press ganged" by Queensland Health to take over as acting Director of Surgery in Bundaberg, after Jayant Patel fled back to the United States. His nephew, Dr Nicholas O'Rourke, is one of the outstanding surgeons of his generation. Other members of their family have also made important contributions to the practise of medicine in this State. But I want to begin by saying something about the late Dr Des O'Rourke, brother to Michael and father of Nicholas.

Des O'Rourke is remembered as one of the great Hospital Superintendents, both in Bundaberg and subsequently in Toowoomba. He was also a ***real*** doctor – in the sense that, despite holding the position of Medical Superintendent, he not only ran those hospitals; he actually performed surgery and treated sick people.

These days, his kind of Medical Superintendent has become unfashionable in larger Queensland public hospitals. And Des O'Rourke is probably a good example of why it has become unfashionable – I am not qualified to comment on his surgical skills, but he had this bizarre notion that the health of patients was more important that bureaucratic paperwork or balancing budgets. Little wonder that he had to go. In the end, the mandarins of Charlotte Street had him frog-marched from the grounds of Toowoomba General.

I am told that, when Des O'Rourke was Superintendent in Toowoomba, the hospital experienced a problem with antibiotic-resistant bacteria infecting one of the wards. His solution was typically practical, although somewhat unorthodox. He acquired a number of mirrors, and had them set up throughout the ward to shine sunlight into every nook and cranny. He reasoned – correctly, as it turned out – that the infectious bacilli could only survive in the dark.

Today, new and much more virulent pathogens are threatening the health of this State's public hospital system. These parasitic organisms also thrive in an environment of Cimmerian gloom, and have evolved an immunity to even the most powerful remedies.

There are several species. The more widespread, low level infections consist of two in particular – ***Mathematicus fabarum vulgaris***, the common bean counter, and ***Propellor papyri molestus***, the officious paper pusher. Less common, but more dangerous, are ***Simulatus census***, the falsifier of statistics, and ***Medicus maledictus***, the spin doctor. However, the very worst outbreaks have been associated with ***Procurator malignus*** – the mordacious bureaucrat. (I note, parenthetically, that the Latin can also be translated as "the mordacious politician").

Any attempt to control these infections by conventional means is worse than useless. Even if you succeed in getting rid of significant numbers, you eliminate only the weakest and least harmful. Those remaining are hardier, and even more resistant to control.

The only treatment which has any chance of success is the antimicrobial ministration pioneered by Dr Des O'Rourke. These organisms, inhabiting the crepuscular recesses and crevices of the public hospital system, are susceptible only when exposed to direct light. Experimentation which I have conducted over recent months shows that even the threat of exposure sends them into frenzied paroxysms – like Dracula, they crumble to dust when subjected to direct sunlight.

Professor Con Aroney has described the conduct of such organisms as "sociopathic". In an attempt to understand what Professor Aroney means by that, I have done a little research of my own. According to one source, a sociopath appears normal, and is therefore not easily recognisable as deviant or disturbed. The clinical indicators associated with this personality type include: glibness or superficial charm; a grandiose sense of self; a lack of any remorse, shame or guilt; callousness or a lack of empathy; and a failure to perceive that anything is wrong with them. Sociopaths are described as authoritarian, secretive, manipulative, paranoid, and pathological liars.

Those who think that Professor Aroney was guilty of exaggeration when he adopted the expression "sociopath" might care to look at a particular document generated out of Queensland Health's headquarters in Charlotte Street – a so-called "risk rating matrix". This document, we were told, is designed to assist staff in categorising the seriousness of adverse events. A death – whether resulting from medical malpractice, or resulting from a workplace health and safety incident – is regarded as a "major" issue. On the other hand, significant damage to Queensland Health's own reputation is an "extreme" issue. Who, but a sociopath, could have designed an official document which rates the death of a

human being – any human being, whether a patient in one of the Department's hospitals, or even an employee of the Department – as a less serious matter than an injury to the Department's own enviable reputation?

The palpable dishonesty of Queensland Health with respect to waiting list figures is another example. To borrow Andrew Lang's aphorism, Queensland Health uses statistics as a drunken man uses lampposts – for support, rather than for illumination.

What is the extent of this pestilence? To describe the situation as an epidemic is no exaggeration. "Pandemic" is perhaps a more accurate term. The best figures I have been able to obtain suggest that the total staff of Queensland Health is about 64,000. Of these, fewer than 1,500 are doctors, and some 13,000 are nurses. For every single healthcare professional who actually provides clinical services to patients, there are four other people on the Queensland Health payroll. To be fair, these include some people who perform vital functions – wardsmen and caterers, cleaners and laundry staff, gardeners and maintenance personnel, laboratory technicians, electrical and mechanical engineers, and so forth. But the fact remains that some 50,000 people – four out of every five employees – are performing non-clinical duties.

What, then, are the consequences of this plague? Seventy years ago, Queensland led – not only Australia, but the entire English-speaking world – in the provision of a universal free public hospital system. We pre-empted, by more than a decade, the National Health Service in Britain. As recently as thirty years ago, we not only had the best free public hospital system in Australia – in fact, we had the ***only*** such system in Australia. In a mere three decades, Queensland has gone from the top to the bottom of the list – from the best to the worst – regardless of which comparative criteria you use.

Our doctors and nurses are amongst the lowest paid in the country. Our waiting lists are amongst the longest. The ratio of medical practitioners to population is amongst the poorest. Mortality rates are amongst the highest. Per capita expenditure on public health is amongst the least – and is falling further behind as each year passes.

There are good demographic reasons why Queensland should be spending ***more*** on medical care than any other State or Territory. Geographically, we are one of the largest and most decentralised States – the only mainland State in which more than half the population lives outside the capital. We have an ageing

population, fuelled by retirement refugees from the Southern States; but, at the same time, our workers are more likely to be employed in physically arduous and dangerous occupations, such as the mining and agricultural industries. We face the unique challenges of sub-tropical and tropical diseases – the health consequences of being the "Sunshine State". At one extreme, we are exposed to the epidemiological factors affecting the major population centre in the South-East of the State – soon to be, if it is not already, the second-largest urban concentration in the country. At the other extreme, we must meet the very different (but equally significant) challenges involved in the provision of health-care to regional, rural and remote communities – communities which are as far from Brisbane as Moscow is from London, as remote from Charlotte Street as Hong Kong is from Singapore.

In the 1930s, when Queensland established the first universal free public hospital system in the English-speaking world, we were one of the poorest States in the nation. We are now, on a ***per capita*** basis, one of the richest. Since the mid-1970s, the Federal Government has taken over responsibility for a large proportion of the cost of providing public medical services. Yet, in the same three decades, we have allowed our public hospital system to fall into a condition of decrepitude. That this has happened is an indictment on governments of all political complexions. And it is a searing indictment on the bureaucrats who have presided over the collapse of a medical infrastructure which, at its prime, would truly have justified us in calling ourselves the "Smart State".

When we come to the Jayant Patel phenomenon, what we should understand, very clearly, is that it was never more than a secondary infection – an opportunistic or adventitious disease, which took advantage of a body already weakened and debilitated by years of malnourishment, and bedridden by the primary infection which had destroyed all of its defence mechanisms.

Unless our public hospital system was already moribund, Jayant Patel could not have caused any harm, whether in Bundaberg or anywhere else in the State. There was no shortage of safety measures, supposedly in place, to prevent such a biomedical disaster. Even if one or two had failed, others should have cut in. For Patel to have practised as a surgeon at Bundaberg for two whole years, killing and maiming dozens of patients, required an environment in which ***every*** line of defence had been breached – or had simply disintegrated through neglect.

To start with, it required a Medical Board which made no serious attempt to check his credentials – despite their having documentation, provided by Patel himself, which, on close scrutiny, would have alerted any careful enquirer to unresolved problems in Patel's professional background. It required a Medical Board which was content, without adequate enquiry, merely to take Patel's word that he was duly qualified and fit to practise surgery in Queensland.

It cannot be said that the Medical Board had no warning of the deficiencies in its processes. Just months earlier, it had discovered a similar mistake, when it had taken the word of a man named Berg – an alleged paedophile, convicted of theft on two Continents, and self-proclaimed Bishop of the Russian Orthodox Church – that he was duly qualified and fit to practise psychiatry in Queensland. For Patel even to come to Queensland required a Medical Board which had learnt nothing from its past mistakes, even after Berg was exposed as a fraud.

It also required a Medical Board willing to assume that a private employment agency – a firm which expected to earn about $13,000 for placing Patel in Bundaberg – had conducted all the necessary checks with Patel's previous employers and professional referees.

It is almost 1,000 years since the first recorded system of medical registration was instituted by a wise ruler – Roger, the Duke of Salerno. He decreed: "Who from now on, wishes to practise medicine, has to present himself before our officials and examiners, in order to pass their judgment." It may fairly be said that the Medical Board, in Queensland, has turned back the calendar to the Dark Ages.

So much for the Medical Board.

Next, Patel's presence in Queensland required a public hospital system, willing to employ him as a surgeon, without making even the most rudimentary inquiries or investigations regarding his previous employment or professional standing. A private company would be expected to take more care in employing a night-watchman. If Patel had applied for a job, stacking shelves at Woolworths, he should have expected to face more rigorous integrity checks.

Above all, Patel's employment in Bundaberg required a health system which was driven by budgets, statistics, and other bureaucratic falderal – a health system which was totally oblivious to the welfare of patients. The primary object in appointing Patel to the vacant surgical position was to find somebody – anybody – who could be relied upon to work long hours for a modest salary, without

making waves with his bureaucratic masters. The standard of his surgical skills was an irrelevancy. There is no other explanation for the fact that Patel was appointed to Bundaberg as an “area of need”.

It should be understood that the “area of need” concept was implemented by government with the perfectly sound object of protecting remote communities, which may be unable to attract a doctor who has either been trained in Australia, or been assessed as having training and experience equivalent to Australian standards. The intention was that, if such a community could not attract a doctor who satisfies Australian standards, they would be better off with a doctor who doesn’t satisfy Australian standards, than to have none at all. But this entire concept was corrupted, it was perverted by the Charlotte Street bureaucrats, and turned into a kind of “secret passage” to inveigle the likes of Jayant Patel into our public hospitals.

Not only in Bundaberg, but throughout the State, hospital administrators were granted “area of need” approval merely for the asking. This was critical to the Patel phenomenon. The fact is that, without “area of need” approval for Bundaberg, Patel could never have worked there. Without such approval, Patel would have had to submit his credentials to scrutiny by the Royal Australasian College of Surgeons – and it is highly improbable that they would have been so lacksidasical as the Medical Board in overlooking Patel’s erratic past.

Even to describe Bundaberg as an “area of need” is laughable. Bundaberg not only possesses one of the top dozen public hospitals in Queensland; it also has two private hospitals, which surely would have closed their doors long ago, if it were truly an “area of need”. First class surgeons – surgeons of the calibre of Dr Brian Theile and Dr Pitre Anderson – were living and working in Bundaberg, but were not welcome at the public hospital. Other surgeons – competent and even outstanding surgeons like Dr Charles Nankivell, Dr Sam Baker, and Dr Lakshman Jayasekera – had been willing to work in Bundaberg, but were driven off by a public health system which did not value their qualities. Dr Geoffrey de Lacy – an exceptionally competent surgeon and former director of surgery at the QEII Hospital in Brisbane – arrived in Bundaberg shortly after Patel, but was turned away from the Bundaberg Base Hospital, because they already had what they wanted in Jayant Patel.

They, the bureaucrats, had exactly what they wanted: a compliant surgeon. A surgeon who could be trusted to fill in the right forms – no matter whether the information which he entered into the forms bore any resemblance to the truth. A

surgeon who would show respect, deference even, to the non-clinicians who presided over the hospital's administration – no matter that he was intolerably rude to lesser mortals amongst the hospital staff, such as the nurses and junior doctors who actually looked after patients. A surgeon who was ready to move into action at a moment's notice – no matter that he didn't bother to wash his hands after going to the toilet, or to change his surgical gown after slipping out to the carpark for a quick fag – no matter even that he didn't bother to ensure that the patient was properly anaesthetised before starting to work with the scalpel. A surgeon who not only operated within his budget, but even made a positive contribution to the budget, both by achieving the hospital's quota for elective surgery, and by helping to educate a new generation of surgeons with his own unique insights into surgical practice.

Why would any bureaucrat want to work with Brian Thiele, or Charles Nankivell, or Sam Baker, or Geoff de Lacy – Australian-trained surgeons of impeccable standing and ability – when they had the choice of a Jayant Patel? All else aside, just think of the money which Patel generated for the Bundaberg Base Hospital. Under the Byzantine system of "weighted separations" adopted by Queensland Health, hospitals are rewarded for doing especially difficult or dangerous elective surgery, and the rewards are even greater if the patient is seriously ill. Who but Patel could have been trusted to perform operations – operations which were both unnecessary and impossibly complex – on patients who were already close to death's door, merely to fill the hospital's coffers with much-needed pieces of silver? And if the patients died – as they often did – so much the better: post-operative care is an expensive business, and Queensland Health offers no financial incentives to hospitals which actually keep their patients alive.

I am not sure how widely understood it is, even now, that Patel was never accredited as a surgeon in Australia. Under Australian law, he could not have obtained a "provider number" to practise surgery anywhere in the country. Under Queensland law, he was not entitled even to call himself a surgeon. But that meant nothing to Queensland Health. Of the unsuspecting patients on whom Patel was foisted by Queensland Health, not one was told that the man, held out by Queensland Health as its "Director of Surgery", was not even qualified to be called a surgeon in this country.

That explains how Patel got to Bundaberg. But for him to be appointed as Director of Surgery, the local hospital administration had to break every rule in the book.

Patel's employment at Bundaberg had been approved by the Medical Board on the condition that he be supervised ***by*** the Director of Surgery – nobody thought to mention to the Medical Board that Patel was in fact going to be employed ***as*** the Director of Surgery, not supervised by anyone. Make no mistake about it: from his first day in office, Patel was acting illegally – with the active connivance of Queensland Health's bureaucrats.

Credentialing and privileging procedures are supposed to ascertain a specialist's level of competence, and to set limits for the procedures which he or she is permitted to undertake. In Patel's case, these procedures were simply ignored. There was not even an interview panel – or any of the other usual and proper processes – to fill the vacancy.

Yet, even accepting all of the misadventures which led to Patel's appointment as Director of Surgery in Bundaberg, there were still further safeguards, supposedly in place, to protect patients.

There were peer review systems, such as Mortality and Morbidity Committees – systems by which the performance of one surgeon is supposed to be reviewed by his or her professional colleagues. Those systems ought to have picked up problems with Patel's surgical practice. But Patel himself, as Director of Surgery, was put in charge of such systems for the Surgical Department at Bundaberg. Not surprisingly, the systems over which he was appointed to preside failed to detect his own incompetence.

On paper, Bundaberg had every safeguard imaginable – and then some – to detect and deal with such medical disasters: every committee, every clinical forum, every departmental meeting, every system for recording and documenting adverse events and complaints. Even the most fastidious bureaucrat, conducting an audit of Bundaberg Hospital's quality assurance systems, could have ticked every box. Surely, with this state of the art array of alarm bells, one of them had to go off, sooner or later!

The truth is that the alarm bells did start to sound, perhaps faintly at first, but fairly quickly nonetheless, and with increasing volume as the body-count mounted. However, an alarm bell is utterly useless, unless someone is listening – someone, that is, in a position of authority, both willing and able to react.

The suite of executive offices at the Bundaberg Base Hospital is far removed from the clinical departments of the hospital. The occupants are hermetically sealed behind glass doors. Is this to maintain an appropriate air-conditioned ambience, which ensures that their working environment is optimised, so as to allow them to fulfil their heavy burden of paper-shuffling and navel-gazing during the few brief hours when they are in attendance? Or is it to keep out the undesirables who might interrupt their deep cogitation on important budgetary and administrative issues – undesirables such as sick people or, worse still, people who look after sick people?

The executive offices may be remote from the clinical departments of the hospital – both physically and spiritually. But, by Christmas of 2004, at the very latest, those offices were reverberating to the tintinnabulation of alarm bells. Still, nothing happened.

Even the calibre of the bureaucrats inhabiting the executive offices at Bundaberg – itself a very significant contributing factor to the Patel phenomenon – was merely symptomatic of a far more fundamental malaise within Queensland Health. People of that character, occupying such positions, are not employed by chance. From my observation, most of these individuals would not even make the short-list with a private sector employer, seeking a manager for a far less complex business, with fewer staff and a much smaller turnover than Bundaberg Base Hospital's multi-million dollar budget – say, a Coles supermarket, or a McDonalds hamburger restaurant.

Such comparisons are, however, unfair. Private sector employers look for managerial staff who are resourceful – who have judgment and discretion, presence of mind, initiative – who are innovative, progressive and proactive. Those same qualities in fact ***disqualify*** a person from appointment or promotion within the Queensland Health bureaucracy. District Managers, Directors of Medical Services, and the like, are not expected to think for themselves; in fact, they are not even allowed to. The reality is that the executives in Bundaberg did exactly what was expected of them – no more and no less – and the real blame lies with the architects of a system which set them up to fail.

One of the ultimate protections against medical malpractice – at least in cases where it produces fatal consequences – is the ***Coroners Act***, under which it is mandatory to report any death which "was not reasonably expected to be the outcome of a health procedure". But even that did not stop the Patel juggernaut. Of the 13 deaths which have been identified as connected with sub-optimal care

on his part, only one was reported to the coroner. Of the remaining 12, none was the result of emergency surgery – they were all "elective" operations, in the sense in which that term is used by Queensland Health: in other words, they were operations where the patient's survival did ***not*** depend upon urgent surgery. Without the benefit of the Patel experience, one might have thought that ***any*** death resulting from "elective" surgery would be regarded as unexpected.

Sir Arthur Conan Doyle – the Scottish medical practitioner who created the character of Sherlock Holmes – observed that: "When a doctor does go wrong he is the first of criminals. He has nerve and he has knowledge." The ***Coroners Act*** certainly offered very little challenge to a man of Patel's ingenuity. So what, if a patient like Mr Kemps died in the course of elective surgery? The cause of death was clear enough – massive blood loss. And how could anyone say that a death is unexpected, when the patient has suffered massive blood loss – that is exactly what you would expect! So, of course, there was no need to report the matter to the coroner! But, just in case, we had better get the most junior and inexperienced doctor on the surgical team to sign the death certificate – after all, when you have a medical career as chequered as Jayant Patel's, you don't want to go around signing bits of paper which may come back to haunt you.

There is one final line of defence in our medical system against the likes of Jayant Patel. When all else fails, there remain the loyal, hard-working, competent and conscientious clinical staff – the Toni Hoffmans and the Peter Miachs of this world – to blow the whistle. They are the white blood cells in the medical system's body politic – the final, natural, defensive barrier against dangerous parasites and pathogens.

Tragically, though, the worst of the pathogens which have infected the body politic of Queensland Heath – ***Procurator malignus***, the mordacious bureaucrat – is in the nature of a retrovirus: its first function is to destroy the body's natural defences, to kill off the white blood cells which protect the body from infection and disease. Whistleblowers are lucky if they are just ignored – the moment they show any sign of being effective, the retroviruses go all out to destroy them first.

That is why it takes courage – extreme courage – for a Toni Hoffman or a Peter Miach to blow the whistle. They are acutely aware of the consequences: the risk of being sent to Coventry; the risk of facing trumped-up disciplinary complaints; the risk of having their work hours re-scheduled to less convenient times; the risks to their prospects of career advancement; indeed, the risks to their entire

careers. But white blood cells are like that – they go into battle against dangerous pathogens, despite every risk that they will be destroyed in the process.

As I have said, the only treatment which can work against these dangerous pathogens is the treatment pioneered by Dr Des O'Rourke – to expose them to light. That is what Toni Hoffman did, with the assistance of Mr Rob Messenger and Mr Hedley Thomas. I am confident that there are many others out there – nurses and doctors – prepared, if necessary, to take the same risks and make the same sacrifices as Toni Hoffman, for the ultimate protection of patients. But the viability of our public health system cannot be left to depend on individuals willing to take such risks or to make such sacrifices.

Mr Peter Forster has suggested some changes to our public health system. He has suggested that more money is needed, and he is undoubtedly right. He has suggested that some bureaucrats have to go, and again he is undoubtedly right. But he does not seem to have suggested any systemic changes which will ensure a full and permanent recovery. He has offered symptomatic relief, but he has not treated the disease. He has prescribed a course of antibiotics, which may reduce the number of dangerous pathogens, but will not eliminate all of them – and which may well leave the most virulent even stronger, and more resistant to control.

What Queensland Health really needs is systemic reform – changes which will ensure that the curtains are torn down, and that light floods in to every dark corner and corridor, so that the pathogens can no longer fester in the impenetrable gloom which is their natural habitat:

- We need added protection for "whistleblowers" in the public health system, including provisions enabling people to report their concerns to Members of Parliament, unions, professional associations, and the media.

- We need to address the impossible conflict of interest which exists within Queensland Health, which is currently both the largest provider of healthcare services in this State, and also the principal regulatory body overseeing the provision of healthcare services.

- We need to create both the appearance and the reality of genuine independence, by stripping away from Queensland Health, and investing in a separate commission, responsibility for matters such as the registration, credentialing and accreditation of health practitioners and health facilities;

monitoring of internal and external complaints; clinical audits and reviews; maintenance of institutional standards across all Queensland Hospitals and healthcare institutions; and oversight of professional standards and disciplinary issues.

- We need to give local communities, particularly outside Brisbane, "ownership" of their own hospitals, and a genuine role in the decision-making process.

- We need to ensure that practising clinicians – doctors and nurses, and allied healthcare professionals – have a genuine role in overseeing hospital management.

- We need to address the reputation of Queensland Health for "bullying" staff, and for adopting a "shoot the messenger" attitude.

- We need to re-educate – or replace – administrative and managerial staff, particularly at District and hospital level, to be an effective part of the clinical team, rather than remote and aloof from the day-to-day clinical activities undertaken within a hospital.

- More than anything else, we need to change the culture within the Department's administration, to ensure that clinical problems are addressed in an open, frank and honest way, so that members of the general community are not given unrealistic expectations as to the services available to them from the public health sector; so that individuals can plan their own health needs and requirements in full knowledge of any limitations or delays existing in the public sector; so that members of the community who are dissatisfied with the level of services available in the public sector can express their concerns, in the appropriate democratic way, through the ballot box; so that administrators and clinical staff can sensibly plan and budget to provide the best healthcare service possible within available funding; and so that individual clinicians, both within and outside the public sector, can provide meaningful and realistic advice to patients regarding their prospects of receiving appropriate and timely treatment in the public sector.

Such measures are a very minimum. But they are required, not only to ensure that a Patel-like situation never occurs again: Without such measures, Queensland will never again have the world-class healthcare system which is appropriate for a community in which the expression “Smart State” is something more than a glib political catch-phrase.

One of the great public hospitals in this State is named in honour of Prince Charles, the Prince of Wales. Speaking about the (British) National Health Service, His Royal Highness once asked rhetorically: “Is the whole of the health care system – and the confidence of the public in it – not undermined by the publicity given to what goes wrong, rather than the tiny miracles, wrought day in day out, by an expert, kind and dedicated staff?”

I respectfully agree. There is much to be admired in our public hospital system – and no feature of it is more admirable than the expert, kind and dedicated clinical staff. They perform miracles, and not just tiny ones, on a daily basis. But our community will not be helping the clinical staff if we do not address the systemic problems which are corroding the entire edifice in which they work. The steps which I have suggested may not cure all the ills in Queensland Health – but they will certainly carry us a long way in the right direction.

I imagine that most of you have come here today in the hope – possibly even the expectation – that I will say something controversial. Far be it for me to disappoint you. Given that all I have said so far is fairly mundane, I should like to end by saying something about the circumstances of my removal as Chair of the Bundaberg Hospital Commission of Inquiry.

It would, of course, be completely inappropriate for me to question the correctness of Justice Moynihan’s decision. But what I wish to say is this: on the assumption that decision of Justice Moynihan correctly states the law in Queensland, the law must be changed. I say that, essentially, for four reasons.

First and foremost, the success of a public inquiry depends on attracting and maintaining the support and goodwill of the public. In a nutshell, the public need to know that the inquiry is “fair dinkum”. Public confidence is vital.

Secondly, it is essential that any Inquiry Commissioner must have a sufficient scope of discretion to decide which witnesses are called, and when – to decide the forensic strategies and tactics which are best calculated to bring out the truth – even if that involves treating some witnesses differently from others.

Thirdly, public inquiries must be informed by what Justice Thomas has called "a sense of social, political, moral or economic direction". For a judge in a court of law, there is a roadmap – it may sometimes be imperfect, sometimes ambiguous, sometimes incomplete – but a roadmap nonetheless. That roadmap is the law, comprising Acts of Parliament, regulations and other subordinate legislation, and previous judicial decisions. But public inquiries do not have any such roadmap: they must navigate by dead reckoning, informed by their own moral compass.

The fourth and final reason is the most important. As the word "inquiry" implies, the process is an investigative one. The idea that one can conduct any kind of investigation, with a mind that is a blank canvass, is simply farcical.

It was a great personal honour and privilege to be asked by the Premier to head the Bundaberg Hospital Commission of Inquiry. But, like most honours and privileges, I sensed that it carried with it certain duties. To my mind, my foremost duty – and I make no apology for this – was to ask the questions and pursue the issues which I imagined that the people of this State would want answered, if they had the opportunity to confront the witnesses who appeared before me.

If the person chairing a public inquiry is prohibited by law from forming and voicing suspicions, drawing inferences, and developing hypotheses, then we might as well give up. There is simply no point in having Commissions of Inquiry, or Royal Commissions, whilst the law in Queensland remains as stated by Justice Moynihan.

If the Bundaberg Hospital Commission of Inquiry has any lasting influence on the conduct of public inquiries generally, I hope it will flow from the successful experiment of allowing the proceedings to be televised. My fear, however, is that Justice Moynihan's decision will lead future public inquiries in a very different direction: away from the ideals of openness and transparency which were my touchstones, and towards a recognition that any attempt at openness and transparency increases the risk of a successful judicial challenge. If that were to happen, I think that the public would be the losers.

That is why I say to you, on the assumption that Justice Moynihan's decision is correct in law, that the law must be changed. Fortunately, our constitutional system of government already embodies a procedure which permits public inquiries to be conducted without fear that they will transgress Justice Moynihan's ruling. Parliamentary inquiries – including inquiries conducted by

Parliamentary commissioners – are exempt from judicial scrutiny. They are not subject to judge-made rules of the kind applied by Justice Moynihan. They are accountable only to the Parliament and, through the Parliament, to the electorate.

I see a future in which there are no more Royal Commissions or Commissions of Inquiry in this State – a future in which public inquiries, like the Bundaberg Hospital Commission of Inquiry, will be conducted by Parliamentary Commissioners, free of judicial oversight, but subject to the ultimate control of the legislature and the electorate.

And that is how it should be. Serving judges have withdrawn from participating in public inquiries, for the very reason that such inquiries are properly viewed as part of the political process – part of the legislative/executive branch of government – rather than an exercise of judicial power. The next logical step is to recognise that, as part of the democratic processes connected with the legislative and executive branches of government, public inquiries should be exempted from oversight by unelected judges, and brought under the direct control of the State's foremost democratic institution, the Parliament.