PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO HOSPITAL TRUST ACCOUNTS

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 3 DECEMBER 2001

Members

Mr D'Orazio (Chairman)
Mr House (Deputy Chairman)
Mr Bradshaw
Mr Dean
Mr Whitely

Committee met at 2.05 pm

GEELHOED, DR GARY CORNELIS,
Medical Practitioner/Doctor,
Emergency Department, Princess Margaret Hospital for Children,
examined:

DUNCAN, DR ALAN WILLIAM,
Medical Practitioner,
Paediatric Intensive Care, Princess Margaret Hospital for Children,
examined:

BAKER, DR DAVID LAURENCE,
Director, Department of Haematology/Oncology,
Haematology Department, Princess Margaret Hospital for Children,
examined:

The CHAIRMAN: Welcome to the inquiry into the public hospitals trust accounts. You have indicated you want to give evidence to the committee. Before you do that, I will read you a note that I need to read to witnesses for the procedure for the examination of witnesses. The committee hearing is a proceeding of the Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the details of witness form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet regarding giving evidence before a parliamentary committee.

The Witnesses: Yes.

The CHAIRMAN: Have you made a written submission?

Dr Geelhoed: We wish to put in a written submission. I believe the opportunity for doing so finishes on Friday. We would like to put that in later, if we may, because all the clinical staff executive want to look at it and read it. Although they have seen rough drafts, it has been difficult for them to do that. We would like to read a statement today, if possible, and put in the written submission later in the week.

I will make some statements and then address the terms of reference one by one. Trust accounts at Princess Margaret Hospital for Children exist to enhance the standard of basic care for children that the State Government provides. PMH clinical staff were made aware of potential weaknesses of the trust account system that was set up by hospital administrators and have cooperated fully with a series of audits to examine these problems and to improve the system.

Mr Michael Moodie was an ineffective, destructive chief executive for Princess Margaret Hospital for Children. The assertion by Mr Moodie that the Clinical Staff Association executive approached him and threatened him and asked him to “back off” on the trust accounts or he would be removed is untrue. PMH staff were largely unaware of any suggestions of illegality or impropriety until after the former chief executive was removed. PMH staff have not had access to the audit reports until

very recently and have therefore been unable to defend the reputation of the hospital. Despite public allegations of wrongdoing for over a year, no staff has been charged or reprimanded. We suggest that a campaign of deliberate distortion and exaggeration of audit findings has damaged the reputation of Princess Margaret Hospital for Children. An improved system for management of trust accounts is now in place.

AN OVERVIEW: the PMH clinical staff executive welcomes the opportunity to make a submission to the Public Accounts Committee inquiring into hospital trust accounts. PMH doctors were largely unaware of the allegations of trust account misuse until 30 September 2000 when *The West Australian* newspaper proclaimed "Health Rorts". The headline the previous day had informed that Mr Michael Moodie had been removed as chief executive of PMH. I will refer to him as the former chief executive. Since that time, we are not aware of any doctor being reprimanded or charged with any offence; however, the allegations have continued in a very public manner, both in the print and electronic media, leading to a loss of public faith in the clinical staff of PMH and hence PMH.

We welcome the chance to address the terms of reference of the committee but would, under the last term of reference, like to provide details surrounding the transfer of the former chief executive. This is necessary given the emphasis put on it by the former chief executive in his evidence to the committee on Wednesday, 7 November. To ignore the factual account of the events would deny natural justice for the PMH clinical staff and further erode the reputation of PMH. We would like it noted that we volunteered to appear and requested it be as soon as possible for the sake of the reputation of PMH.

The nature and purpose of trust accounts: in layman's terms, trust accounts are a mechanism whereby funds that are raised for hospitals in addition to that provided by the State Government may be secured and used to augment the funding of the provision of medical services in hospitals. They are an integral part of teaching hospitals in other States and overseas.

The terms of agreement between the Australian Medical Association and the employer - for example, the Metropolitan Health Service Board AMA Medical Practitioners Agreement 1999, number PSA AG 25 of 1999, show that excess earnings from doctors exercising rights of private practice are deposited into accounts styled trust funds. A significant amount of money in some of the trust funds reflects the dedication and initiative of hospital medical staff in funding Perth's hospitals over and above what the State and federal Government provide. A large proportion of the funds raised by doctors is used for research, and the amount may range from as little as $1 000 to hundreds of thousands of dollars. An example of such a large amount would be the oncology or cancer unit of PMH.

Due to the excellence and commitment of the medical staff working in the oncology unit, it has become only one of a few hospitals outside North American to be involved in the Children's Oncology Group. This network of hospitals performs continual research refining the treatments of all types of childhood cancers. To support the work at Princess Margaret Hospital, hundreds of thousands of dollars are provided to employ staff, collect data and ensure that staff can travel to centralised meetings to stay abreast of the latest developments and maintain uniformity throughout the system. The ultimate outcome of the oncology unit's trust fund is that children in Perth have better outcomes for childhood cancers than most cities in the world and with fewer side effects from toxic chemotherapy. It exists not because of State Government policy or Department of Health or hospital administrators' initiatives but purely through the efforts of dedicated hospital doctors.

Opportunities also exist at times for doctors in different specialties to perform drug trials with the support of drug companies. This may be to examine whether different preparations of the same drug are as effective or whether a new drug is more effective than established treatments. All such studies are approved by the PMH ethics committee. Any surplus money may be applied to other unfunded research or alternatively be used for equipment for that particular department on the basis that the hospital has not been able to fund it.

It would appear that while staff who held the trust funds controlled to some extent where the money was spent in the hospital, there is little evidence that they benefited personally in any way.

Sources of funding: in addition to the above-mentioned sources, funding is also obtained from general donations from the public, reward for teaching or lecturing and bulk-billing. When donations are made to the hospital as a whole, we understand they go into general revenue. At other times, donors and grateful parents may specifically ask that money donated is spent in a particular area of the hospital where their child was treated; for instance, the oncology unit trust fund or the respiratory unit trust fund.

More recently and controversially, money generated from commonwealth money in the form of Medicare cheques has also been placed in trust accounts. It is our understanding that this is a very complex area and that the controversy arises from the situation in Australia where health spending is divided between the State and Commonwealth. For the sake of simplicity it is necessary to note that generally speaking, the federal Government funds medicine in the community - that is, private general practitioners, specialist's appointments etc, and private hospitals - while the State Government is largely responsible for the running of state hospitals, such as PMH. It is however legal for doctors to bill private patients they treat in public hospitals.

Cost shifting between the state and federal system has always existed. For example, the Royal Children's Hospital in Melbourne runs its outpatients, and even part of its emergency services, as privatised clinics where all patients are bulk-billed and moneys are received from the Commonwealth. We have documentation for that. We have been advised that approximately half a billion dollars worth of money is raised in hospitals in New South Wales in a similar fashion, and the State of Tasmania also practices this concept with the full knowledge and cooperation of its State Government. The acknowledgment of this practice in this State is evidenced in the former chief executive's opening address to the staff of Princess Margaret Hospital when he arrived, wherein he noted that the federal funding being attracted to Western Australia was much lower than in the eastern States. He flagged this as a possible way of increasing revenue streams for the hospital.

Prior to this in the early l990s, hospitals administrators, including Dr David Formby and Dr Andy Cumming, raised the possibility of such practices being initiated at PMH - see attachment. Some departments that showed some reluctance to do this were labelled as not being team players. Legal advice was received from the Crown Solicitor's Office and discussed at a number of general meetings of PMH doctors. The legal advice given was that if the clinics were set up appropriately, it was possible to legally increase the amount of federal funds for PMH.

In summary, the doctors were required to raise Medicare cheques and then donate money back to the hospital. The funds were tax deductible because it was a donation and the full amount would go to the hospital. The doctors did not benefit personally. Although on paper their incomes would be augmented, their take-home pay would be exactly the same. The doctors viewed the money raised in this way as hospital money. At a Princess Margaret Hospital for Children executive council meeting on 16 August 2000, chaired by the former chief executive, under the item "Budget", it read, "There is a $2.9 m revenue target for private patients in outpatient clinics." At the next meeting on 13 September, again chaired by the former chief executive, it was stated that the "advised meeting will be held on 15 September 2000. The hospitals will be funded for $2.9 million cash." Although the rights and wrongs of bulk-billing are yet to be decided, we point out that it was pure hypocrisy for the former chief executive to portray the activity as illegal when he was openly discussing the increased use of the practice at PMH within weeks of his departure.

In the past year, it has been vocally and repeatedly declared in the media that this practice is illegal. If this proves to be the case, many doctors around Australia will be found guilty. Another interpretation of this situation is that honest professionals were persuaded to risk criticism for no financial gain to help the hospital at which they worked and ultimately the children of Western

Australia by accessing additional, much-needed federal funds. We can only speculate why the former chief executive would go out of his way to denigrate medical staff by portraying this practice in such a negative light and to wrongly accuse doctors of benefiting personally. To be a brave whistleblower requires a crime; without it, one is just a failed administrator.

The situation of the privatised clinics has been well known and discussed at various levels within the Western Australian health system both in the hospitals and the Department of Health for many years. The Minister for Health opened a Sleep Unit at PMH, which is funded by Medicare money. The continuation of this service is now in doubt due to the very public campaign to portray these services as illegal. A country diabetic service that no longer requires children with diabetes to travel to Perth is also at risk. It is possible the former chief executive distorted and placed trust account audits into the public arena not to right a wrong, but to discredit the staff of PMH so that their objections to his management style would be overlooked and dismissed as "shooting the messenger".

USE, ADMINISTRATION AND MANAGEMENT OF TRUST ACCOUNTS: the use of trust accounts was explained above. I am talking now about the situation that existed previously, not the current situation. The financial department of PMH would allow doctors, nurses or play leaders to set up trust accounts to hold funds from various sources. A trust account form would be completed that outlined the purpose of the account, the nature of the revenue and expenditure, the reporting requirements, authorised signatures and examples of specimen signatures. The form is then sent to the financial services department where a cost centre account would be established. Revenues received were not subjected to scrutiny as to the source of funds, nor why they were placed in a particular account. Expenditures were based on the authorised signatories being the sole delegates for the account and were limited to the balance of funds in the account unless otherwise authorised by the hospital executive. Expenditure could be queried if a proposed payment was not in line with the original application form. To make a point, having read Mr Moodie's transcription this morning, cash would be given out at times; however, I am informed that it would be petty cash to the value of $20 or $50 at most if some little specific thing was required. Reports were sent on a monthly basis to authorised signatories. Transactions and balances of accounts were reported to monthly finance committee meetings.

Although the operations were in accordance with financial and other regulations and practices, in retrospect, they left the hospital vulnerable to uninformed comment and may have left too much control in the hands of the authorised signatories. A new system that addresses these potential weaknesses is now in place. I have an attachment of the new committee and how it addresses those potential problems. A hospital audit committee was in place until March 1997 when the Metropolitan Health Service Board abolished it.

STATUTORY REQUIREMENTS, ACCOUNTABILITY AND COMPLIANCE: I will leave the issue of the hospital administration to comment on other points. However, before I do, I will inform the committee that the doctors at PMH were happy to work with the new acting chief executive officer, Dr Bill Beresford, to set up more appropriate guidelines once the potential problems of the old system became apparent after the former chief executive left.

THE COST BENEFITS AND POTENTIAL LIABILITIES TO THE HEALTH SYSTEM OF TRUST ACCOUNTS: the costs to the health system are minimal while the benefits are enormous. The amount of $8 million in trust accounts in PMH should be seen as a testament to the initiative and hard work of the medical staff of PMH. This money has been raised to benefit the children of Western Australia. To portray the trust accounts as slush funds for doctors' personal benefit is a great disservice. We believe about $2 million a year passes through the accounts.

The ability to raise these funds and perform research and teach is what keeps many highly qualified doctors in the public system. If such a practice were banned or became so onerous as to not be worth doing, many staff would leave the system. They could seek employment either in the private

sector, which would be more financially rewarding but not as interesting, or they could seek employment in a system that welcomes and encourages such practices. Again, we can only speculate about why the former chief executive's view of trust accounts is so far from reality. However, it sheds light on his comments that the chief executives of the teaching hospitals supported the trust accounts, as they clearly understood their true nature and benefits.

Even if some irregularities were found, it would have been more appropriate for a chief executive to reassure the public that the vast amount of money raised and used benefited the children of Western Australia. A responsible chief executive would have protected the reputation of his institution and public confidence while at the same time managing the problem appropriately. We repeat that we were not aware that there were allegations of gross impropriety with regard to trust funds until after the former chief executive left the PMH.

ANY OTHER MATTERS THAT THE COMMITTEE DEEMS NECESSARY TO INVESTIGATE: the following section is provided to this committee only to defend the reputation of the PMH. Following the former chief executive's inaccurate, biased and at times incorrect testimony that placed PMH and its staff in such a bad light, the hospital has recently received abuse calls from the public. We also note the negative effect on fund-raising activities for PMH. The former chief executive alleged that the PMH Clinical Staff Association executive approached him informally and threatened him and told him that if he did not back off, the association would have him removed. The executive rejects that any such meeting or communication ever took place in any way, shape or form, but notes that the allegations have been damaging to the reputation of the individuals of the clinical staff executive and, by implication, PMH generally. We challenge the former chief executive to repeat his allegations outside of parliamentary privilege so that the truth of the matter can be tested in a court of law. To better expose the truth or lack thereof, we urge the committee to question the former chief executive further as to when and where the alleged meeting took place, who was present at the alleged meeting and what exactly was said.

We believe it important that the committee has insight into the history of the former chief executive and to examine in detail documentation of his time at PMH, as a pattern will be obvious to members. We believe it raises serious questions as to his appointment and also as to why no attempt was made to have his performance at PMH examined when serious allegations of poor management practice were made.

We have provided to the committee a 15-page appendix with 72 attachments documenting in chronological order and in detail matters relating to the former chief executive's past history, performance at PMH and events leading to his ultimate removal. We ask that they be placed on the public record to show unequivocally that the PMH staff acted honestly and honourably and objected to the former chief executive because of his management style, not because of trust funds. We will show that the former chief executive had a controversial past history in New South Wales where similar accusations were made against him to those raised at PMH.

We believe that one of the first acts of the incoming Minister for Health in Queensland was to remove the former chief executive for his -

The CHAIRMAN: Up to this point, the committee has been very careful to protect the reputation of some people. When the chief executive named certain doctors, the committee suppressed those names. I suggest you be very careful about what you say. We do not want to allow open slather without the former chief executive being able to defend the allegations. We can ask the chief executive to come back to the committee to put his side, but please be careful about what you say.

Dr Geelhoed: I repeat that this is purely to defend the reputation of the PMH. We believe we have been subjected to vilification for the past year or more; that is, individuals in this room and doctors in the hospitals. We believe that vilification is completely unwarranted, and it all comes down to the credibility of witnesses. We believe we have evidence to show a pattern and that it should be on the public record.

Mr DEAN: It sounds like shooting the messenger to me.

The CHAIRMAN: We are happy to get that evidence.

Dr Geelhoed: We are happy to give it and then members of the committee can question us about it so that the committee can decide whether we are shooting the messenger.

The CHAIRMAN: I do not want you to read that submission out in this public forum right now. I am happy for the submission to be submitted for the committee to examine. I can give an undertaking that the committee will check the validity of any information that is provided before we release it on the public record.

Mr HOUSE: I do not agree with that. The former executive has made serious accusations against some doctors. The staff at the PMH have every right to defend themselves. I have no objection -

Mr WHITELY: I am far more interested to hear about the problems of the former chief executive officer's management style while he was working at Princess Margaret Hospital for Children than I am in hearing about something that happened in New South Wales.

Dr Geelhoed: It establishes a pattern. The allegations made there are exactly the same as the allegations being made here. If the committee is to examine what has been going on, surely the fact that Mr Moodie has a record exactly the same in New South Wales is relevant.

Mr WHITELY: The chairman has indicated that the committee is happy to take that information on board. I am more interested in hearing about what happened at PMH.

The CHAIRMAN: The committee will recess for five minute. We need to consider whether we will allow this information to be put on the public record.

Proceedings suspended from 2.28 to 2.31 pm

The CHAIRMAN: The committee is happy to allow any statement you wish to make about the CE's operations at PMH if you have a direct knowledge of them. Your information about his previous employment will be accepted in a written submission. The committee will check the authenticity of those documents. If the information is verified, the information will be placed on the public record. The committee is happy to accept any information you have about his conduct as the CE of PMH.

Dr Geelhoed: In that case, I will read my account of his time at PMH.

The CHAIRMAN: Members are more than happy to hear that.

Dr Geelhoed: We believe that the former chief executive was appointed to that role despite reservations expressed by some members of the Metropolitan Health Service Board about his past record and the fact he had not worked in a large teaching hospital. He was apparently approached to do the job despite the fact that another applicant was informed that "experience in a large teaching hospital is virtually mandatory, together with the ability to be a good team player". He was appointed at a time when hospital boards had been abolished and replaced by the MHSB. The advertisement for the position stated that as board members of the MHSB, the chief executives would be expected to take a metropolitan-wide perspective in strategic development of health services and the reallocation of resources. That might involve the transfer of staff, resources or services to other health providers, the termination of services and the breaking down of longstanding institutional allegiances in the interests of coordinated health reform. One can only assume that the intention was to put in a stronger administrator who could manage such reform. However, we believe that by appointing a man with such qualities as demonstrated, the board set the new chief executive on a collision course with two highly respected teaching hospitals. In retrospect, we believe that the former chief executive, although he had a long history in health, did not understand the roles and complexities of tertiary teaching hospitals and had none of the personal skills required.

When introduced at his first general meeting with staff at PMH, the former chief executive merely asked, "Any questions?" He offered nothing more. That action was considered rude and inappropriate for a chief executive addressing his new staff for the first time.

When the former chief executive commenced work, he brought with him what are referred to as "mates from New South Wales", including Mr Alan Jones and Mr Jerry Cassis. He advised that Mr Cassis was to be on our payroll and was to advise on case mix and clinical costings. Mr Cassis was placed on the payroll but remained working in New South Wales for a time. He was working for the hospital, but he was in New South Wales. A computer was shipped to him from PMH. He had a management and personnel diploma from Wagga Wagga Institute of Higher Education, but no tertiary qualification.

The former chief executive and his advisers informed Sue Terry, the director of nursing, and for a long period the acting chief executive of PMH, that the hospitals were overstaffed with nurses. The former chief executive had come to this conclusion as a result of comparing PMH figures to that of 300 other hospitals. Mrs Terry queried the relevance of this as there are only eight pediatric teaching hospitals in Australia and only they would provide meaningful comparisons. Obviously, more complex teaching hospitals would require a higher ratio of nursing staff than a simple country hospital. When Mrs Terry began to explain the reasons for a higher nurse to patient ratio in pediatrics, the former chief executive stated that 250 positions would go. He said, "We'll keep talking corporate as the source of the redundancies, but about 170 full-time equivalents will come from nursing, and I don't want to pay any redundancies." Mrs Terry expressed concern for the hospital and its patients about that plan. When Mrs Terry asked which pediatric hospitals the figures referred to, she was told the only one was the Mater Children's Hospital in Brisbane. Mr Jones stated that PMH nursing figures were much higher than the Mater Children's. Mrs Terry explained that she had checked with the Mater the previous year and its figures were significantly higher. She then asked him whether the figures he was quoting were real. He initially said that they were, but then said the figures he was comparing PMH to were staffing levels that he had only suggested to the Mater. When Mrs Terry followed this up with the director of nursing at the Mater Children's Hospital in Brisbane, she was informed that although Mr Jones had submitted a report to the hospital, it was never implemented because the staffing levels were judged to be unsafe. This then was the basis on which the former chief executive was suggesting reducing nursing numbers at PMH.

At a meeting of the executive council on Thursday, 15 April 1999, Mr Moodie, Mr Jones and Mr Cassis gave their view that PMH's casemix information, national benchmarking studies funded by the federal Government, clinical costing and budgetary information was inaccurate and inconsistent. This was not the view of the PMH staff. On Friday, 16 April, Mrs Terry, following concerns being expressed by the clinical care unit directors, or divisional directors within the hospital, met to discuss the implications of this benchmarking casemix advice. Mrs Terry undertook to contact Mr Moodie and to request a meeting with his two consultants and relevant members of PMH staff to compare the data. That meeting was also to include members of the executive council. She sent the request in an email as she was going interstate.

On Thursday, 23 April, on her return to PMH, Mrs Terry asked Mr Moodie's secretary whether he had arranged a meeting. She was told he had refused to have a meeting. While standing by the executive fax machine, a fax came through from the Health Department of Western Australia. The fax indicated that a Mr Eric Dillon had been offered the position of executive director, corporate services, on a six-month contract at PMH. As Mrs Terry had been talking to Mr Bill Simpson, the incumbent in the job, about another matter, she knew he had no notion he was no longer the executive director, corporate services. She rang the former chief executive and asked him what his response was to her e-mail. He stated that he did not plan to meet with the proposed group. She informed him that she had seen the fax about Mr Bill Simpson's position and voiced the view that it was outside public sector guidelines to give someone a position when that position had a

substantive incumbent. He said he was angry that she had read the fax. He then said that the position he had given to Mr Dillon was a different one. Mrs Terry told him that that was not on the contract. She also said that she found his behaviour intimidating and that members of the executive council did not feel safe to speak up because of his manner. He asked her to put that view in writing and then said, "And then I will sue you." The conversation then finished. The former chief executive never spoke directly to Mrs Terry again until she was called into the boardroom at King Edward Memorial Hospital for Women and told that her position and that of Mr Bill Simpson and Dr Andy Cumming, director of medical services, had been abolished. He stated that he would accept no comments or questions and that they were not to attend the executive council meeting the next day.

Medical staff at PMH were appalled by the nature in which the three well-liked and respected directors were removed. Much sympathy was extended to Mrs Sue Terry because her husband had recently died. It was well known that the directors had gone out of their way to welcome the former chief executive and his family to Western Australia. Staff objected strongly to the nature in which the dismissals had taken place as was documented in the CSA minutes. However, there was acknowledgment that, under the new devolved management scheme the hospital had adopted, there was a certain logic in abolishing the jobs. Staff expressed their abhorrence about the way in which the dismissals had taken place, but gave the chief executive the benefit of the doubt as to his motives. It was only later that we found out that it was a deliberate coup and that those highly respected directors with intimate knowledge about how the hospitals worked were challenging his inaccurate and dangerous view of the hospitals and his methods. A review of the dismissals was undertaken and the former chief executive was instructed to apologise for the manner of the dismissals. The review was never made public.

We believe that Mr Jerry Cassis lived essentially rent-free in a house that belonged to King Edward Memorial Hospital for Women for a number of months on the former chief executive's instructions while the rest of the hospital was subjected to savage cutbacks. He was initially placed on a three-month contract as a project officer level 7, despite his lack of qualifications. We believe the position was never advertised. The contract was extended, but when questions were asked about his appointment, Mr Cassis disappeared, only to reappear as a consultant with Arthur Andersen Business Advisors on, we believe, a higher salary. We questioned the coincidence of Mr Cassis being recruited by Arthur Andersen so quickly and being seconded to PMH and the cost to the hospital. We believe this to be certainly against the spirit, if not the law, with respect to public sector guidelines.

Mr Cassis made a point of speaking with the head of a non-clinical department and informed her that he knew one of the young women in the department. He asked that she be looked after; if that did not happen, the head of the department would answer to him.

The CHAIRMAN: What does that have to do with the -

Dr Geelhoed: Some months later, that same young woman was promoted a number of levels to work as acting director of executive services.

The CHAIRMAN: What is the connection?

Dr Geelhoed: We believe that was inappropriate.

The CHAIRMAN: What evidence do you have that it was inappropriate? How do we know whether it was inappropriate?

Dr Geelhoed: I take the point. Please bear with me.

Over a period, it appeared to staff that the former chief executive was not working for the good of the hospital or the children it served. When asked directly whether he saw himself as being an advocate for the hospital -

Mr DEAN: How do you know that? Please elucidate. You have made 5 000 points, including the last point about his not working for the good of the hospital. Can you explain?

Dr Geelhoed: If you allow me go through this statement, I will show that.

The CHAIRMAN: Please continue the statement. When you have concluded, we will ask questions.

Dr Geelhoed: When asked directly whether he saw himself as an advocate for the hospital, he replied in the negative.

Mr DEAN: Who asked him?

Dr Geelhoed: I did. His style of management was such that he would brook no opposition, and if people stood up to him they were marginalised. He took to repeatedly parking in no parking areas at both hospitals, illustrating that while he was a stickler for petty rules to apply to other staff, he was not bound by them. He instructed the public relations department to cease referring to PMH as a centre of excellence and to cease putting forward good-news stories to the Press. He stated that the hospital claimed to be doing a good job but was in fact doing a "shit-house job". He instructed the publicity department and the play leaders at different times that he would get rid of them if he could. He advanced the view that PMH should be not be looking after children with chronic illnesses, appalling staff who heard this.

An executive council had existed in the hospital that included the heads of the clinical care units or divisions to oversee the running of the hospitals. The former chief executive moved to stop the executive council meeting within months of arriving after disparaging it at other meetings. As the hospital board had already been abolished, the checks and balances that had existed in the past were gone and we were left with an autocratic chief executive, who increasingly proved to be a poor administrator. When the CSA executive consulted widely with heads of departments throughout PMH, both medical and non-medical, the same story was repeated. They complained that they never saw the former chief executive, communication was all one way, important decisions were put off for long periods, he made promises that were never kept and gave different stories to different groups. He continually played a game of bad-mouthing one group to another.

He centralised powers from directors of the clinical care units. He would countersign virtually all orders for equipment and so on even to the extent of ordering sandwiches and coffee for meetings. In effect, he used the argument of devolved management to justify removing the directors of nursing, medical and corporate services, but then moved to centralise all power to himself. The clinical care units have a medical head and a director - usually a nurse. He changed the contracts for the medical directors to three months only and foreshadowed that he might abolish the positions altogether.

He placed a moratorium on replacing all staff who left, other than those doing direct clinical duties, in line with the MHSB policy, but continued the policy long after the ban had been lifted elsewhere. That resulted in inconvenience at best and dangerous situations at worst. For over a year he refused to replace secretarial support services in the genetics unit. That was despite continual attempts at communication by Dr Jack Goldblatt by telephone, e-mail and letters. It was pointed out that lack of support in such a sensitive area might lead to mistakes for which the hospital might be liable. No response was forthcoming.

It was demonstrated that secretarial support was indicated under recognised guidelines based on the population served. Mr Moodie was heard to announce, "Goldblatt will never get his secretary." The end result of these multiple problems was an increasingly unhappy work force which started to more and more forcibly voice their concerns. Many people spoke of problems with the performance of the chief executive but were, and still are, afraid to speak out due to the former chief executive's tendency to threaten to sue.

The situation continued for the remainder of 1999 with the former chief executive continuing to show he did not have the right personality or administrative skills. It was generally regarded that he insulted invited guests at the annual Macdonald lecture at Princess Margaret Hospital by his manner and by the fact that he left with no apology or explanation soon after he had introduced the invited speaker.

On Christmas day 1999 the former chief executive toured the wards with play leaders - workers who play with the children while they are in hospital and who visit all the wards of the hospital. Again his behaviour was such that the play leaders stated that they would never accompany him again on such a round.

On Thursday, 14 March 2000 at 12.30 pm a meeting was held between the former chief executive and PMH doctors. The former chief executive informed the group that Mr Andrew Weeks, chief executive officer of the Metropolitan Health Service Board, was likely to take the funds from the PMH trust accounts. Later we were to learn that Mr Weeks never suggested any such action. The former chief executive stated that there was approximately $8 million in the funds. He suggested that the funds be audited and procedures tightened up so that it would make it less likely that the MHSB would take the money. However, he proposed that all moneys be placed from the trust accounts into a central fund. He outlined a plan whereby he would control the money and determine where it was used. Staff acknowledged that there were problems with the trust funds and that, although theoretically they could be used only for designated purposes by the trustees, moneys would at times be used by administrators without approval. Mr Moodie said that others complained that the accounting system was such that they could not get reliable information about the balance of the trust funds. The staff generally, however, agreed that they would welcome a change that would give them accountability, transparency and certainty about the trust funds. While they acknowledged that the money was clearly the property of the hospital and therefore the MHSB, they argued vehemently that if input on how the money was spent was taken from the doctors there would be no incentive for the doctors to raise funds. It was stated that to do so would kill the goose that laid the golden eggs. It was pointed out that doctors spent much time and effort raising moneys from sources such as national grant bodies, drug companies etc to augment the services and research already performed at PMH. To take away the certainty that money raised for a particular project would be used for that project would compromise the whole system.

Mr WHITELY: What are you talking about when you refer to doctors having input and certainty? Do you want the doctors to have total control of the trust funds?

Dr Geelhoed: Not at all.

Mr WHITELY: How can you achieve certainty without total control?

The CHAIRMAN: Can we wait until the end for that question because it will lead to a heap of questions by the time we are finished.

Dr Geelhoed: The former chief executive promised to hold further meetings to discuss trust accounts but this meeting never took place, despite repeated requests by staff to hold such a meeting. Over time, however, interest in the trust accounts once again abated as other events unfolded and no result from the original audit was given to hospital staff. At no time were there discussions, suggestions or accusations by the chief executive that there was in any way illegal or criminal activity occurring with respect to trust funds. Staff assumed the audits would be unremarkable, as they had been in the past. Unofficial feedback from the MHSB suggested this also.

Throughout 2000, frustration with the management style of the chief executive continued to increase. In early 2000, to help counteract the lack of communication and management within the hospital, clinical staff set up their own clinical coordinating committee. This was largely because the management committee of the hospital had been abolished by the chief executive. The minutes

of 21 March 2000 of the clinical coordinating committee noted under "communication" that frustration had been expressed by heads of department with the process to employ new staff from lack of communication between the chief executive and heads of department.

While meeting with the chief executive officer, Mr Andrew Weeks, on 1 May about another matter, the chairman of the clinical staff association broached the subject of the former chief executive's management style for the first time. The former chief executive, on invitation, had attended the monthly PMH Clinical Staff Association executive meetings for approximately a year. On Tuesday, 16 May the atmosphere in the hospital became very heated due to the continued poor management style. There was general talk among medical staff about a vote of no confidence in the chief executive officer. This was prompted by such a motion being passed by the King Edward Memorial Hospital's Clinical Staff Association. On 12 May a meeting of the 150 medical, nursing and midwifery staff at King Edward passed seven motions. Motion 5 stated that the meeting expressed its total lack of confidence in the chief executive. Motion 6 stated that the meeting called on the minister and the MHS board to take seriously the issues raised by the medical, nursing and midwifery directors and senior staff to replace the chief executive with a manager who would respond to the needs of the hospital.

Although a vote of no confidence had been spoken of for some time at PMH, the general consensus was that the time was not appropriate. However, as the King Edward staff publicly declared no confidence in the chief executive, the staff at PMH felt that not to pass such a motion would be to endorse the view that there were no problems at PMH when clearly there were. It was decided to discuss these matters with the former chief executive at the next executive meeting. The former chief executive did not attend, as he usually did, and gave no apology. As his staff had been in contact to confirm the time and place of the meeting and who would be present, it was held over until 1820 hours in the expectation that he would arrive; he never did. The following day, Wednesday, 17 May at 1745 hours, a general meeting of the clinical staff association of PMH took place. Prior to the meeting the staff had indicated that they would move a motion of no confidence from the floor. The chairman of the executive rang the former chief executive and informed him that it was not on the agenda but it was likely that a vote of no confidence would be put. The former chief executive informed me that he was suing the Clinical Staff Association of King Edward for passing a vote of no confidence in him. I asked whether he had any other contribution to make and he indicated that he did not.

There was general agreement by clinical staff that effective communication between the clinical staff and the former chief executive had broken down. Examples were given when important communications to the former chief executive had failed to receive replies, sometimes over months. It was noted that important decisions were reversed without effective communication to those concerned. Staff noted that the executive council no longer met and, as such, a forum to discuss wider issues within the hospital by the heads of clinical care units no longer existed. Opinions were given that the former chief executive preferred to deal with small groups of individuals in an autocratic fashion leading to poor overall communication. It was reported that advice from managers on clinical matters such as staffing priorities had been rejected. The meeting also expressed disappointment with the lack of implementation or discussion of the recommendations made by the committee convened to look at winter strategy.

A proposed vote of no confidence was debated at length and rejected on the ground that Mr Moodie had not been formally approached with these concerns. Following considerable discussion the following motions were carried without dissension -

> the CSA expressed concern that the management style of the chief executive has led to a breakdown in communication and effective decision making in overall hospital management;

it was the opinion of the CSA that the failure in the chief executive's leadership was contributing to poor morale, staff resignations and difficulties in recruitment;

the CSA expressed its concern at the failure of the chief executive to effectively address issues regarding staffing, equipment and resources;

the CSA stated strongly that standards of clinical care were being maintained only by the dedication of staff while working under these adverse conditions;

the CSA felt that patient care would suffer if present management practices continued; and

the CSA proposed that the chairman ask the MHSB or its representatives to meet with representatives of the CSA and clinical care units to work to restore effective management at PMH.

At that time it was agreed that a meeting of medical, nursing and allied health staff would be arranged in eight days to progress the matter further, and it was anticipated that a general vote of no confidence from the hospital would be recorded, as had happened at King Edward. The chairman stated that despite the strength of feeling of staff, the outcome of the general meeting should remain confidential prior to his meeting with the MHSB or its representative.

On 18 May the chairman of the CSA wrote to Mr Ian McCall, the chairman of the MHSB, with a copy to Hon John Day, the former Minister for Health, informing him of the outcome of the general meeting of the CSA and asking for a meeting to discuss possible solutions. The former chief executive was also informed of the outcome of the meeting and of the request of the CSA to meet with the MHSB or its representative. A letter was also sent to Mr Andrew Weeks, chief executive officer of the MHSB, informing him of developments. Mr Andrew Weeks asked to set up a meeting to speak with the clinical staff association executive, the heads of the clinical care units and the university representatives. I e-mailed Andrew Weeks requesting that the former chief executive officer be invited to the meeting. He stated that the meeting felt that we should work together to come up with some arrangement that we could all live with, that would allow the hospital to function effectively and would involve a timely review on progress. The hospital moved to a devolved structure some years ago which worked well. Although Michael Moodie removed the last vestiges of the old structure by making the director of nursing, medical etc. redundant, he was then concentrating all the decision making back to the chief executive. Despite this, there was no effective management. The meeting felt that the devolved structure should be respected and supported, and some sort of governing committee reinstituted to coordinate and advise. I e-mailed Andrew Weeks on 24 May saying that we all recognised there was a problem and we wanted the meeting to be a positive one trying to find solutions. Although we were happy to illustrate what we believed to be problems, we felt that debating the rights and wrongs of individual incidents should not be time-consuming, and it may make it difficult to remain positive and be constructive if not controlled; that is, we wanted not a continuation of the stand-off that we had had, but a concerted effort to move forward.

The meeting took place later that day, Wednesday 24 May. Mr Alan Bansemer, the former Commissioner of Health also attended. The former chief executive, although invited, did not attend as he was apparently unwell. Two versions of that meeting are attached; one by Professor Peter Le Souef and one by me. Despite repeated requests for an official copy of the minutes of the meeting, as reported by a clerk with Mr Weeks, they were never forthcoming.

The general problems with the former chief executive were discussed but staff emphasised the need to solve the problem to move forward. It was agreed that some sort of management forum be put back into place so that the hospital could move forward. The notes state that it was thought that the devolved management structure with proper representation should meet regularly with Mr Moodie. Clinicians would be more prepared to live with budgetary restrictions if they were involved in decisions regarding how the budget was used. Mr Weeks and Mr Bansemer asked that the clinical

group engage with Mr Moodie to, hopefully, resolve their difficulties and to allow for a more harmonious management of the hospital. It was felt that there was goodwill to manage the hospital effectively, but this would require the cooperation of both clinical staff and Mr Moodie. It was agreed that there would be a regular review of progress and re-establishing effective management of PMH. Mr Weeks concluded by saying that he was happy to talk again at any time but he would encourage Mr Moodie to fix the problems that had been alluded to, that he would take a strong personal view of how this process was handled and how it proceeded and there was a strong willingness on his part to meet again when and where it was necessary. Mr Alan Bansemer, the Commissioner of Health at that time, voiced the opinion at one stage that Mr Moodie was going to be around for a long time, so PMH staff should get used to him. Professor Le Souef, of the University of Western Australia, at that time pointed out that he did not expect to stay in his job indefinitely if in fact he was doing a poor job and asked was this not true of the chief executive position also. Mr Weeks intervened at that time.

the chairman of the Clinical Staff Association wrote to Mr Moodie inviting him to meet with the representatives of the Clinical Staff Association, the university and the heads of the clinical care units to restore faith in the management of the hospital. In the letter referring to the previous meeting, the Chairman of the Clinical Staff Association wrote -

> We expressed the strong view to . . . work closely to restore effective management at Princess Margaret Hospital for Children. We feel it has been increasingly difficult for you to make appropriate decisions with regard to the management of the hospital due to the lack of formal structure in management at Princess Margaret Hospital and lack of input from clinical staff. We would suggest that some sort of executive representative group meet regularly with yourself to manage the hospital.

The letter concluded -

> From a personal point of view you have always been frank and friendly with me and we have not had any major issues between us. The strong feel ing of the clinical Staff Executive and Heads of the Clinical Care Units is that we would like the hospital to function efficiently and to have a close working relationship with you to achieve that end. This would however involve the ability of both sides to listen carefully to each other, be consistent and respect each other's views.

I also wrote to Mr Bansemer on 24 May thanking him for attending the meeting on that day at PMH to discuss concerns that clinical staff had with management. I said -

> I hope that the direction agreed on at the meeting will produce a future where staff can confidently have faith in their hospital and its management structure once again. The acknowledgment that a form of clinical staff executive may be helpful in resolving problems was welcomed. I am pleased that progress will be reviewed in the next few months.

The letter concluded -

> Today's meeting was very encouraging as although it was difficult in some ways, we made progress and felt we contributed something important to the future of our hospital. This is the very sort of meeting that has been missing at the hospital for this past year.

I e-mailed Andrew Weeks on 29 May informing him that a meeting with the former chief executive would take place.

The CHAIRMAN: How long do you have to go? I love listening to your diary but at the end of it how do we tie this back to the issues?

Dr Geelhoed: This shows conclusively how the PMH staff tried through two separate processes to work with Mr Moodie and how Mr Moodie just sabotaged them. This shows how the staff had no option in the end. This is very important. It shows clearly that we were trying to help.

The CHAIRMAN: As far as I can see it shows two different groups with two different opinions. That does not necessarily mean that one is right and one is wrong.

Dr Duncan: It also shows that the focus was not on trust funds, it was on the management of the hospital. Mr Moodie's testimony suggested that all the aggro against him was directed at his inquiry into trust funds. The trust funds were a minor issue.

The CHAIRMAN: We will get to that in a minute. It is not only Mr Moodie's evidence that contradicted that view. However, let us get to the end of the statement and then we will get to that matter.

Mr HOUSE: How much more of the statement is there?

The CHAIRMAN: You could present that to us in evidence and we will read it.

Dr Geelhoed: All right. Shall I attempt to paraphrase it?

The CHAIRMAN: That would be nice.

Dr Geelhoed: It is all documented in this statement and I ask you to go through it and read it. As I indicated, we wanted to set up a meeting with Mr Moodie. He was invited to the meeting with Mr Weeks and Mr Bansemer, but he did not attend. I tried to meet with him over the next three or four days in an attempt to build bridges. Meetings were set up and cancelled on a number of occasions. I then communicated with him by e-mail to ask if he would meet with the clinical care directors and representatives from the university and the Clinical Staff Association the following Wednesday to discuss these matters and the possibility of setting up a management group. He agreed to that. We then learnt that he met with only the clinical directors the day before the meeting, and directed them to not go to the meeting on the Wednesday. We then thought that Mr Moodie was not playing ball. That meeting had not been agreed to, so we decided to not go to the Wednesday meeting. However, the clinical directors said that Mr Moodie was going to meet with us on the Wednesday; had already met with clinical care people; and would meet everyone on Friday to nut out the issue. We met with Mr Moodie in good faith, but the Friday meeting never took place.

During the meeting, we went through the problems we felt we had with him, and suggested that one way forward would be to set up a management group. At that stage, Mr Moodie put forward the view that he would have done that earlier if we had asked him. He got angry and insisted that we release a statement saying that everything was okay at the hospital and that we had no problems with management. We said that there were problems with management, and that we had agreed to only a series of meetings. We said that the problems had not been fixed.

Mr WHITELY: Is that not similar to what you asked Mr Moodie to do earlier? When the problems with trust accounts were identified, you wanted him say that everything was hunky-dory; that although there are some minor problems with the hospital, everything was tickety-boo. Did Mr Moodie not ask the same things of you?

Dr Geelhoed: He asked us to release a statement there and then. We said that we would be happy to release a statement a couple of months later saying that the hospital was working well, if that was the case. We said that we would be happy to release that statement if the committee were set up and the hospital started functioning again. We would have been happy to do that, in the same way that we would be happy to put out a statement and say that the way the trust accounts are managed at the hospital are fine.

Mr Moodie at that stage gave an undertaking that he would get back to us about setting up a committee comprising representatives from all the various groups. There was no communication with us, but Mr Moodie set up a management group that excluded the university and the Clinical Staff Association. It was not what we had agreed to. The people at that meeting insisted that it be called not the management group but the interim management group.

Mr DEAN: Is that documented?

Dr Geelhoed: It is all documented.

Mr DEAN: Can you produce that for us?

Dr Geelhoed: Now?

Mr DEAN: No, sometime this week.

Dr Geelhoed: It is all here.

Mr DEAN: I do not mean your submission. Is there a minute somewhere?

Dr Geelhoed: I have an attachment.

Mr DEAN: Is it a minute of a meeting?

Dr Geelhoed: Yes.

The CHAIRMAN: Whether it was called the interim or management committee, what is the point you are trying make?

Dr Geelhoed: We were trying to set up something whereby the hospital could work again. Mr Moodie seemed to be trying to divide groups. He set up a committee that was not representative of the hospital at all. That is the point I am trying to make.

The CHAIRMAN: I am happy for you to finish the statement. We will ask questions about the submission. It is now ten past three. You may continue, but we have heaps of questions for you.

Dr Geelhoed: I am sure you have.

We tried to put something in place. Mr Moodie suggested that he address the Clinical Staff Association's general meeting. We said we were pleased to have him come along and talk to us about that. There was not a vote of no-confidence before he attended that meeting. We asked him to talk about setting up a management committee - to build bridges. However, he stated that the medical advisory committee, which would be represented on the new committee, should be abolished. The committee was one of the few structures remaining in the hospital, and he thought it should also be abolished. Staff were so angry that when he left, they passed a vote of no-confidence in him.

We then had another series of meetings with Mr Weeks. The hospital was not functioning at all by this stage. A management committee was finally set up as we wanted, with Mr John Day, the Commissioner of Health, and the chief executive of the Metropolitan Health Service Board, Mr Andrew Weeks. It was agreed that we would have a three-month trial of this committee, and that a member of the Metropolitan Health Service Board would sit on it. I said that we were happy to go along with the committee, if it worked. At no stage did Mr Moodie acknowledge a problem existed. When we asked what he thought of the votes of no-confidence, he said that he did not understand them. We have documented in the submission about four or five examples that show that the situation was impossible and that the hospital was not working. Those examples include the ethics committee, the electoral committee and the divisions within psychiatry and pathology. There were ongoing major problems with management in those areas. The hospital was not working. That is why we agitated: to say that the hospital was no longer working.

We had a final meeting which Mr Moodie spoke about. We heard that the management group was meeting and that Mr Day, the minister, and Mr Ian McCall, the chairman of the board, would go to that meeting. The committee may remember that, prior to that, we had met with the Premier to talk about the problems with Mr Moodie.

Mr DEAN: When was that?

Dr Geelhoed: I am not sure. I can find out.

Mr DEAN: Did you meet with the Premier to talk about Mr Moodie?

Dr Geelhoed: That is correct.

Dr Duncan: The meeting was at 3.00 pm on 22 September.

Mr DEAN: Did you discuss the removal of Mr Moodie?

Dr Geelhoed: No; however, we discussed the problems we were having with him.

Mr WHITELY: Did they include trust accounts?

Dr Geelhoed: No reference to trust accounts was made. Mr Court asked how Mr Moodie compared with Gareth Goodier, because he knew we had also had problems with him. I said that although it was on the public record that we had had many problems with Gareth Goodier, at no time did we question his desire to try to make the hospital better. We knew that he was an advocate for the parents, patients and staff, and that he was working for the hospital. We had a difference of opinion over how we would make it a better hospital, but we never queried his commitment. However, Mr Moodie worked against the hospital the whole time. We asked if he was an advocate for the hospital, and he said no. He denied that he was an advocate.

The CHAIRMAN: Why should he be an advocate for the hospital? He is an advocate for the health system, and his role is to try to improve it. He was not necessarily an advocate for that specific hospital. He was obviously a manager for the hospital system.

Dr Geelhoed: The staff felt he should be an advocate for the hospital.

Mr WHITELY: As an example, he found problems with things such as the Megazone budget, in which $3 million or $4 million was spent. There was also the original problem of $500 000. Do you think it was appropriate for him to be an advocate and defend the hospital's performance when these problems seemed to be obvious?

Dr Geelhoed: That was not discussed with us. We did not talk about the Megazone issue. We were talking about the general workings of the hospital.

Mr WHITELY: I am giving an example of what on the face of it appears to be incompetent practices and problems with the hospital as a result of prior management. Surely Mr Moodie's role was to get value for money and deliver effective health service rather than advocate for the existing structure. Could he have meant that he was not an advocate for the hospital but trying to do an appropriate job for the health service and provide appropriate health service delivery?

Dr Geelhoed: You would have to ask Mr Moodie.

Mr WHITELY: You have made that reference a couple of times. I suggest that that is another interpretation.

Dr Geelhoed: That could be one interpretation.

The CHAIRMAN: From what you have said, it appears that you wanted everything to go your way, and because Mr Moodie was not going to let that happen, you got stuck into him.

Mr DEAN: How long was Gareth Goodier the chief executive officer of Princess Margaret Hospital?

Dr Duncan: At least five years.

Mr DEAN: You have had troubles with CEOs for eight years.

Dr Geelhoed: No, the difference is -

Mr DEAN: You just said there were problems with Gareth Goodier.

Dr Geelhoed: Yes, but this was a quantum difference. We worked with Gareth. He was an effective chief executive in all sorts of ways. We had disagreements over some things, but, generally speaking, we worked with him and thought he was a good administrator.

The CHAIRMAN: Have you finished your statement?

Dr Geelhoed: We are happy to take questions. I would like the committee to read this submission in detail.

The CHAIRMAN: Absolutely. That has been presented and will be incorporated in evidence. We have a pile of witness submissions, and we will go through all those in considering the evidence. We also want to quiz you on some of the areas on which you have made comment. We would like to test those statements.

Dr Geelhoed: I have a short summary. The Clinical Staff Association of PMH acknowledges that the rules under which the trust accounts were set up could be improved, but it does not believe that there is evidence of abuse of trust funds. The system has been restructured to protect the interests of the hospital, children and staff. If Medicare fraud has occurred, it should be seen in the context of staff trying to support the hospital, as is the practice in the eastern States. We cooperated with the series of audits and believe -

Mr HOUSE: Could you repeat that last sentence?

Dr Geelhoed: We cooperated with -

The CHAIRMAN: No; about the eastern States.

Mr HOUSE: You said "if Medicare fraud had occurred". Did I hear you correctly?

Dr Geelhoed: Yes, I said that if it had occurred, it should be seen in the context of staff trying to support their hospital, as is the practice in the eastern States.

The CHAIRMAN: Fraud is fraud is fraud is fraud. If it is fraud; it is fraud.

Dr Geelhoed: I cannot judge that. The practice of cost-shifting is a huge part of the health service in Western Australia and Australia.

The CHAIRMAN: Cost-shifting is one thing; fraud is another.

Dr Baker: I think "fraud" is the incorrect word. He should have said "cost-shifting".

The CHAIRMAN: Let us get this clear, because if it is fraud, it is fraud. There is no defence for fraud.

Dr Geelhoed: I agree.

Dr Baker: It is cost-shifting.

The CHAIRMAN: Let us see if it is cost-shifting.

Mr HOUSE: I was under the impression that you were making an excuse for fraud. You are now saying that you were not. However, that was the way you said it.

Dr Geelhoed: What I am saying -

Mr HOUSE: Do not get impatient with me.

Dr Geelhoed: I am not impatient with you.

Mr HOUSE: You are here to give evidence, and I am here to listen to it. I want to be sure of what you said. I think you were excusing fraud. I want you to give me an undertaking that that is not the case.

Dr Geelhoed: I do not think any fraud has occurred at Princess Margaret Hospital, if that is what you are asking me.

Mr HOUSE: That is what I am asking you.

Mr DEAN: Let us look at the specific example of the diabetes outreach program. This came to our notice about two months ago. A letter was sent from the director of that particular section of PMH stating that if the Government did not desist from what it was doing - I assume it meant us - the outreach service would have to be curtailed and patients would have to come to Perth to partake of

it. My understanding, although I could be wrong, is that part of that outreach service involves the swiping of Medicare cards to bulk-bill a service that is provided by Princess Margaret. That money is paid to salaried officers and staff and returned to the so-called trust fund. The audit report tabled last week specifically says that that practice should cease and the trust fund closed. To the best of our knowledge, it is still happening. Is that fraud or cost-shifting?

Dr Geelhoed: I do not know the answer to that. I think it is cost-shifting.

The CHAIRMAN: There is a clear example from one of your own doctors. The doctor wrote, in evidence already given to the committee, that he did not want to be part of the practices of his predecessor. Are you telling me that that is not true?

Dr Geelhoed: What is not true?

The CHAIRMAN: The doctor said that the practice adopted by his predecessor was wrong and in contravention of all sorts of policies. We have not tested that evidence, but we will. Are you saying that if that case was fraud, it should not be considered as fraud because it was done for the benefit of somebody else?

Dr Geelhoed: We became aware of that in July. That was brought to my attention.

The CHAIRMAN: In July of which year?

Dr Geelhoed: In 2000. That head of department brought it to my attention. I went through the issue, but I could not work out what was going on and whether it was right. As far as I was concerned, the program was set up with the clear intention to establish a new service using federal funds, as the hospital administration had asked us to do. That service involved diabetic clinics going throughout country Western Australia. I understood that the doctor involved was not working for the hospital when he was operating the service; and that the bulk-billing funded the service. I was not sure. I thought that if there were any questions about that, they should be raised. I subsequently raised the issue with Paul Carman, the head of the clinical care unit, and suggested that we should let Mr Michael Moodie, the chief executive, know about it. It had come to my attention. Paul got in touch with Mr Michael Moodie on 17 July. I said that should be documented. My letter to him states -

> Dear Paul
>
> I am writing to you to confirm our recent conversations regarding diabetic outpatient clinics.

The CHAIRMAN: It was not about the diabetic clinic. It was another allegation.

Dr Geelhoed: Was it?

The CHAIRMAN: Yes.

Dr Geelhoed: The letter continued -

> Recently, Dr Tim Jones brought to my attention concerns he had regarding the running of those clinics over a number of years. Specifically he raised concerns regarding the different ways in which monies raised in these privatised clinics were handled. I believe, after our recent conversation you informed the Chief Executive, Mr Michael Moodie, of these concerns but were informed by him that the manner in which these clinics were run and their relationship to trust funds, was before the Metropolitan Health Services Board and as such he felt no further action need be taken at this time.

The CHAIRMAN: In the evidence you previously gave to the committee, you said that you did not know anything about problems with trust funds until 30 September 2000. I wrote that down when you said it. However, this letter was written in July. Reports go back to 1996 and 1998. You said that you knew nothing about problems with trust funds, yet now you have said that you knew in July.

Dr Geelhoed: No. What I am saying is that audits had been done for many years and were all okay.

The CHAIRMAN: No, they were not okay. They were not okay in 1996.

Dr Geelhoed: We were not aware of that. No-one brought that to our attention.

The CHAIRMAN: You just said that you knew in July. However, you said a minute ago that you did not know until September.

Dr Geelhoed: No. What I am saying is that there were subsequent allegations about massive rorts, frauds and all the rest of it. One example came to my attention then. We brought that instantly to the attention of the chief executive. That was not in the context of thinking that there was a huge problem at Princess Margaret Hospital for Children. As soon as we thought there was one problem, we let him know.

The CHAIRMAN: Do you find it strange that a member of the audit committee would tell Michael Moodie that they should destroy the evidence? Do you think that is decent conduct for people defending a system that you are telling me is -

Dr Geelhoed: That is not for me to comment on. You should be asking those people.

The CHAIRMAN: We will. You are sitting there and telling me that there are no problems with the trust funds. I am putting to you that if that sort of conduct occurred, there must be a problem.

Dr Geelhoed: We had no idea. No-one, at any stage, said that to us. Up until Mr Moodie left, we had no idea that there were allegations of gross illegality, rorts or problems like that. We thought the trust accounts were fine. They had been audited in the past. We had been given unofficial feedback from the Metropolitan Health Service Board that there was no problem with the trust funds. That is what I am saying. There was no reason to think -

The CHAIRMAN: Is that why there was no problem when they set up a special audit committee? It asked for further information, there were further reports and there was no problem?

Dr Geelhoed: We were not aware of that.

Dr Baker: There are two issues. The testimony of our former chief executive implied that doctors were benefiting personally and were rorting trust accounts at PMH. We are not doing that. There are issues of bulk-billing, double-dipping and cost-shifting in trust accounts but that, to my way of thinking, is a different issue than the issue of us, as individuals, personally using the proceeds of trust accounts to take trips overseas etc, as Mr Moodie implied. That is what I am here to speak about. We acknowledge that we were aware of the privatisation of clinics. Cost-shifting is practised throughout Australia. That system was set up by the Health Department and by previous administrators over the years. We complied with that, as we knew that the money went to the children and not to us.

Mr HOUSE: That is true, but you have just spent an hour and a quarter giving us a diatribe about why you do not like Mr Moodie. You have every opportunity to talk about what you are here to talk about. I welcome your evidence to this committee so that we can understand what you want to say. I would like to hear exactly what you want to tell us about.

Dr Geelhoed: If you want to ask us about the trust accounts, go right ahead.

The CHAIRMAN: That is what we are here for. This committee is looking at trust funds. The current structure of the funds means that they are not actually trust funds, but funds of the hospital. You are being exposed as much as the hospital and the system because there are no safeguards or processes. No-one knows where the hell they are. For the chief executive of the system not to know about the problems or the protocols is a problem in itself. You should be defending the setting up of protocols. It is interesting that all these new guidelines occurred a month after the committee started its investigation.

Dr Geelhoed: No.

Dr Duncan: That is a generalisation. As you know, there are hundreds or thousands of trust funds across the system. Many do not have anything to do with doctors. Some of the biggest funds have proper constitutions, trust deeds and minuted meetings. The biggest fund at Princess Margaret Hospital is the full-time clinical staff education fund, which holds in the order of $800 000. It has functioned in the way you have described for many years.

The CHAIRMAN: That is the way trust funds must be set up, so that accusations are not made about doctors take money out of the trust funds to pay for trips overseas. That is happening because of the way the system was set up and structured. Ninety-five per cent of doctors do a good job. There will always be an element in every profession who might not do the right thing. We understand that and we are not here to bang doctors. That is not our role. We want that to be very clear. We want to make sure that processes are in place to protect doctors and the system. They are not at the moment; the system is in a shambles. That is bad not only for doctors, but also for the hospital and the health system. You made the comment that it was not the trust funds that brought Michael Moodie before us. Why did the previous Commissioner of Health indicate that the problem was not with his management style but with the trust funds and the report at King Edward Memorial Hospital for Women? You say it was not.

Dr Geelhoed: It was not.

The CHAIRMAN: The acting commissioner made the same comments; that he did not think that it had anything to do with management style, but with the trust funds at PMH and the report at King Edward. You are saying that is not true.

Dr Geelhoed: Sorry, you were saying the commissioner. The ex-commissioner said -

The CHAIRMAN: The ex-commissioner, Alan Bansemer.

Dr Geelhoed: From reading his testimony, I thought that he said that doctors were objecting to Michael Moodie's management style.

The CHAIRMAN: In the end his opinion was that his management style had nothing to do with it; the problem was with the trust funds and the report. Did members gain that impression from his submission?

Mr HOUSE: David, you started to tell us about the differentiation. Can you please continue.

Dr Baker: Between? With the management style?

Dr Duncan: Whether there were problems with the way trust funds were being used or with the way the moneys were originating from those funds. I will provide a bit of history about privatised outpatient clinics. I was, if not chairman of the clinical association, secretary at that time.

Mr DEAN: What are privatised outpatient clinics? Define that for us.

Dr Duncan: In the early 1990s, money was tight in the hospital system. It has been for a long time. In the early 1990s, I think it was about 1992, the then medical director, David Formby, essentially instructed doctors to privatise their outpatient clinics. In other words, he wanted the doctors to make them private clinics in which patients would be bulk-billed and the cost would be shifted to the Commonwealth.

Mr DEAN: Were they on the premises at PMH?

Dr Duncan: Yes, it was going on throughout Australia, but this was particularly with doctors at Princess Margaret Hospital.

Mr DEAN: Were they using facilities at the hospital? Were they paying rent for those rooms?

Dr Duncan: I am not sure whether they were paying rent. At that time the doctors expressed considerable concern about the fact that rent should be paid and that there should be proper trust

deeds etc. I do not believe that any of those things were properly put in place. Doctors who felt uncomfortable with the arrangement gradually dropped out of the system. Some continued. The diabetic clinic, sleep clinic and one or two others continued. The doctors were essentially told that if they did not raise money in that way - the way money was being raised in all other States - the hospital would not fund their secretaries or equipment. In other words, they were told that if they wanted to keep their departments running, they had to go out and generate money through privatised outpatient clinics.

Mr DEAN: That money was used to pay nurses and secretaries and to buy equipment?

Dr Duncan: Mainly for staff.

Mr DEAN: Were not those staff paid by PMH?

Dr Duncan: It went into those funds and then from those funds to pay secretaries.

Mr DEAN: Are you saying that there was internal remission from that account?

Dr Duncan: Staff did not feel comfortable with it, but -

Mr DEAN: They should not have done.

Dr Geelhoed: There are two documents here. One concerns privatised clinics and the establishment of a service delivery model at PMH, and the other concerns privatised clinics for adolescent eating disorders. It was seen as a template; it contains clinic times, patient referral to revenue rebates, staff, diagnostic services and how it would be set up, provider numbers, professional liability etc. That was with Dr Andy Cumming.

The CHAIRMAN: This is about setting up clinics. The way it is being done in Victoria and New South Wales was recently discussed in the media. In those States, clinics are set up, patients are treated and bulk-billed, and the revenue goes back to subsidise the health system.

Dr Duncan: This was done without putting good systems in place. That is the problem.

The CHAIRMAN: It is standard. It is being considered in current reports. That is what we have been talking about with the visiting medical practitioner service. We have been looking at the possibility of category 4 or 5 patients being treated in clinics rather than at emergency centres, because the treatment of those patients in emergency departments just clogs up the whole system. It is a way of cost-shifting, but it is not illegal.

Dr Duncan: There was no secret about this activity. The Health Department was well aware of it and in fact wrote a very detailed letter to the hospital in 1995 or 1996 requesting explicit details of all privatised clinics. I am not sure whether the department ever received a response, but it was well aware of the practice.

Dr Geelhoed: David heads up the oncology unit. That unit was used a lot as an example of money coming from North America for research and how that worked. You might perhaps like to talk to him about that.

The CHAIRMAN: We are glad to receive any evidence about how those funds work.

Dr Baker: I will tell you how my trust fund works. I call it a trust fund because that is what the hospital told me to call it, but to me it is a research fund. Into that fund I put my international grant, which I received from the National Institute of Health, which is a key body that reviews grant applications. I, as the principal investigator, received that grant. That is into its third of five years. I have a specific budget for that money. I do not get the grant without applying for it and having a very rigid, specific budget. That money is deposited into the trust account, from which I sign funds. The funds I use are only those that I can spend within my budget.

Mr HOUSE: I am sorry to interrupt you David. That money comes from international sources. Is it given to you as the doctor, or to the hospital?

Dr Baker: It is given to the hospital. I am the principal investigator but it is given to Princess Margaret Hospital.

Mr HOUSE: Is it distributed downwards to other doctors or health professionals?

Dr Baker: It is put into my research account, of which I am the principal trustee and signatory. To all intents and purposes, I sign most of it out.

Mr HOUSE: Is it solely for your use?

The CHAIRMAN: Is that process not also a problem because you are the only signatory to an account?

Dr Baker: I am not the only signatory; two others can sign for it when I am not around. Someone in finance reviews it. I acknowledge that it is a problem and we are changing that system, because I could be seen to benefit from it.

The CHAIRMAN: Exactly, and you will be open to challenge by somebody who might think -

Dr Baker: I agree. That is a problem of process and not of personally trying to fraud or rort the system.

Mr WHITELY: An administrator should be concerned when the process does not have in-built checks. The administrator should say, "Hold on, I do not know whether fraud has occurred, but I am concerned because mechanisms are not in place to identify it". Those mechanisms should be in place to protect people like you who are acting in good faith. That brings me back to a comment Gary made fairly early in his submission that because of the way trust accounts were set up, an application identified the type of revenue and expenditure. That is all well and good, because it gives the purpose of the account, but what about the actual day-to-day authorisation of account expenditure? Is what David just described typical? Do people have total discretion? If that were the case, that is where the problem lies, and that is the area any efficient administrator would address. I am not saying that fraud is occurring, but that it might occur.

Dr Geelhoed: I keep trying to make this point: despite my letter about that particular problem and the chronology of it, we really did not know that there was a concern or problem with trust accounts until after Mr Moodie left. We realised then that it was a hot topic. People were saying that it was all about process and so on. Since then we have worked with our acting chief executive to set up a new system so that everyone will be protected and there can be no finger pointing. That process has being going on over many months. The Western Australian Women and Children's Research Advisory Committee is now up and running. I have its constitution and information about it with me. Even the system before was much more rigorous than it has been portrayed here, in the sense that it has been implied that the doctors had the money and could do what they wanted.

Mr WHITELY: What is to stop that, because in what you have described there is nothing to stop that?

Dr Geelhoed: If they wanted to access money from it, they would have to apply to the finance department of the hospital, which would make out all the cheques. For example, if they wanted to buy equipment or hire staff, or something like that, they would need to have the documentation. What they wanted to do would also have to match up with the purpose of the fund. Obviously they could put in whatever they liked for the purpose of the fund, but, strictly speaking, it would have to be to support staffing, or to provide equipment in the oncology unit, and so on.

Mr WHITELY: Suppose I said it was to attend an education conference, and I put in an application for a Qantas business class air fare to London -

Dr Baker: That would not be approved.

Mr WHITELY: Why?

Dr Baker: Because we only provide a discount air fare, not a business class air fare.

Mr WHITELY: Why could not an economy class air fare be funded without any knowledge about whether it was for an appropriate purpose?

Dr Baker: When I put in an application, I need to have not only a quote for the economy air fare but also the registration documentation that the person will be attending a conference.

Mr WHITELY: What is the consequence of not doing that? Who is going to tell you that you cannot go if you do not do that, because you are the man who is determining whether the money is spent, and you may do that because it is good practice for you, but unless someone is overseeing it -

Dr Geelhoed: You are quite right. This is where there are problems with the old system, and that is what we have now addressed. The point we make, though, is that I do not think there are any examples of any doctor who has literally gone on the flying holiday that was mentioned, or -

Mr WHITELY: Seriously, how would you know?

Dr Geelhoed: In the sense that you would have to put in documentation. If a doctor put in something to say there was a conference and it was fictitious and he had lied and so on, I guess it would be possible, but we do not know and no examples were found that I am aware of that that was going on. Essentially people were regarded as honest professionals who would do the right thing. We acknowledge that there were problems with the system, but we have now addressed them.

The CHAIRMAN: Who has addressed them?

Dr Geelhoed: A committee has been set up to try to address all these points so that the money is held at arm's length from the people who can access the money. People are still raising the money, through all the ways we have mentioned, to go into these funds, but now to access them there is much more rigorous documentation. We believe it achieves exactly the same as before, only now it will be documented much better to show that it is at arm's length.

Mr HOUSE: Does each trust account have a set of guidelines? For the money that you get to go overseas, to get back to that example, is there a set of guidelines by which you apply and that money is provided?

Dr Baker: A strict budget.

Mr HOUSE: Is there an auditing system whereby at the end of the year you have to account back to the people who provide that money to you?

Dr Baker: Yes. Each year I have to give a report of my expenditure, and clarification that the funds have been expended on those items.

Mr HOUSE: Is that audited by anybody?

Dr Baker: It is audited by NIH. It is not audited within the hospital, but it will be under the new system.

Mr HOUSE: The new system will pick up an audit for that?

Dr Baker: There will be two levels of checking - one within the hospital on a six-monthly or a yearly-basis, and one for overseas.

The CHAIRMAN: So why would you not set up a proper trust structure?

Dr Baker: We have.

The CHAIRMAN: A legal, formal structure?

Dr Baker: We are told it is. It is the Western Australian Research and Advisory Committee. It has a formal structure. We have to put in a submission for any funds that we spend out of that, and the Women and Children's Research Advisory Committee will then review that submission and approve the expenditure of those funds.

Mr HOUSE: Would you be prepared to table an example of that?

Dr Geelhoed: Of the new system?

The CHAIRMAN: Yes.

Mr HOUSE: I would like to look at the old system too to see how they compare.

Dr Geelhoed: This is a draft constitution, going some months back, of the new committee and how it attempts to address the problems.

The CHAIRMAN: Do you realise there are 1 000 accounts? We do not need 1 000 trust accounts.

Dr Geelhoed: There are 250 at PMH, but they are being reduced as well.

The CHAIRMAN: If we had one structure -

Dr Baker: There will be two committees. The Women and Children's Research Advisory Committee will oversee expenditure on research trust accounts - the whole legal term that they are going to use now; and we will give you a submission of that. All the other funds, such as community donations that are not specifically a grant or a research application but are moneys that have been given to oncology from the community, will go into another general research or general purpose fund, for which we will have to apply to a similar committee to WACRAC that is in the process of being set up.

The CHAIRMAN: How come you have been able to do this in the space of months when you have not been able to do it for four years?

Dr Geelhoed: Because it was never perceived as a problem and it was never raised with us as a problem.

The CHAIRMAN: It has been in the media since 1998.

Dr Baker: You would need to ask Michael Moodie about that.

Dr Duncan: Not all trust funds are the same. There has been a fair bit of focus in the past few months on travel. The vast majority of medical travel comes from two large funds in Princess Margaret Hospital that together hold $1 million. The travel that is related to the specific requirements of the children's cancer study group is just a minute part of hospital medical travel. I have been at the hospital for 15 years. This $1 million has always been managed by a committee, with guidelines and proper reporting. The committee does not have a majority of doctors on it. It is at arm's length from the clinical staff. Doctors have to submit full details about registration fees, airline fares and living allowance fees, justify their attendance, and make a full report back, which is then published in the hospital.

Mr HOUSE: That is exactly what we want to hear.

Dr Duncan: That was going on before I arrived.

The CHAIRMAN: Is that a trust fund? Is that money that has been raised -

Dr Duncan: That money comes from the excess private practice earnings of full-timers like me and donations from the sessional doctors. Doctors like me who are full-time in the hospital have a limited right of private practice - 25 per cent. If I earn excess moneys, that has to be deposited in a trust fund. That is in our industrial agreement.

The CHAIRMAN: Excess funds of what?

Dr Duncan: Over and above what I am allowed to retain for myself.

The CHAIRMAN: Over the 25 per cent?

Dr Duncan: Yes. That goes into a full-time travel fund. Since I have been there, it has built up from $180 000 to $800 000, and doctors very carefully restrict the amount of travel they have to

make sure that fund remains viable. They take the rest of their entitlements under their award and always have done. That is all documented.

Dr Baker: None of those funds have come from cost-shifting or bulk-billing.

Mr HOUSE: The question was not about travel. I think travel is very necessary to improve your skills, and I think most people would agree with that. The question was about the process and accountability. The question arose because we were given evidence a couple of weeks ago that a cheque for $60 000 that had been raised by the Friends of Princess Margaret, I think -

Dr Geelhoed: The ladies auxiliary -

Mr HOUSE: - had gone missing, and obviously there was not a process in place that picked that up until someone asked where had the money gone. What we are interested in is the process, not what you actually spend the money on. That is not the issue. That is for your peer groups and others to determine, not us.

Dr Duncan: There was a bit of a focus on travel; that is why I mentioned it. The processes for managing the $1 million for medical education are very well managed and always have been.

Mr HOUSE: There is a story about politicians' travel in the Press every week, if you are worried about travel.

The CHAIRMAN: That fund that you are talking about -

Dr Duncan: There are two funds - one for full-time doctors that is worth about $800 000, and one for sessional doctors that is purely money that is donated by the doctors themselves.

The CHAIRMAN: What is the purpose of donating the money to the fund?

Dr Duncan: They make a donation of $300 a year and get a tax deduction. Many of them never draw on the fund. What has happened is that the sessional doctors have built up a fund that can be used for education processes or other educational needs of the hospital. There is $200 000 in that fund.

The CHAIRMAN: Who has access to the $800 000 that you have talked about? Is it only the doctors like you?

Dr Duncan: Full-time clinical staff. However, the money is also used for other purposes. It has been used to buy computing equipment for the medical illustration department, and that sort of thing. We also fund pathology technicians so that they can travel. We give money to the junior doctors so that they can attend scientific conferences.

Dr Geelhoed: And some doctors who cannot contribute to it, depending on where they work and so on, have access to it as well just to show that the people who are putting in the money are not the only ones who can benefit from it.

Dr Duncan: It has a constitution, proper accounts that are considered at every meeting of that body, and very rigorous reporting.

Mr DEAN: Is that a full discretionary trust in the legal sense?

Dr Duncan: It is an account, with a constitution, a committee of five, and two signatories that have to sign off on every cheque. It looks ridgy-didge to me.

The CHAIRMAN: That is what we are chasing - accountability and process - so that you do not have the problem of being exposed to accusations of all sorts of things.

Dr Geelhoed: That is exactly it, because to just a casual listener or someone reading the paper, they have been talking about flying lessons, and doctors going on holidays. I do not think there are any examples of that at all. We are happy to say that under the system before, perhaps it could have been tighter; therefore, there is potential for that sort of thing. However, none of those examples as we know from looking at the reports actually exist. The flying lessons -

The CHAIRMAN: That was part of the Ernst and Young report, and we will be dragging them in here -

Mr HOUSE: The bloke who gave that evidence tried to justify it, so I think the flying lessons were documented -

The CHAIRMAN: We will test some of that when we get Ernst and Young in here and go through some of the findings in its report; and obviously at a later date the people who are going to be under scrutiny will have the chance to respond.

Dr Geelhoed: What we are trying to get across from the point of view of the trust funds is that from what you tell us now and from what we read, we can say sure, the system could have been better. It was something that was set up by the hospital, where it said these are the trust accounts and this is how it works; and we just assumed that it knew what it was doing. We did that for years. There were no concerns about the trust accounts. We knew there was some talk about the need to tighten them up and so on, but there were no concerns about them until after the chief executive had left. One or two little things would come up, but again we thought that was just one incident. That is what I am trying to get across. It was just not an issue in the hospital.

The CHAIRMAN: It seems very coincidental that his departure was at the same time as all this pressure.

Mr WHITELY: It was a bit more than that, because the commissioner was aware of it also.

The CHAIRMAN: It was not just hearsay.

Mr WHITELY: We have talked about accountability within the trust funds, but there is a bigger picture issue here; for example, the Megazone project. The budget we were told was \$500 000 to start with, but it ended up blowing out to \$3 million or \$4 million. That may not have been inappropriate or fraud on anyone's part, but it paints a picture of a lack of control and overview of the intent of the funds. That was one of the problems that was identified by Michael Moodie in his evidence. In other words, this money is raised for specific purposes, and it is being wasted. What was supposed to be a \$500 000 project blows out by 700 per cent. Can you tell us what you know about those sorts of trust funds and what controls there were in those funds?

Dr Duncan: Whether Megazone was a waste of money is debateable, but it is an extraordinary facility. However, it is fair to say that when Dr Goodier was going down the path of developing the Magazone, it did not have the support of the clinical staff. Money was tight in public hospitals and most, if not all, of the doctors felt that the moneys could have been better used for issues related to direct patient care.

Mr WHITELY: Michael Moodie said there were worn out beds and broken chairs in the wards -

Dr Duncan: That might have been an exaggeration, but the amount of money spent on the Megazone was considered by the doctors to be inappropriate. However, Gareth liked institutions to look fantastic. He spent a lot of energy on quality programs, etc, to make institutions look good, and on things like the Megazone, which are a statement for the hospital even if they do not impact directly on patient care.

The CHAIRMAN: What about the fact that the administrator did not have access to control of location etc? What about the fact that Michael Moodie, as the chief executive officer, could not get access to plans?

Dr Duncan: That has nothing to do with the clinical staff.

The CHAIRMAN: I understand that, but these are the problems that you are talking about.

Dr Geelhoed: This is why I said that we thought Gareth was a good chief executive in many ways, but we certainly had problems with him over the Megazone. That is what I was trying to say before. He sold it by saying that a lot of people who wanted to donate money to the hospital wanted

to make a positive statement for the kids as opposed to supporting the Government treating them; they wanted to give something to the kids. A lot of donors would give money on that basis. We argued that the money that was raised should go into services. To be fair to Gareth, we looked at it from the point of view that there is never a good time to build an Eiffel Tower or a belltower, which were thought to be a terrible waste of money. One can judge those things only five years down the track, because money can always be found to put into services. We thought that he had a different job and he must have an overview of the hospital and look at it in five or 10 years, and maybe that would be a good thing. To some extent he has been proved correct in that we now think it is a success. I looked at the figures the other day, and about 3 000 kids have gone through it in the past three months. It is generally considered to be working well. The medical staff use it for meetings and so on. We ignored it for a long time and pretended it was not there. The history of the Megazone will be written over time. Generally speaking, we now feel that it is an asset to the hospital. As to the money and the funds, that was not our responsibility; we had no input into that.

Mr WHITELY: If a hospital administrator sees that an unknown amount of money has disappeared into what is believed by most people to be a frivolous project, that person would also see that there are problems with a lack of control and accountability in the individual accounts. Would it not be reasonable to pursue the whole issue of accounts and concentrate not on those that are running well but on those that have problems?

Dr Geelhoed: What you are saying is quite true. I do not disagree with you. Mr Moodie raised the trust accounts with us, but it was more along the lines that the Metropolitan Health Service Board was going to take all our trust account money. That got our attention, as you can imagine. Then he had a meeting. It goes to personal style, because Bill Beresford -

Mr WHITELY: Did Andrew Weeks not confirm that that would happen? He might have dressed it up a little, but did he not say that that might be a logical consequence?

Dr Geelhoed: When we told him directly that we were told that the board wanted to take our money, he said that that had never been on their mind; he just denied it.

Mr WHITELY: Earlier in your evidence you said that he said there was a series of processes and if this outcome did not arise at the end of the processes, the board would take the money from you.

Dr Geelhoed: As told to us by Mr Moodie?

Mr WHITELY: No; I thought you said in your evidence that Mr Weeks said that.

Dr Geelhoed: No, I did not -

The CHAIRMAN: I will read you some comments from Mr Bansemer. He basically said that the confrontational approach was difficult because he did not speak to many new clinicians, but that a number of senior clinicians were supporting what he was trying to do at Princess Margaret Hospital for Children and King Edward Memorial Hospital, and a group of them were in staunch opposition. Bansemer also made the comment he did not believe it was anything to do with style; he thought it was because the doctors got to a point at which they believed he was not on their side and he was making life uncomfortable for them.

Dr Geelhoed: I have read only part of it. In the part I saw I thought he said that there was a problem with management.

You said that some doctors did and some doctors did not. After we saw the Premier, we told him that we had major problems at Princess Margaret Hospital. The next day or the day after that, Mr Court was reported in the paper as saying that it was just a few disgruntled doctors who were trying to discredit their institution. We then put a petition in the common room saying something as simple as, “We, the doctors of PMH, state that we have problems with management and we would not discredit our institution.” Within about 48 hours, 80 doctors signed that petition saying that we

had problems with management. One or two people may have supported him. At the start he set up things for research and so on. He was trying to do things. It was a problem of communication.

I return to the comment that Mr Whitely made about it being reasonable. It would have been reasonable, but he came to us and said that the board was going to take our funds and that he would put them into a central fund and have control. Maybe he meant something different, but all he did was inflame everyone. It sounded like he was going to centralise all the money and we would have no input into it. Yet these were the people who raised the money, and they felt that they should be able to raise funds for research within certain guidelines. However, the trust funds then dropped off the radar screen. It was not raised again until after he left. It was not like he was engaging with us and saying that we had to solve the problem.

Dr Baker: Bearing in mind the background of previous administrators creating megazones etc without our input or support, you can see that we had an inherent distrust of central control.

The CHAIRMAN: Whatever you do in the end, if you are trying to change the system, it will be difficult. Whatever changes are attempted, you seem to think that nobody can change things.

Dr Geelhoed: As soon as we became aware that that was the problem, we set up this committee with Bill Beresford. If that is what Mr Moodie was trying to do, he certainly did not communicate it to us and he did not sit down with us to try to work through the process.

Dr Duncan: You referred to support for Michael Moodie from clinicians. “Clinicians” is a very broad term. These days it often includes not only doctors, but also nursing staff and allied health groups. Mr Moodie had a small core of support from a couple of doctors, some senior nurses - although not the majority - and a couple of allied health groups. Some of it was because they were owing to him. Secondly, checks and balance -

The CHAIRMAN: Your saying “owing to him” insinuates that there was some deal. Is there any evidence to support that? You cannot make the comment that only people who owed him supported him. I could say to you that the only reason you opposed it was that you knew there were rorts and you did not want them checked.

Dr Baker: Point taken.

Dr Geelhoed: At the last meeting we had, which Mr Day and Mr McCall attended, there was some support from some of the nursing directors. Just prior to that, we were told that those nursing groups that were on three-year contracts were given permanency and pay rises. That may be coincidence, but it was taken note of.

Dr Duncan: A big pay rise.

Dr Geelhoed: Mr Moodie also spoke about the minutes of the meeting at which he said there was a vote of 12 to three in support of him. As far as I know, there were no minutes of that meeting. We have asked the hospital and there were no official minutes. My recollection of that meeting is that we were told at very short notice that Mr Day and Mr McCall would be attending. We turned up and Mr McCall said clearly that they were there to talk about the chief executive and he threw open the meeting. Obviously that was a very difficult time for everybody. We felt strongly about this, but we were talking about a man’s future. Not many people spoke up. Finally, they asked me directly what the Clinical Staff Association thought. I said that the view of the Clinical Staff Association was quite clear: we felt that we had had major problems with Mr Moodie over a long period. We had been through two separate attempts - that is what I was trying to laboriously go through - to engage with him to get the hospital back on track, and both attempts had been sabotaged by his inability to do what he said he would do and to cooperate. I said that we felt we had done this in good faith for a long time through the board, and we could not work with him any longer. Two other doctors spoke up in support of that. Dr Paul Carman, the respected director of the paediatric clinical care unit -one of the biggest units in the hospital - documented problems dating back 18 months. There was support for some positive things that Mr Moodie had done.

However, not much was said. Mr McCall then asked Mr Moodie to leave the room. Then there was a lot of talk about there being major problems at the hospital. It was a very unhappy place and there had been a major breakdown in communication over 18 months in the way the hospital worked. This was talked about around the table. No vote was ever taken. However, the defining moment was when Mr McCall said something like, "I have come here today to find out about the chief executive. Some people are saying that they prefer he was not here at this stage and some are saying give him another month because of the process in place. However, what I am not hearing is any strong support for the chief executive. Is that right?" He more or less invited people who supported him to speak up, but nobody spoke.

The CHAIRMAN: What does that prove? That proves he has upset a few doctors. So what?

Dr Geelhoed: I am saying that no-one was arguing for Mr Moodie as a good chief executive and no-one wanted him to stay on. He said that there was a 12 to three vote in support of him. I am saying that that just did not happen.

The CHAIRMAN: We have spent a helluva lot of time on Mr Moodie. Mr Moodie is out of the equation and his sacking is another problem that we must look at. Our problem is trust funds. The trust funds do not go away and do not get any better by you bucketing Michael Moodie. You agree that there are problems with the process and it needs to be improved.

Dr Geelhoed: We think it has improved.

The CHAIRMAN: We have not seen that evidence yet, but we assume that it has improved. Did you know nothing about these trust funds being a problem before September 2000?

Dr Geelhoed: We knew there had been some audits in the past and that they had been okay. We heard unofficially that there was nothing in it other than that they needed a bit of accounting or something like that. It was not an issue.

Dr Duncan: Mr Whitely was talking about checks and balances in the system. A major change of which you should be aware was that until the hospital boards were disbanded, each hospital board had a finance committee, which was dominated essentially by business people. Most of the finance committee's time was spent scrutinising trust funds. It was the biggest part of every finance committee meeting. That was a major check and balance that went out of the system with the scrapping of hospital boards. There was no longer a finance committee meeting at hospitals. It was a huge loss.

Dr Geelhoed: That has been re-established and there is also an audit committee in the hospital.

The CHAIRMAN: We understand that, but we still must look at the process to make sure. We heard at the last meeting that consolidated funds were put into the trust funds.

Mr HOUSE: Are you aware of any abuse of trust funds at all?

Dr Geelhoed: No.

Dr Duncan: I am certainly not.

Dr Baker: When you say abuse, do you mean cost-shifting?

Mr HOUSE: No, but what I would call -

Dr Baker: Using the money for personal gain, tax evasion and that sort of thing.

Dr Geelhoed: We instantly got in with touch with the chief executive about the one that was brought to my attention. That still needs to be resolved. I do not know the rights and wrongs of that, but I knew there was enough there to raise it. That is what I did; I thought it was appropriate. Other than that, there is nothing.

Mr HOUSE: There is one.

Dr Geelhoed: That is the one that you mentioned.

Mr HOUSE: You all just shook your heads and said no, but then Gary said yes.

Dr Geelhoed: I am saying that a question was raised over that one. I am not sure what the answer is.

Mr HOUSE: There is one with some uncertainty.

Dr Baker: I am a bit confused too. Are you talking about the diabetic country -

Dr Geelhoed: Yes.

Dr Baker: That is what I am trying to get at.

Dr Geelhoed: Is that what you are talking about?

Mr HOUSE: No ; that is not what I was talking about.

Dr Geelhoed: You mean out-and-out rorts, doctors pocketing the money, going on the trip -

The CHAIRMAN: Double-dipping or triple-dipping.

Dr Geelhoed: The answer to that is no.

Mr HOUSE: Is the system under which trust funds are managed in this State - you have given the example of the finance committees of hospital boards going through a process - similar to that in other States? Is there is any major difference in other States?

Dr Geelhoed: I understand that it is the same, but I do not have intimate knowledge of it. Colleagues in those States seem to operate on something similar.

Dr Duncan: I ran the intensive care unit in the children's hospital in Melbourne. I spent 15 years at the hospital. Before I left, I had a very large departmental fund - I did not call it a trust fund - of the order of $600 000 and there were no checks and balances.

The CHAIRMAN: They also have the same problems, and they have tightened the guidelines.

Dr Duncan: That is a good thing.

Mr HOUSE: Would it be fair to say that there would be a bit of peer pressure and knowledge if things were going wrong? If somebody was stepping out of line, would you or would you not know about it?

Dr Baker: As Martin said, it is possible that we might not know because the checks and balances in the old system were not as tight as they should have been. I would like to think that my fellow colleagues would not do that.

Dr Duncan: Are they not questions that should be addressed to the finance department?

The CHAIRMAN: If we uncover examples of problems, would your association totally support our making sure that those loopholes were closed and people brought to account?

Dr Duncan: The committee is doing us a favour.

The CHAIRMAN: We are doing the whole profession a favour.

Dr Baker: I watch my research account like a hawk. Most of the problems I have had with my account are with moneys coming out of it that I have no knowledge of, and are not authorised transactions.

Mr HOUSE: Who takes that money out?

Dr Baker: It is more by accident rather than fraudulent and knowledgable design. An example would be that of the finance department signing off $12 000 out of my account for the leasing of a piece of equipment in another department. It happens because they have not known the correct cost code to use and have signed the cheque or authorisation for the money to come out.

Mr DEAN: That is the problem with pseudo-trust accounts.

Dr Baker: Yes. I have personal experience of that happening continually and that is why I watch my research account very rigorously.

The CHAIRMAN: You may do that but how many others do?

Dr Baker: I do not know. I am more obsessed about it than most.

Dr Geelhoed: After Mr Moodie left Princess Margaret Hospital for Children and King Edward Memorial Hospital for Women on the Friday, the headline came out on Saturday that there had been rorts within the system. That was the first time a lot of us knew that a major issue was hanging over our heads. We published an article a few days later that summarised what we then felt. The article in *The West Australian* on 4 October stated -

> CHRONIC underfunding of public hospitals and the health funding problems experienced by both State and Federal governments led to many hospitals around Australia having privatised outpatient clinics to gain access to Federal funds and thereby provide a better service.
>
> The Royal Children's Hospital in Melbourne has openly operated on this model for many years.
>
> Some years ago the doctors at Princess Margaret Hospital, against a background of chronic underfunding and underdirection from the administration of the time, began such an arrangement on a more limited scale.

It then goes on to say -

> This arrangement did not benefit the doctors involved as all funds were paid to the hospital and held in identified trust funds. These funds have been used to pay for ancilliary staff and equipment.
>
> This has been the situation for many years. Legal advice was sought to ensure the arrangement was legal and doctors were not exposing themselves to risk. Some staff at PMH continued with this arrangement though the question of risk had never been fully resolved.
>
> When the Health Department recognised the problem and provided funds it enabled most of these clinics to cease functioning. The few clinics still operating used models similar to those in other Perth teaching hospitals.
>
> AN audit of trust accounts at PMH/KEMH has been carried out with the full knowledge, cooperation and blessing of the clinical staff in recent times and has been on the desk of the Metropolitan Health Services Board for many months.
>
> The audit has not been an issue for medical staff as it was assumed it was concentrating on how the trust funds were used to provide services and not how money was obtained as this had been standard practice here and elsewhere in Australia for many years.
>
> If, as alleged, money obtained through these clinics has been inappropriately placed in private accounts then those concerned should be fully investigated. As we have not seen the report, it is hard to respond to specific claims.
>
> The fact that the trust funds were being audited was not a concern and in no way influenced medical staff in their opposition to . . . Michael Moodie.

In that article we state very clearly -

The CHAIRMAN: That is only one aspect of the trust fund and it may not even be the point we are making.

Dr Geelhoed: If anything is wrong, by all means, call it wrong and investigate it. If someone has done something wrong, we will support the committee in its investigation.

Mr HOUSE: This bloke has obviously got under your skin. Why would he make these accusations? You have given testament to this committee in good faith and from the evidence we have taken from doctors, we have a lot of respect for the profession. We would be as disturbed as you would be if something were wrong. However, why has this one bloke tried to say these things if there is no justification or evidence? He will be found out if he is wrong.

The CHAIRMAN: We are focusing on issues other than his evidence. He was only one witness and his evidence was only a general view of the accounts. Let us wait a while before discussing this matter because once Ernst and Young give evidence with regard to the auditing of the accounts, you might be defending a different position.

Dr Geelhoed: I accept that.

The CHAIRMAN: I understand you are trying to highlight the inadequacies of the management by one person. However, we are inquiring about the trust fund and there are three damaging reports. We must highlight some of that evidence and you may be back here defending another issue.

Dr Geelhoed: In answer to your question, can that evidence be taken in camera?

Mr HOUSE: That is a consideration for the committee as a whole.

The CHAIRMAN: We cannot do it right now. A written submission must be made asking that the evidence be taken in camera and we will then consider that request.

Dr Geelhoed: It is because of qualities unique to Mr Moodie.

Dr Duncan: Would all doctors notice if things were happening to their trust accounts that should not be happening? I suspect that most would not be aware of these things. Doctors are not particularly good businessmen.

Mr HOUSE: I think Christo Moll has proved that.

Dr Duncan: Some months ago I discovered that a change had been made to the allocation of interest to trust accounts of the hospital without the knowledge of the trustees or signatories to those accounts. Does the committee know who did that? Michael Moodie signed-off those changes in August 2000. It unilaterally changed the amount of the interest going to David's account, my account -

Mr DEAN: But he is the administrator; that is the point. It is his role to be doing that.

Dr Duncan: Can the amount of money that a trust account is earning be changed?

Mr DEAN: But they are not trust accounts.

The CHAIRMAN: Those funds are not trust funds. That is the point that has been made over and over again. They are only funds of the hospital. Therefore, any interest earned goes back to the hospital, not necessarily to the trust fund. It is a decision of the administrator as to where that money goes. Those funds belong to the hospital - no disrespect to you learned people who think the funds belong to you.

Dr Geelhoed: I agree with what you are saying. However, this was done unilaterally and with no consultation. Although we accept that it is money belonging to the hospital, people spend a lot of time - often their own time - and effort raising this money and feel that they should have some say in the matter.

The CHAIRMAN: If doctors want control of funds, they need to be separate to the hospital and in a trust fund that they have control over. As it is set up, the administrator can make the decisions that he feels are in the best interests of the hospital. If I were the hospital administrator, I would

think it quite smart to get interest from a $8 million fund and put it back into the hospital fund to the benefit of the hospital.

Dr Baker: I will address that issue as it pertains to my research account. I spent 10 to 15 years building up my research account from nothing. I had the specific vision of creating a fund, equivalent to that of an endowment fund, to have a capital base from which interest will drive research in the hospital, which directly benefits the children. This research will not go on unless this is done because the health budget is in such a poor state with no extra money for excellence in research; funding only exists for mediocrity. If we want to provide excellence for our children, we must do it through this mechanism. That is what I have done for the past 10 or 15 years. In the stroke of a pen, my chief executive - without talking to me or trying to understanding what I have been trying to achieve for the children or the hospital - has taken away that interest base. My research program, which is run-on that interest-base, has disappeared overnight.

Mr DEAN: That is very short-sighted of you if you did not have an incorporated body or a proper trust with a set law, trustees and beneficiaries, etc. Quite frankly, you have got yourself to blame.

Dr Baker: I acknowledge that, but I am not a businessman; I am a doctor. I am guided by my finance department who advised me that this is what I should do over the years. I did it in good faith.

Mr DEAN: There is a saying where I come from that one is born every day.

Mr HOUSE: You have made a fair point. It goes to the very heart of the problem and if this committee is to be positive and recommend positive outcomes - that is our desire - then that is exactly what we need to hear so that recommendations can be put in place by administrators. At the end of the day, government controls those administrators. That is the deal and we can help you with regard to that.

Dr Baker: And tighten up the process so that you are not only doing the right thing, but seen to be doing the right thing. Statements by our former chief executive officer in forums like this have created attention that we should not have had.

The CHAIRMAN: Yes. However, let us look at the processes that are in place. They are shoddy and the comment was that the only way we can remedy it is to have a shock to the system, which Michael Moodie was trying to do and met a lot of opposition in the process.

Dr Baker: Our position to Michael on this matter was not related to what he was trying to achieve but the process he used to achieve it.

Dr Geelhoed: He raised the issue about the trust accounts. We had a big meeting in which he talked about centralising the accounts. People were very angry about that because of his manner and the way in which he was doing it. However, there were to be a series of further meetings that he never arranged. We asked him when the next meeting was to discuss this process but he never called one. We knew that audits had occurred but we only found out later that there was an inquiry that involved the Metropolitan Health Service Board. We were oblivious to that -

The CHAIRMAN: Did you have a representative on that board?

The Witnesses: No.

The CHAIRMAN: Did you have a representative on the audit committee?

The Witnesses: No.

Mr HOUSE: Alan said earlier that a group of business people were a subcommittee of the hospital board. To return to the point you made a minute ago, I am aware of a few of those people in the business world and I am very surprised that those people did not advise you differently on how to set up trust funds. There are some good business people involved on hospital boards.

Dr Baker: I talked to the finance clerk and -

Mr HOUSE: What I said was a statement rather than a question.

Dr Duncan: We are considering it on a macro-level rather than the way the individual accounts operate. I suspect that the finance committee believed that it was all in order.

Dr Geelhoed: I spoke to our finance people recently to try to get some sort of overview of the issue as I work in the emergency department and this is not my sort of area. There is an audit of the hospital each year from one group that looked at the trust accounts. Another group was doing the external audits and Ernst and Young were doing the internal audit and looking at different areas at different times. Arthur Andersen was doing -

Mr HOUSE: Every accounting firm in this country has been involved with this hospital.

Dr Geelhoed: All of these people were giving reports and we assumed that it was their job and they were doing it right. If it was not being done correctly, then recommendations would be made.

The CHAIRMAN: Since the first report there were problems.

Dr Geelhoed: Which report was that?

The CHAIRMAN: In 1996, Arthur Andersen's first report showed that there were problems.

Dr Geelhoed: We were not aware of that.

The CHAIRMAN: In 1998 the company obtained further information and now it wants evidence to show that -

Dr Geelhoed: Presumably, the administration at that time must have taken it on board but -

The CHAIRMAN: Nothing was done about it.

Dr Geelhoed: We never knew there was a problem. The clinical people running the trust accounts never knew -

The CHAIRMAN: We are not blaming you. A problem exists that is best addressed by getting the process right and not by blaming the doctors. The doctors are, in their best interest, trying to do the right thing. Apart from one or two of them, the majority of doctors have done the right thing.

Dr Geelhoed: I agree but perhaps another individual could have done this at a level that would not have been so traumatic and not in the public domain. There is no reason for this to have been such a public issue. We were not fighting the issue. We were not even aware of it. It was dumped on us publicly. We were not aware of an issue that needed to be addressed and suddenly, there were audit reports that we only got to read about three weeks ago. We had never seen those reports before then. We have had this issue hanging over us for a year and yet, we never were allowed to see the reports.

Mr WHITELY: Did you respond prior to that? You were not aware of the audit reports or the systematic problems; however, when Michael Moodie began to pursue the issue of the trust accounts, would you characterise your response as being defensive in hindsight? Michael Moodie came along as a new administrator and saw major problems with the individual trust accounts and their accountability mechanisms. He saw a waste on projects such as the Megazone project, and tried to address the problem that may have meant taking some autonomy away from the doctors. Perhaps it was not explained to you correctly, but would you characterise your response as having been a defensive one?

Dr Geelhoed: First, we were clearly told that the Metropolitan Health Service Board wanted to take the money. We were not happy about that as you could imagine. The second issue was that, as Michael explained it, he would centralise all the money himself. Again, it probably gets down to personal style in the sense that Bill Beresford did it and there have been no problems, so we were happy to go along with the process. However, we were told that Michael would control the money and determine where the money would go. We argued that unless we were a part of the process,

why would we raise the money and go through all that if we felt that it was completely at his discretion. It is a matter of personal style, and what you are saying is quite true. Bill Beresford, the acting chief executive, did it very easily.

Mr WHITELY: I am playing devil's advocate here, but what about the argument that he did it after the problem had arisen, whereas Michael Moodie identified the problem -

The CHAIRMAN: And the pressure on you guys in the public sense was to toe the line because if you did not, it was going to happen anyway.

Dr Geelhoed: Sure. People take notice of headlines like that in the paper. However, we were never led to believe that there were huge problems or illegalities. We believed Michael was going to centralise it and we felt that we could not get across to him the nature of trust accounts and how they were being used. He strangled that system by going about it in the wrong way. We were meant to have a series of meetings but they were never held, and in the minutes it states this and that that no further meetings had been planned.

Mr DEAN: A hospital account that is several million dollars in excess of daily requirements is fair game to be reined in by any accountant who is roaming through the Government sector. To me it is logical to have that taken away.

Dr Geelhoed: That would be very short-sighted.

Mr DEAN: I am not talking about short-sightedness. I am saying that there is $8 million that is doing nothing.

Dr Geelhoed: We would say that it is doing a lot, but I take your point.

The CHAIRMAN: That is at PMH. Take the example that was brought up about Sir Charles Gairdner Hospital and the $3 million to $4 million was taken out of consolidated funds and put into a trust fund. When they came to do a project they suddenly and magically produced the money.

Dr Geelhoed: Obviously I cannot comment on that.

The CHAIRMAN: This is the whole issue of trust funds - if there is no control and if the structure is not right, the doctors and the administrators are in a position in which they are open to public comment not only by this committee but also others who will believe that the process is not right. Therefore, the doctors and administrators are subject to innuendo that is damaging to both their reputation and that of the hospital because of the lack of clear-cut transparency and process. Doctors should be pushing to have that in place for their own sakes.

Dr Baker: We fully support that.

Mr WHITELY: I want to ask Dr Geelhold about the meetings that were held with the former Premier. Was it just one meeting? Who was there and what was said?

Mr HOUSE: What does that have to do with this inquiry? Who was there and what was said at a meeting between the doctors and the Premier is not an issue for this committee.

The CHAIRMAN: The question was asked with regard to the terms of reference of the item.

Dr Geelhoed: The trust accounts were not discussed at all.

Mr WHITELY: There was no discussion of trust accounts, whatsoever?

Dr Geelhoed: It was just the management, salaries -

Mr WHITELY: Did any of the examples relate to trust funds at all?

Dr Geelhoed: No.

Dr Baker: In my dealings with Michael and the trust accounts it was never brought up as an issue with me in oncology, apart from the issue of the Whiteman bequest and its use for the Megazone. He discussed that with me -

The CHAIRMAN: Why would he bring that up with you?

Dr Baker: In theory it was supposed to be a part of my -

Mr DEAN: Did you not write a letter of discord -

Dr Baker: It was a confidential letter but it seems to have got around. The background to this is the very generous $2 million Whiteman bequest to cancer care and research at PMH. I became aware of that bequest only after it had literally arrived at the hospital and after it had been received and deposited into the foundation. The foundation is an incorporated body - it was suggested earlier that that should be the case with all of our research accounts. I became aware that an amount of that bequest was channelled into the Megazone. I believed that this was inappropriate so I discussed the situation with the administration and fundraising department. I felt it inappropriate that an agreement had been made by one of the executives to donate that money to the Megazone, and I had an argument about the matter in the public arena. In the end I accepted it, but I stated that no further funds for the Megazone should come out of the Whiteman estate. In effect oncology would not use it because of cross-infection issues -

Mr DEAN: I believe that Michael Moodie shared that opinion.

Dr Baker: About 12 months later I became aware that there was a move to obtain more money from the Whiteman estate because the budget was blowing out and promised funding and donations were not coming in. I vehemently opposed any further -

The CHAIRMAN: Why did the Whiteman money go into that fund in the first place when it was donated to the hospital?

Mr HOUSE: He has already said that he disagreed with that decision.

Dr Baker: I did disagree with it.

Mr HOUSE: Is it possible to define the various types of trust funds. I do not want you to do it now, but I am having difficulty understanding how many there are. I understand the examples given, but is it possible for someone to give the committee a written definition of the types of trust funds -

Dr Baker: As we have already stated we have redefined them for a new process into research accounts and general purposes accounts so there will be two major umbrellas. The research accounts are moneys directly tied to a department for research, and will entail grants and even donations for specific oncology research. There will also be a general purposes trust account controlled by directorates that will take interest and general public donations that are not targeted to a specific unit.

The CHAIRMAN: Are these changes specific to PMH?

Dr Geelhoed: They are specific to the women’s and children’s units.

The CHAIRMAN: I understand that. However, PMH is not the only hospital to have a trust fund, as Sir Charles Gairdner Hospital and Royal Perth Hospital have trust funds. Have they been ticked off by the commissioner?

Dr Geelhoed: You are asking the wrong people.

The CHAIRMAN: The problem is that you are saying that there is a certain process -

Mr HOUSE: It is not their problem.

The CHAIRMAN: I understand that, but the process must be ticked off.

Dr Geelhoed: I dare say they will go through a similar process given that all these issues have been raised. We were just the first cab off the rank -

The CHAIRMAN: We want to ensure that the process is in place -

Dr Baker: Doctors want a process that will be transparent and interactive, that will protect our rights and that will protect the funds from any impropriety that may occur. I hope that that is as you would wish but -

The CHAIRMAN: Are there any other questions? It is now time to wind up. Are there any other statements you would like to inform the committee about?

Dr Geelhoed: I think we have said enough today.

The CHAIRMAN: As I stated earlier we might need you to return before this committee. The submissions period closes on 7 December, after which time we will talk to the auditors about specific examples. We might need your association's view on specific items. If you are all happy with that, we may call you back before this committee.

Dr Geelhoed: We will put an answer in a submission some time later this week.

The CHAIRMAN: Thank you for your evidence.

Committee adjourned at 4.23 pm