SHAM PEER REVIEW
Medical malice and mischief

Written by Dr John Wright

Introduction

In 1963 I was appointed to the full-time thoracic surgical staff at the Prince Henry Hospital, Sydney, a major, university teaching-hospital. In September 1985, I accepted appointment as foundation Director of a new Paediatric Cardiac Unit at The Prince of Wales Children's Hospital, Randwick.

[Note: In response to a draft of this article, Dr Beveridge, head of Paediatrics, wrote that I never had this title. But a letter of 17 December 1985 from Mr W. G. Lawrence, Chief Executive Officer, advised that, "Professor Wright has been formally appointed Director of the Paediatric Cardiothoracic Surgery Unit by the Board of Directors".]

In December 1986, I chose to be dismissed rather than accept an offer which was meant to suppress my longstanding concern about dangerous practices at the Prince of Wales Children's Hospital. I had no recourse in law. My contract allowed my dismissal with or without a reason being given or, in fact, existing.

To find a post to replace what I had done for those 25 years was difficult at the age of 57 but it was easy to take up consultancy work. I had been a senior registrar and tutor in other teaching hospitals and in residential colleges of the University of Sydney and had spent many years in overseas centres. I had taught and examined senior students in all fields and had been involved in the management of intensive care wards which admitted patients with all varieties of trauma and major illness. I later developed a large practice in complex, skin cancer surgery.

Initially, my sense of revulsion was overpowering as I examined how and why these events had occurred. A distinguished journalist told some of my story in 1990 without saying enough to run the hazard of defamation claims. Time has shown that such a story as mine reveals unpleasant human behaviour within the medical profession and elsewhere. I believe that the events which I will describe are unique within the medical profession in this country, at least. They uncover the selfish and destructive power of “dominance" behaviour between medical groups whose motivations were complex and sometimes obscure.

Fear of defamation responses originally inhibited my exposure of many hospital management defects which were obvious and undeniable. Clearly, I had provoked antagonism and had a response which was surprising in its violence. There is no doubt that I had been uncompromising to my own disadvantage. The result was inevitable. In the final analysis, I suffered a large professional and personal penalty.

Administration of the Prince Henry and Prince of Wales Hospitals, 1986

Non-medical
Chairman: Sir H. Dickinson (deceased); later Lady S. Street
Chief Executive Officer: J. Delaney (deceased); later W. Lawrence
Deputy CEO: D. Crofts

Medical
Director. Medical Administration: P. Brennan; later T. Smyth

Divisions
Surgery: G. Murnaghan (deceased)

Cardio-Thoracic Surgery: J. Wright, D. Newman, D. Horton

Anaesthetics/Intensive Care: G. Davidson (deceased), T. Torda, D. Kerr, A. Pybus

Medicine: R. Blacket (deceased); later J. Dwyer

Cardiology (Diagnostic): R. McCredie, M. Swinburn

Paediatrics: J. Beveridge (deceased)

Surgery: A. Bowring (General), J. Wright (Cardiac)

Registrars: S. Cooper, R. Weintraub, B.Currie

Anaesthetics/Intensive Care: J. Vonwiller (deceased), B. Duffy, M. Crawford

Background

After early years in surgery at The Royal Prince Alfred Hospital, Sydney, I became captivated in the late 1950's by the advent of surgery of the heart and great blood vessels. In particular, I was fascinated by the application of this type of surgery to children. After preliminary work in Sydney, I travelled to England and the USA for additional experience in some of the finest cardiac surgical centres in the world. My work increasingly involved open-heart surgery for patients of all ages.

In 1963, I was offered a full-time specialist post at The Prince Henry Hospital, Sydney, where a new surgical department had been established a couple of years earlier to serve the newly-established Sydney medical school at the University of New South Wales. I was to work with Associate Professor Bruce Johnston to develop a division of cardio-thoracic surgery. Those early days meant much hard work and we were not warmly welcomed by some long-established departments of surgery in the older teaching hospitals in Sydney.

Johnston and I were conscious of the initially decrepit state of our hospital although our operating rooms had been upgraded. We were also disadvantaged by the fact that The Prince

Henry Hospital was somewhat remote from the city. We needed a much more central metropolitan location, such as at our sister-institution, The Prince of Wales Hospital, which was being refurbished at Randwick and much closer to a larger population of patients.

Tragically, in May 1968, Bruce Johnston suffered a stroke from which he never completely recovered and I was asked by the head of surgery to take over the running of the division of cardio-thoracic surgery. In agreeing to do that, I tried to capitalise upon the remarkable pioneering work which Johnston had carried out singlehandedly before my arrival. Very soon, an “amalgamation” of our units was suggested by Harry Windsor, the senior and respected chief of cardio-thoracic surgery at the St. Vincent's Hospital, Sydney. My rejection of that suggestion led to a less cordial relationship with Windsor.

As time passed, talented specialists were appointed to various components of our cardio-thoracic enterprise where I had great support from John Ludbrook, head of all branches of surgery, Ralph Blacket, head of all branches of medicine, and John Beveridge, head of paediatrics. Beveridge was headquartered at the Prince of Wales Hospital but had beds also at the Prince Henry Hospital. Cardiology and cardio-thoracic surgery were not then included within the plans for his department, largely because of the singular expense of cardio-thoracic activities already existing at the Prince Henry Hospital at Little Bay.

Not long after my arrival in the hospital group, Beveridge demonstrated generous friendship and sought my collaboration in trying to persuade the hospital administration to relocate, sooner or later, the children's cardio-thoracic surgical activities to The Prince of Wales Hospital. In principle, I was in agreement but well-established precedents for location of services between the two hospitals would have to be overcome. There were also political issues based on government funding and the wish to avoid duplicated services.

By the early 1970's we were providing a large number of surgical activities at The Prince Henry Hospital with a high standard of care. There was great cooperation from all areas with which we collaborated in the hospital group, even though our physical circumstances involved a great deal of sacrifice and personal inconvenience to patients and staff. Naturally, I took every opportunity to emphasise our difficult circumstances to any administrator who was prepared to listen.

Being by then of professorial rank and head of our surgical division, I believed that administrators would become receptive to the repeated advice which I gave with increasing vigour. Nonetheless, precedents and practicalities did not facilitate negotiation. It seemed that the original planning had been set in stone and no specialty allocated originally to the more favourably sited Prince of Wales Hospital was prepared to move over and let us find a place there.

Our department rapidly developed a high place in the surgical environment of Sydney and gained the respect of those who were our friendly "competitors", particularly those at the Royal Alexandra Hospital for Children at Camperdown. Of course, I envied its children’s cardiac surgical division being firmly located within, and having access to, all the resources of a comprehensive children's hospital. On the other hand, we were required to perform not only as surgeons but also as managers of intensive care and emergencies at all hours without serious assistance from our cardiological and paediatric staff.

The head of anaesthesia in our two hospitals was George Davidson who was primarily located at The Prince of Wales Hospital. Tom Torda was the local anaesthetist in charge at The Prince Henry Hospital. Both were of high reputation but neither had a substantial background in cardio-thoracic surgery and, particularly, in open-heart surgery. Torda certainly brought energy and enthusiasm to our surgical enterprise and we were grateful to have such help.

Our relationship with the Department of Anaesthesia (later re-titled "Department of Anaesthesia and Intensive Care") was composed of many strands but it was, ultimately, complicated by a souring of personal and professional relationships. That was aggravated when, at a surgical seminar in 1972 attended by most of the surgical staff and a mass of medical students, one of our surgical trainees presented information about a large number of our patients who had undergone surgery. The results were presented according to the problems treated, the operations performed and the complications which followed – including death. I was not aware of the details to be presented because these seminars were meant to enable junior staff to exercise their research skills without interference.

As chance had it, my department was hosting Dr Eoin Aberdeen, a distinguished surgeon with whom I worked in North America and for whom I had been a visiting professor to the Great Ormond Street Hospital for Sick Children in London. At the end of the presentations, the chairman of the seminar courteously asked Aberdeen to open the discussion. With meticulous care, Aberdeen demonstrated that more than one-half of all morbidity and mortality in our department arose from errors of anaesthetic care in the operating room and recovery ward. He recommended that all anaesthetic management protocols should be reviewed.

Aberdeen had identified a developing danger zone - the demarcation between responsibilities properly taken by surgical and nursing staff, and those which fell within the reasonable responsibility of anaesthetic staff. He fanned the flames of a conflict about responsibility and authority in patient care. A somewhat guarded relationship between my surgical unit and the anaesthetists (specifically Davidson and Torda) thereafter worsened. None of the anaesthetists allocated to our work over many years had past experience or special interest in precariously ill children after heart surgery. Nor would the ambitious Beveridge appoint paediatric staff to ease our surgical burdens.

Differences of opinion about management and authority of patients were exacerbated by the pressures of fitting an ever-enlarging number of patients into a restricted number of post-operative beds. Children who required very special and protracted post-operative care after heart operations, were, therefore, increasingly looked upon with disfavour at The Prince Henry Hospital. Fortunately, the nursing and resident staff were brilliant in their selfless dedication to that type of our work

Dangerous Prophesies

Without any idea, either then or now, of how it might have occurred, I began to hear rumours which involved me. Some of the bureaucracy and anaesthetic staff "hated" me and were determined to exercise a "vendetta" – as Beveridge advised me. Relationships with anaesthetists were aggravated by my insistence that the critical operation of heart lung machines (for open-heart surgery) was ideally performed by technician of high standard who was dedicated to nothing else. Anaesthetists believed that they should be responsible, with a

technician to assist them, and that the anaesthetist should tender an account, even though none of them understood the fine details of their use.

In their quest for vastly increased power and income during the 1970's, our anaesthetists asked for an autonomous department of anaesthesia, and intensive care, headed by a full professorial appointment. The surgical department generally opposed the idea because it was intended to promote profound strategic implications in issues of "dominance" and ability to reduce the independence of surgeons in caring for their own patients. I believed that, whether I liked it or not, I was regarded by families and courts as the "captain of the ship". The buck always stopped with the surgeon. All complications ultimately reflected on the surgeon and were referred to him, regardless of how they might arise and by whom.

Of course, my attitude promoted friction with anaesthetists who had different views, even though (as my own history later showed) I needed to provide a continuity of care for anybody on whom I had operated because nobody else was interested to shoulder that load and I knew more about what I had done inside a patient's body than anyone else.

Anaesthetic groups around the English speaking world wanted to infiltrate post-operative and other intensive care wards (as "intensivists") which caused great alarm in surgical groups. For example, in 1982 the president of The Australian Society of Anaesthetists clearly expressed concerns about their down-market status within medicine and the community at large. They saw an urgent need for media publicity to enhance their professional image, power and income generally.

In 1988, the American College of Surgeons pointed out that special training in "critical care" was now being undertaken by anaesthetists to the detriment of training young surgeons in these areas. And yet, young surgeons (and particularly cardiothoracic surgeons), who may not always have access to specialist assistance later in their careers, needed such training to be able to manage and understand critical care , especially when surgical aspects were involved.

Despite those endeavours, I never believed that exclusive or total autonomy existed in any medical group and that collaboration and consultation were essential to manage complex surgical activities. Surgeons were much more likely to be blamed for complications and, therefore, needed to protect themselves and their patients by their vigilance and dedication to detail during and after surgery. After all, any surgeon who would operate on sick patients must carry a humbling, and depressing responsibility for outcomes.

1980

Because of my perception of responsibility for these professional matters, I constantly campaigned for improvement in the physical aspects of our Prince Henry activities. I insisted that, sooner than later, it should be entirely refurbished (which proved an impossible wish) or relocated to rebuilt Prince of Wales site at Randwick (which, after anguished years, has now happened.) Not only would that allow an overall improvement in all facilities, but it would also allow the integration of our children’s activities within the general children’s hospital which had been rebuilt at Randwick. There, ultimately, paediatric heart patients had to be accommodated in a dedicated unit.

It seemed to me that a senior examination of our department and its activities at various times

of the day, night and weekend would show any responsible party the conditions under which our patients were treated and the intensity of our care. That didn't seem much to ask but it never happened during the 25 years of my service at the Prince Henry Hospital. Futile plans were frequently drawn up for extensive refurbishments after the chairman of the "Health Commission" recommended a multi-story redevelopment. That doyen of American heart surgery, Dr Michael DeBakey visited our unit in 1973 and recommended the same b obstacles were raised at every point.

During those troubled years, Beveridge phoned me late one night after attending a hospital function. He wanted me to know that Dickinson hate me and he, Beveridge, would sacrifice me if he ever had to choose between promoting my ambitions and those of his own department – even though those ambitions were similar. He said he felt a "turd" to be saying that. Beveridge repeated it later when thanking me for operating on his heart and recalling his late-night confession. [In response to a draft of this article, Beveridge stated that he had never used the word "turd" about anyone, including himself. He found the accusation “amusing”.]

In 1980, after my further attempts to improve our service, matters came to an explosive head when the Acting Chief Executive Officer (David Crofts) once again responded that, " … my Boards of Directors… believe that it is not practicable to accede to your request that the (operating) theatres be (re)located (to) The Prince of Wales site. Nevertheless, there will always be a most important need to ensure that the treatment available to children at The Prince Henry Hospital is of the highest possible standard".

I regarded that as an unforgivably fatuous decision based on Murnaghan’s views which were entirely uninformed. I responded to Crofts by saying that the attitude of the Boards of Directors was inexplicable. I pointed out that there had been no senior administrative examination of our facilities in 20 years and that I believed that the Boards had relied on poor advice. I went on to say that the question of standards of treatment for children was of particular importance and that I believed that our facilities were "sub-standard". I went on to say that, "I find the decision to deliberately perpetuate inferior standards quite unacceptable. Our shortcomings cannot be defended or concealed."

It took one week for me to get a very direct response from the Chairman of the Hospital Boards of the Prince Henry, Prince of Wales and Eastern Suburbs Hospitals, Sir Harold Dickinson. His letter of 2 September 1980 stated:

“I must say that I find your characterisation of the Boards' decision not only wrong, but needlessly offensive. It completely misinterprets the Boards' decision. I am especially concerned that you find the decision ‘quite unacceptable’. While this remains your attitude, the appropriate course would be for you to resign.”

I told Dickinson that resignation would be the least appropriate option which I should consider.

I suggested that he must seek a well informed external opinion before an irrevocable step was taken by his Boards. Needless to say, that brief, angry exchange damaged my position for all time but I felt that that was the price to be paid for informing the administration of its responsibility to provide proper care in our department which, by that stage, was described by a senior executive officer as "the flagship of the hospital group

1983

In early January, 1983, I met with the parents of a child who had died without explanation at the end of a simple, uneventful heart operation. I could offer them no satisfactory explanation for their son's death. On 10 January 1983, while still deeply concerned about such issues, I wrote in the following terms to Dennis Kerr, a recently-appointed staff anaesthetist at the Prince Henry Hospital. "For some time it has been apparent that our attitudes to patient management have been at substantial variance. In so far as this is inimical to the interests of good patient care, I believe that our regular operating arrangements should not continue. I regret this decision because I respect you and your professionalism." For me, this was a situation of elemental importance and conscience.

The first response was from my administrative chief, Murnaghan, who was angry that I had written without consulting him and blaming me for provoking conflict with the anaesthetists. He expressed no concern about my beliefs. In fact, he regarded our quite momentous technical procedures with scorn. A day later, he advised me that the anaesthetists had complicated the matter by accusing me of incompetence and that Dickinson was infuriated by my conduct.

John Delaney, Chief Executive Officer, asked would I, as a favour to him, withdraw my letter to Kerr. Out of respect for Delaney, I agreed to do that if there were a commitment by the Boards to undertake a proper evaluation of conditions or work and relationships between Davidson and Torda, and my department. Delaney undertook to promote that investigation urgently, and said that, while he was on leave (he had apparently been ill for some time), Crofts would pursue that path. I also advised Delaney that Kerr and I should not work together until all matters had been investigated.

On 21 February 1983, I was asked to attend a meeting with Crofts, Dickinson and Dr Peter Brennan, Director of Medical Administration (and my former student). Dickinson was very angry and blamed me for ignoring correct “procedure”. He refused my request that minutes should be kept of the meeting and had no interest in my concerns. I told him that I believed the attitude of the anaesthetic department after my letter to Kerr had been maliciously orchestrated by Davidson.

On 11 March 1983, I was invited to meet Murnaghan and Blacket (Professors of Surgery and Medicine) privately at the Prince of Wales Hospital. On my arrival, Dickinson, Crofts and Brennan suddenly entered from a side-room – a form of ambush. Dickinson instructed me to either take leave or be stood down for one month while the Boards investigated my “competence”. Again, there was no mention of minutes of the meeting or an investigation of my complaints. (Much later, Dickinson wrote that he had considered my dismissal at that time but no reason was given.) I took leave immediately.

On 25 March 1983, Brennan advised me that the Medical Practices Committee would conduct an inquiry into the allocation of anaesthetic services to me. I was to prepare documentation which would compare my surgical results with those of my surgical colleagues. A junior, administrative clerk would collate the data for presentation to the investigating committee. I made precautionary contact with a solicitor and the Public Medical Officers' Association of which I was a member.

The analysis of results vindicated me from any charge of incompetence as it also vindicated my two surgical colleagues who were not being investigated for any claim of incompetence. Blacket later told me that "no shred of incompetence" in me had been found by that

investigation but that Davidson and Torda had become my “implacable enemies”. Months later, Brennan advised me that there was no report of that enquiry and my "competence had never been an issue". The whole enquiry had been directed toward creating "harmony" between those anaesthetists and me. A long period of relative calm followed.

Truce

Without warning, on 8 April 1983 I was again asked to meet Dickinson. He remained angry and said I would be excluded from involvement if paediatric heart surgery were ever transferred to The Prince of Wales site because the anaesthetists would resist any move to give me additional authority. He was not prepared to acknowledge that his enquiry had confirmed my competence or had even discussed it. He asked me to keep him posted of any further anaesthetic problems that I might encounter. He did not acknowledge my further communications of that sort and I am unaware if he took action about them.

I had continuing concern about Dickinson's attitude and the fact that the enquiry had given me no approval. To clear my name of any unresolved imputations, on 27 April 1983 I contacted an old acquaintance, Dr Max Diment who had been a Health Commissioner in New South Wales. He advised me to keep a dossier of everything which occurred and arranged for me to meet the Secretary of the Department of Health, Bernard McKay, which I did on 8 August 1983. McKay heard me out and I had no further contact with him. Thereafter, there was a remarkable improvement in all my relationships although I sensed continuing currents of resentment from Davidson and Torda.

On 26 August 1983, Dickinson yet again invited me, this time “personally and privately”, to meet with him at The Prince of Wales Hospital. He had received a call from McKay asking him to sort out my problems as soon as possible. Dickinson hoped that I would give up the idea of moving paediatric heart surgery to The Prince of Wales Hospital because the anaesthetists were antagonistic to such a move. Dickinson was “grateful” for my contributions over the years and “I should feel secure in that fact”. We parted on first name terms.

Because, once again, Dickinson wanted no notes kept, I dictated an account of our conversation before leaving the hospital and contacted my solicitor an hour later to formulate a letter of response. I wrote to Dickinson on 29 September 1983 to summarise my understanding of our conversation. He replied on 14 November 1983 saying that he disagreed with most that I had written and that he resented my writing to him at all because he had spoken to me “privately” without the Boards’ knowledge. Thus, Dickinson's recollection of our meeting was entirely different from mine. In December 1984, he resigned or was replaced.

A new administration

On 27 February 1984, I wrote to Lawrence, a newly appointed as Chief Executive Officer after Delaney’s tragic death. I was seeking a comprehensive administrative examination of what had occurred in 1983 because I wanted restoration of my reputation and removal of a continuing stain on our corporate record. He promised to examine the situation urgently.

By that time, Beveridge had returned from overseas leave and immediately renewed his attitude of warm friendship. In accordance with the administration’s request, he immediately allocated two of his most senior registrars to help with the intensive care of paediatric cardiac

patients. There was an immediate and unprecedented surge of comfort and confidence in all of our procedures. Beveridge told me that the anaesthetists continued to resist any move of paediatric heart surgery to the Prince of Wales Hospital but they had agreed to collaborate if they were "so directed". Beveridge said he knew nothing more than that but I should be reassured.

By mid-1984, he had offered me frequent occasions of dinner, golf and sailing. As I had planned to visit South Pacific islands to examine children with heart problems in late 1984, I offered support for Beveridge's travel from funds in my R&D Account at the hospitals. I needed his support as he needed mine to further promote the re-establishment of surgery at The Prince of Wales Hospital.

In November 1984, Beveridge made two remarkably bold suggestions to me. Firstly, I could use his personal computer to store my own financial documents. That move alarmed me. A day later, he offered me the post of Director of all cardiac activities in his department, with a full professorial chair. He admitted he had no authority or funds to make that offer but insisted that he was sincere.

I had frequently expressed my objection to Beveridge posing as a children's heart specialist which, by all definitions, he was not. I was greatly disturbed when he explained that cardiology was the only section of his department to which a dedicated specialist had not been appointed at that time and he desperately needed to boost his private practice income from pretending to be a cardiologist for children. I suggested that we should seek to appoint a specialist cardiologist urgently in order to refine our diagnostic services.

Moving house - a fatal error

During late 1984 and early 1985, our surgical activities at Prince Henry Hospital were rewarded by excellent results, even in the most complex cases. There was an increasing cohesion between all of those concerned with the enterprise and there was a more comfortable relationship in the operating rooms. There were fewer complications because the excellent trainee paediatricians whom Beveridge had placed at my disposal assisted the anaesthetists in every part of their duties. Administratively, they were under his control but while we were located at The Prince Henry Hospital where I had been in charge for twenty years, I found no management difficulty.

It was against that happier background that the hospital Boards suddenly resolved on 3 June 1985 that the transfer of paediatric heart surgery to The Prince of Wales Hospital should occur and that I would head up the new department with a working party to assist me. I knew nothing of plotting at that precise time between the anaesthetists, Beveridge and the administration. (This was revealed by Beveridge's close colleague, Bowring, in an explicit affidavit written a year later in which he said that Davidson would not resist my appointment to Prince of Wales so long as Beveridge and Bowring would support my removal on a pretext of incompetence. Lawrence and Bowring later both denied any such plan. Clearly, Davidson greatly resented his failure in the same endeavour two years earlier.)

It is not clear who else knew of Davidson's continuing attitude but later events showed that many others were aware that my transfer and new title were elements of a crude conspiracy to destroy me. Bowring later denied I had been closely involved in paediatric surgery for 20 years. According to the Boards' latest Chairman, Lady Street, it is possible that the Boards

were unaware of the plotting. Of course, I knew nothing of it for another year.

To facilitate the transfer of our specialty from the Prince Henry Hospital to the Prince of Wales Hospital, a young anaesthetist lately returned from overseas study, Matthew Crawford, was appointed by Davidson to head up The Prince of Wales anaesthetic team to manage the transition of our surgery. He was unconditionally recommended by Davidson, Beveridge, Smyth and Vonwiller as having high credentials and much experience from the distinguished Mayo Clinic of Rochester, Minnesota. His training had placed "special emphasis" on paediatric cardiac anaesthesia.

On that basis, by September 1985, I felt that we could proceed with our first major (open heart) procedure at The Prince of Wales Hospital. By then, I had re-established myself personally and almost exclusively in the Department of Paediatrics where I had an office next door to Bowring. My office door carried a label arranged by Beveridge, saying: "Director of Paediatric Cardiac Surgery". I was prepared to be patient and meticulous in everything I did for the success of that new unit by ruffling no feathers.

I soon sensed that there was an undercurrent of inertia which far exceeded what I had expected. It was obvious to others, before me, that my new department was not welcomed in some quarters. Junior paediatric staff were less experienced than their predecessors though willing. It took a long time to train intensive care and operating room nurses although I had been assured of their experience. Most troubling was that Crawford seemed unfamiliar with many aspects that should have been automatic in a person of his alleged experience.

I sensed I was involved in a cold war. Above all, I was apprehensive because I had no personal paediatric staff or assistants and all paediatric resident staff involved were directly responsible only to Beveridge, directly or via Crawford. The insecurity I felt clearly reflected Beveridge's perception of 31 July 1989 that, although I did become the Director of the Paediatric Cardiac Surgical Unit, "there is no formal position as Director. It was and is simply a title: there is no such position". I could understand nothing of those semantics. I was unwilling to believe that Beveridge had deceived me for so long. During that time, Bowring made no mention, although our offices adjoined and we frequently conversed, that there had been a plot hatched at the time of my appointment. Clearly, it had been a contrived appointment of a most sinister kind.

The how and the why

During the first half of 1986, my sense of insecurity escalated at an alarming rate. Beveridge's attitude was secretive and obstructive. Crawford's capability became more uncertain.

Complications were repeated and my management protocols were altered without consultation with me. Fundamental authority for all stages of the post-operative period lay with Beveridge and Crawford. Of course, I was loath to suspend the enterprise so early after its institution. Only by my virtually living in the hospital through those months was I able to abort some catastrophes. I persisted in hope rather than belief that the group’s "learning-curve" would soon reach its top.

Inevitably, there was a cooling of relations between Beveridge and me over a series of confrontations about patient care. In April 1986, I was astonished to learn that Beveridge had

approached the administration with a request to amalgamate my significant research funds with an account which was administered only by him. When I accidentally learned of this, I confronted him and demanded that his improper move should be reversed immediately. He agreed only after heated argument, saying he felt insulted that I had not trusted him. (Clearly, he was ensuring access to my funds before I was impeached.)

In the same month, Crawford admitted to me that he was increasingly troubled by his lack of paediatric or cardiac knowledge. That did not surprise me but I was dumfounded by his frankness and suggested that he should advise Beveridge and Lawrence urgently to that effect. When I asked him on the next day had he done so, he had not. He said he would as soon as he had discussed it with Beveridge. I cancelled some non-urgent surgery until I could see how to proceed.

In May 1986, Beveridge began to close the net on me. In secret discussions with my technical staff, he asked for their estimations of my surgical activities. A month later, he had had private talks with Dr Chang and Dr Farnsworth of the St. Vincent's Hospital, Sydney, seeking their interest in joining his paediatric surgical staff. He wanted to “boost the image” of his department. Shortly after, Beveridge, Smyth and others in administration covertly cancelled an arrangement for the media to interview me concerning the development of the new cardiac unit. (In 2009, the Director of Medical Administration, Smyth, denied any knowledge of any aspect of any of the machinations in that period.)

Malice and Mischief

At 2:30 pm on 27 June 1986, I advised Lawrence that the cardiac surgical unit was becoming too dangerous to continue for several reasons and that I no longer had control of or confidence in our ability to deliver a satisfactory product to our patients. I advised him that a poor set of arrangements over which I had no prior awareness had, indeed, failed. There were swift responses in several areas, all unknown to me at that time.

On 9 July 1986, Beveridge had further discussions with Chang and Farnsworth. Farnsworth expressed interest but Chang refused. Beveridge then advised Lawrence that he had lost confidence in me. Notwithstanding that secret move, he immediately implored me to operate on a very sick child. My surgical judgment was to delay that operation pending a short intensive course of antibiotics which would make surgical intervention much safer. Beveridge was angry that I insisted on making the ultimate decision about the timing of that surgery.

On the same day Beveridge had further discussions with Davidson and Crawford. They determined an appropriate moment to suspend their association with me. I was not to know of these and other bureaucratic moves until the next morning.

Early on 10 July 1986, Beveridge conferred with Lawrence, Smyth, Crawford, Torda, Davidson and Currie (a junior Paediatric Surgical Registrar who assisted me occasionally). Again, I knew nothing of that meeting until later. An hour after, Beveridge came to my office, unannounced, to say that Crawford and Currie were unwilling to work with me. I phoned Crawford to have his version of the matter. He said that he found the surgical results disappointing and his wife complained that he was never home. He finally announced that he saw no hope of success for the surgical unit because there were, "too many people with old scores to settle".

Early on that afternoon, Lawrence handed me a letter saying I was suspended pending an enquiry into surgical matters. It was anonymous to the extent that it referred to the concerns of "a number of clinicians". (Smyth said I would know who they were.) With no mention of the Department of Paediatrics, it stated that the "Department of Anaesthetics" was unwilling to provide routine anaesthetic services. I reminded Lawrence of my meeting with him on 27 June 1986 when I advised him that "services for paediatric cardiac surgery at The Prince of Wales hospital were not adequate for its competent performance" but he said it was in Beveridge's hands.

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There was no doubt that my surgical career at those hospitals was finished for several reasons. Davidson and Beveridge had been the architects of these destructive events. My fate had long been predetermined. I well understood that Beveridge and Crawford were disturbed by matters of conscience and fears that their pretences would be exposed.

When I analysed the whole of my surgical activity at The Prince of Wales Children's' Hospital throughout this difficult teething period, we had lost seven patients out of a total of 70 operations. Of those seven, three had arrested before operation began but were only temporarily salvaged by operation. Three deaths occurred after operation, all in the intensive care ward where I had been denied control of management. Only one died during an operation. That child had uncorrectable cardiac defects which had not been discovered before operation. There had been no significant complications otherwise (see Mee's report).

On 13 July 1986, Beveridge came to my home, unannounced. He brought a piece of his son's wedding cake and flowers for my wife. His apparent purpose was to ask forgiveness for his actions. He said he was surprised that, prior to the meeting of the Medical Practices Committee, there was no survey undertaken by the Chief Executive Officer of surgical results correlated with diagnoses, procedures, outcomes and complications. I told him that I would contest the matter and I did not wish him ever to speak on my behalf or to me again. I asked him to leave and not return. As he left the house he said, in the presence of my wife, "I have been your Judas". The last card had been played. My guesses had been close to the truth.

Courts

This proved the wrong way to go. Lawrence's action had placed me in a remarkable position.

The Boards took pains to vindicate his actions later but he had been obstructive and less than honest at all stages. I took legal action for a stay of my suspension pending a proper enquiry with full particulars from accusers. They were slow to come. At a preliminary hearing, counsel for the hospitals referred to spectacular and damaging accusations made by the hospital counsel based on "safety" factors. Indiscriminate damage was done to me but I had no alternative if I were to control the situation until a proper case analysis was prepared.

It took six weeks for details of the accusations to reach me. I responded to an absurdly large list (generated by Crawford at Davidson's instigation) of alleged surgical deficiency in 8 months of work with 70 patients. Seven "clinicians" who "lacked confidence" in me had been enlisted by the hospital to testify against me. Beveridge headed the paediatric group – Bowring, Currie and Duffy – while Davidson had demanded that Crawford, Torda, and

Vonwiller should respond. Most relied heavily on second-hand information stemming from Crawford and/or Currie. Four of the seven had little or no connection with my surgery. None had expertise in any aspect of my work.

In the event, the whole procedure was a classic form of “sham peer review” designed by those who had resented my standards and contrived a fake “trial”. Davidson gave no written testimony although he was a prime mover in the manufacture of the case against me. Only two of the seven (Beveridge and Crawford) had had any real connection with the surgical enterprise but neither had any cardiac credentials. The depth of their paediatric cardiac experience will be mentioned later.

Their ‘concerns’

Crawford was appointed the prime mover and author of the impossibly large list of charges. He stated his experience at the Mayo Clinic included "special emphasis placed on cardiovascular (and neurosurgical) anaesthesia" (my parentheses). He pretended expertise but had none and wrote as an amateur. His personal and professional criticisms of me were ferocious. (In a later response to a draft of this article, he justified his position by even more extreme and unsupported pejoratives. An independent observer (Dr Boyd Leigh) considered his attack to be pathological.

Acting under Davidson’s instructions, Crawford overlooked fundamentals: firstly, Bowring's affidavit to the Medical Practices Committee indicated that the anaesthetists had already advised the administration, before my appointment, that they would obstruct me at The Prince of Wales Hospital. Crawford knew that. Secondly, he had confessed that his inexperience did not suit his role as my anaesthetist. That was explained by his lack of cardiac training at the Mayo Clinic (see below). Thirdly, I had no supportive team before or after I moved to Beveridge’s department but Crawford was meant to be part of that team.

Beveridge justified his opinions and authority in management on having had "particular interest"..."close association"..."a share in management"... "others providing information". Those claims were intended to conceal his complete ignorance of paediatric cardiology and intensive care though claiming both.

Currie (an inexperienced, surgical trainee who had assisted me occasionally) testified that his testimony was solicited, not spontaneous and confidential. He found no fault in any operation that he understood but, in more complicated cases, he was not able to make any comment at all. He believed that I should have had an expert trainee to assist me. Beveridge had promised to correct these compromised support systems promptly immediately after my appointment to his department but that did not occur before my demise.

Bowring made no personal accusation of substance. He quoted the second-hand views of Vonwiller, Crawford, Davidson and Currie. His report (18 July 1986) stated that, "about one year ago, the Director of Theatres, Dr George Davidson, spoke to me as Chairman, Department of Paediatric Surgery, indicating that the members of his staff were no longer prepared to give anaesthetics for Professor Wright's operations". (This was at a stage when I was operating only at The Prince Henry Hospital and there was no criticism of surgical results.) Davidson wanted his grievances “ … to be taken up directly with the Chief Executive Officer" (Lawrence) but he (Davidson) … later informed me (Bowring) of a revised arrangement whereby anaesthetic services will be provided for Professor Wright's operations

… until the transfer to Prince of Wales … Clearly, Davidson, Lawrence, Beveridge and Bowring had plans to destroy me in place a year before my arrival at Prince of Wales Hospital. The ethical implications of that cartel are very serious.

Vonwiller, who described himself as the Director of Anaesthesia and Intensive Care at The Prince of Wales Hospital, had only slight contact with my surgical activities and knew little of specific issues was poor. He relied on what Crawford had told him. (Increasingly distressed, he phoned me in 1987 and 1988 to say that he was disgusted with himself and others for what he called a "numbers game" and. He would not say by whom he was influenced but it was a matter of "one in, all in". (Vonwiller died in 1992 from a brain tumour.)

Torda admitted that he had witnessed no operation performed by me in at least three years. My records showed that he had given one anaesthetic for me in each of the three years 1979, 1981 and 1983. Thus, he had no first-hand knowledge of any patient involved in this enquiry. He relied on Vonwiller's second-hand views. His opinion was valueless, therefore,
Duffy (Director of the Children's Intensive Care Ward) quoted Currie (see above) as a major source of information. His comparison of my surgical results with those of The Royal Children's Hospital Melbourne should be seen in the light of the report of Dr R B Mee (surgeon in charge at The Royal Children's Hospital) who attended the Medical Practices Committee inquiry as an expert referee.

To summarise the calibre of those critics: none had appropriate qualifications to comment on my work and two misrepresented their experience. They had been enlisted to process a typical "sham peer review". As the nominated agent of Davidson's and Beveridge's conspiracy, Crawford testified in a very vicious fashion, purporting to have credentials to do so. While awaiting developments, I pondered his past history. Davidson, Beveridge and Vonwiller said they regarded his experience in paediatric cardiac anaesthesia highly. Vonwiller went much further in telling the committee of enquiry and me that Crawford had "extensive experience in paediatric anaesthesia, cardiac anaesthesia and intensive care".

Crawford told the Medical Practices Committee that he had placed "special emphasis on cardiovascular (and neurosurgical) anaesthesia" while at the Mayo Clinic. Smyth described Crawford's "specialised training" in cardiovascular anaesthesia.
In the face of those legal documents, I phoned the Fellowships Office of the Mayo Clinic and Foundation on 4 September 1986. I was advised that Crawford's training had, in fact, been as follows:

Research (laboratory only): 9 months_Orthopaedic: 5 months_General surgical: 4 months_Neurosurgical: 3 months_Cardiovascular (adult): 3 months_Critical care (adult and non-cardiac): 3 months

Although there was no mention of "paediatric" or "paediatric cardiac" involvement in that record, Crawford responded to a draft of this article by saying that he had been involved in a research project involving the ventilation of neonates, that he would not infrequently have to "deal with children whose procedures were finishing late in the day" and that he "came in contact, on a regular basis, with children who had undergone cardiac surgery". He finally confessed that his "main aim at The Mayo was to gain neurosurgical anaesthesia experience....."

The implication that these constituted any involvement in paediatric cardiac anaesthesia or

intensive care is absurd. Thus, his own and others' references to his experience of paediatric, cardiac surgery had been falsely presented. That had quickly become obvious to me at work. In a long letter in response to a draft of this article (which he did not want published in whole or part) Crawford was at great pains to justify his pretences and actions by presenting figures which lacked statistical significance. His classification of cases was ambiguous and uninformed. He continued, therefore, to expose his ignorance of professional details of the work he had already confessed was beyond him. Yet he was my prime accuser.

Given Crawford's account of his experience and the glowing references given by Davidson, Torda, Beveridge, Vonwiller and Smyth in affidavits ultimately submitted to a Supreme Court, there is a striking resemblance to the situation with Dr Jayant Patel in Bundaberg. Those responsible for ensuring Crawford's expertise at the time of his appointment and at this enquiry either failed to investigate and confirm his claims or were inclined to conceal their deficiencies. Ultimately, The Boards and Lawrence were responsible for such negligence.

The Enquiry

I attended one session of the Medical Practices Committee enquiry, on 7 November 1986, accompanied by an observer, Dr Boyd Leigh. Although not a cardiac expert, he knew a great deal about surgery and I valued his assessment of the enquiry. The Committee Chairman (Gerathy) stated that they were not examining my competence but the question of my "operating privileges". [He, like Smyth, did not respond or "knew nothing" when I later asked them if they knew of the iniquity of the enquiry.]

The Committee "officially" consisted of three non-medical members of the Boards and two senior doctors, Dwyer, Head of Medicine and Murnaghan, Head of Surgery. Neither had relevant professional credentials. On 7 November 1986, however, Dwyer was not present and no reason was given. Murnaghan announced that he was not present as Director of Surgery but as "himself" – implying that he would not be voting. That meant that the only members of the Committee present on that day who were to make decisions, were the three lay Board members.

As was mandatory in such a matter as this, the Committee had invited a non-voting, expert referee from another hospital to report on my surgery. Dr Roger Mee had been nominated by The Royal Australasian College of Surgeons at the request of the hospital. He was Paediatric Cardiac Surgeon in charge at The Royal Melbourne Children's Hospital and the only expert present, apart from me.

At the outset, I totally rejected the criticisms of my surgery. I reiterated much of the dubious history of the development of the new surgical unit and its dangerous administrative difficulties. I pointed out to Lawrence, who was part of the Committee, that I would not have begun the service at the Prince of Wales Hospital had I been aware that the anaesthetists had told him of their antagonism a year before.

Mee's Report

Mee had already had discussions with the Committee and with my critics who had given testimony. Remarkably, he had been given the impression that Beveridge was a paediatric cardiologist. He was critical of only one case of the whole experience which required a very complex operation. He was critical of others' performance and knowledge and suggested that

I was being "gunned for" by somebody seeking a reason to remove me.

Dr Leigh wrote that my surgical performance had been generally approved by Dr Mee. He considered that some of my critics lacked balance and most relied on hearsay and presumptions. He concluded that the basic problem seemed to him to be a conflict of “personalities".

Mee had already advised Gerathy of his views verbally – that there was no evidence of incompetence and recommending that the issue should not be pursued further for fear that I would be rendered "unemployable" by a campaign which had set out to "get Wright". Gerathy led him to believe that he was considering negotiation with me. Finally, the hospital offered me an alternative post if I was prepared to "go quietly". I rejected that proposition because I had no wish to work again with any of those who had conspired against me.

At 8:00 am on 19 December 1986, the hospital Boards met urgently to accept the Committee's report and to agree that Lawrence had been justified in suspending my operating. It accepted that my association with paediatric cardiac surgery could not continue. Lawrence then contacted Mee in Melbourne to get a formal written report on the Boards' decision.

Mee responded by facsimile at 2:12 pm. He mentioned technical inaccuracies in only two of my cases He was critical of one, though only in retrospect. Both were complex problems. He reiterated what he had said at the Committee hearing – others were ignorant of the specialised work. He regarded no complication of my surgery as unusual or remarkable. He noted that I had been working under less than ideal conditions. He was unable to say that any “lack of confidence” was justified or that I was alone responsible for it.

Contract

My medical indemnifier’s lawyers recommended that I seek reinstatement and compensation. On 4 September 1987, the Supreme Court determined that, as I was under contract to the hospitals, I could be terminated at any time, with or without a reason existing. Mee's favourable report could not affect the judgment because the Boards' decision to dismiss me had been taken (deliberately) prior to having Mee's written comment although Gerathy had that opinion verbally long before. It was, therefore, a matter of game, set and match to the hospital.

Some time later, Mee wrote me to say how concerned he had been about some elements of the inquiry. He said that my colleagues elsewhere would wish me continue in my work but, in a practical sense, I knew that was impossible.

The Court was not made aware of Crawford's concealments and the valueless testimonies. The hospital had simply exercised “expediency” in administration. The judgment acknowledged that the form of surgery involved was “at the frontiers of difficulty and peril and had some of the character of experiment and adventure”. It did not believe that the hospital had made any judgment on my general competence. The situation was that "someone had to go or the work had to be left undone".

Had I known that the issue could be determined in a quasi-judicial fashion on the nature of my "contract", I would not have proceeded to Court. I had no interest in prolonging Court work by

appealing. A small compensation was offered and I proceeded with consultancy work and complex skin cancer surgery during the next ten years. A senior legal opinion later suggested that an appeal was likely to have been successful although I suspect that the hospitals' legal advisers were confident of their position on my "contract".

Conclusions

Quite simply, Davidson held great animosity towards me because my actions had reflected on the services of some of his staff. Dickinson’s bureaucracy resented my reflections on their standards of management. Beveridge orchestrated a plot and admitted to being my “Judas”.

He desperately wanted children’s cardiac surgery to be done within his department, if only to prosper financially from pretending to be a cardiologist. He knew that I wished the same transfer to have better anaesthesia and post-operative care for children. Lawrence co-operated in a scheme which supported the following scenario: If Beveridge could entice me to transfer to the Prince of Wales Hospital and get what he wanted with a false appointment, he would then collaborate with Davidson by betraying me. Crawford, as Davidson’s servant, was commissioned to damage my reputation enough to call an enquiry. All others were bit players in a “sham” enquiry. Their expert referee found favourably for me but my contract left me vulnerable to dismissal, regardless of facts.

My old conflict with anaesthetists about responsibilities for enduring care and ultimate authority, a matter involving medical dominance and reimbursements, was the basis of this history. My demands for safer conditions of work sewed the seeds of management’s antipathy, originally promoted by Dickinson. Such conflicts continue to plague health administrations long after his and my departures.

According to Bowring's and Beveridge's behaviour and writing, my appointment to The Prince of Wales Hospital as Director of Paediatric Cardiac Surgery was not bona fide and it was inherent that I should fail. Beveridge and Davidson made a deal where Beveridge, purporting to be my supporter and entirely aware of Davidson’s resolve to destroy me, enticed me to transfer to his department on the condition that he would then become my "Judas".
It was inexcusable that so many levels of administration would have concealed from me and the Boards what they knew of the entrenched hostility of Davidson and some of his department. Crawford’s role, dictated by Davidson, was to facilitate a corrupt enquiry.

Who helped and who didn’t?

Great support came from family, friends, patients, parents, Dr Leigh and Phillip Knightley’s short article in a monthly magazine, identifying the essential elements of the matter. Knightley's views were never challenged and Lawrence did not respond to repeated requests for comment.

Two State politicians expressed an interest in having Mee's report included formally within a New South Wales Department of Health file. (See “The elusive Mee Report” below.)
My medical indemnifier paid my legal costs and gave helpful support. Remarkably, it did not accept that my seeking a Court intervention was essential to control an extremely damaging media interest in my suspension. Incorrectly in my view, it also encouraged me to accept a token compensation on condition that I did not pursue the matter further.

With a few very notable exceptions who wish to remain anonymous, little or no assistance came from medical colleagues. The Royal Australasian College of Surgeons expressed sympathy in my predicament but found no avenue of assistance.

The Sydney Cardiothoracic Surgical Group and the Medical Staff Association of my hospitals expressed little found no avenue to help. The State Ombudsman's office would not become involved. My approach to the Courts turned out to be futile from the beginning.

The elusive Mee Report

One issue which concerned me a great deal in the final analysis was that a copy of Mee's supportive report of December 1986 should be retained in my file in the NSW Health Department's head office. That evaluation was a summary of my "professional clearance" from the ugly criticisms of my work and was highly critical of the Hospital's performance. I was assured of that in early 1987.

Further history:

17 May 1988: The Health Department could not find Mee's report.
8 January 1990: Phillip Smiles, my local State Member, wrote to Chris Crawford, Executive Officer to the Minister for Health, enclosing a copy of Mee's report in my possession, and noting that it had not been included in the Department's records of the matter. (There was no response to that letter.)

3 July 1991: As Shadow Minister for Health Services, Dr. Andrew Refshauge wrote to me that, "It is vital for you to get a copy of Dr. Mee's report". (I already had a copy from the Court, but I had not been able to obtain an acknowledgment of the report's existence in the Health Department).

12 December 1991: Smiles advised me that Minister for Health and Administrative Services staff had advised him that Mee's report was now included in the Health Department's files and appropriately indexed.

19 December 1991: The Minister for Health's Services Manager personally advised Mr. Smiles and Refshauge (Shadow Minister for health) that Mee's report was now contained in a Departmental file, I was comforted by those assurances until 5 February 1995 when I wrote to Refshauge, by then Deputy Premier and Minister for Health, asking that he might review the matter of "clearing my name" – bearing in mind Mee's report.

3 April 1995: I wrote to Refshauge again, reminding him of my letter of 5 February 1995 of which I had had no acknowledgment.

22 May 1995: I phoned Refshauge's office to ask his secretary to remind Refshauge of my letters of 5 February 1995 and 3 April 1995. She advised me that my earlier communications (which were accompanied by copies of Mee's report) could not be located. At her request, I faxed a further copy.

2 August 1995: At his request, I met the Minister in his office. He said that Mee's report and previous correspondence from me could not be found in the Departmental or in his office files.

7 August 1995: At Refshauge's request, I sent a further copy of Dr. Mee's report to him by personal, registered mail.

22 September 1995: I phoned Refshauge's office at 9.15 a.m. and at 4 p.m., seeking to ask his private secretary to draw the matter to Refshauge's attention. She was unavailable on both occasions and did not respond to my calls. (All staff names have been omitted on request from Refshauge's office.)

5 October 1995: Another member of Refshauge’s staff assured me of total privacy if I sent him a personal fax message. I did so, expressing my distress that I had no response to my registered letter of 7 August 1995.

October 1995: Because Mee’s report could again not be found, Refshauge's private secretary phoned me to ask if the Minister’s personal driver could collect copies of the Mee report and my letters from my home at 7.30 pm. Refshauge's driver would personally hand the documents to him and to no other person.

10 October 1995 (7.30 p.m.): Refshauge’s driver collected the documents. A memorandum from the Minister's Office, signed by both his secretary and his driver, confirmed collection and promised confirmation of their being hand-delivered to Refshauge.

11 October 1995: Phone messages came from Refshauge's private secretary and driver confirming the memorandum of 10 October 1995.

20 November 1995 (11.45 a.m.): The Minister phoned me at home to say that he had now read Mee's report and other documents. He said that the Director-General of his Department would ensure that the documents would be filed in the Department. He indicated that he would consider ways of mitigating some of the damage done to my reputation and that he would keep me informed. He was disinclined to "rake over the coals" of the matter at that stage “for your sake”. He said that he knew that Mee's written report had not been in the possession of the Boards of Directors of the Eastern Sydney Area Health Service at the time that a dismissal decision was on 19 December 1986.

February 1999: I contacted the Deputy Director-General of NSW Health, Robert McGregor when I had read of a weekend "break-in" at the Department and was concerned about the security of documents related to my past affairs. I was assured that no documents had been taken but no file of mine could be found in the department. A later phone call advised that my file was discovered at an Area Health Service office and found to contain a copy of Mee's report.

May 1999: After five requests, I was sent an edited copy of that file. It contained a cutting of my letter (highly critical of health matters) published by a Sydney newspaper on 16 April 1979. (The preservation of that letter to indicated, of course, that somebody in the Hospital’s administration was concerned about my persistent complaints about hospital safety.) At that time, I also sent McGregor a copy of my personal account of this material to be added to the department's file.

June 1999: He wrote to assure me that my request had been accepted. He later phoned me to say that my manuscript (similar to this) had “not actually reached" him. I sent him another copy. He provided me with a file number for all future departmental reference.

October 1999: I met with McGregor to discuss my wish for professional clearance. He described the events of 1986 as being "impossible these days" and asked me "who I knew – such as Dickinson", to call on for independent support. I gave him with the names of seven eminent people other than Dickinson who were agreeable to report to him. There was no response for four months.

February 2000: McGregor promised to contact those persons and by June 2000 he had received responses from them.

July 2000: I again met with McGregor who offered to personally discuss matters with a past Chairman of the NSW Health Commission who had reported to him.
October 2000: After my further letters, he again promised to do that but I have no evidence of such contact.

July 2001: I again wrote to McGregor seeking his response to the testimonials from my seven referees, fourteen months earlier.

August 2001: He responded that he would approach the chief executive officers of the major metropolitan teaching hospitals seeking their views on my "engagement within the public hospital system".
February 2002: After six unproductive calls to McGregor and his staff, I was advised that letters to the CEOs had not been sent until December 2001 and there had been no responses yet.

March 2002: I reminded McGregor that it was three years since his involvement began, one year since I had met with the Minister at the instigation of Alan Jones, five months since his (McGregor's) letters to the hospitals and one month since my last letter to him. I again sought his response. He replied that he had reminded the hospital executives to respond to his requests.

April 2002: McGregor sent copies of those responses to me. All stated that they would welcome my application for hospital appointments as they arose. All believed that I was seeking active clinical positions. That was an entirely incorrect interpretation of my wishes for emeritus consultant appointments.

June 2000: McGregor cancelled an arranged appointment and indicated he could not assist me further.

July 2002: The Minister arranged an appointment with me to advise that he would ask the NSW Medical Board to assess the whole situation and provide him with an objective evaluation of the events of 1986.

5 February 2003: The Registrar of the NSW Medical Board wrote to me to confirm that my registration status was of good standing with the Board, enabling me to undertake whatever medical work I chose. (That status had never been in doubt.) It was also pointed out that the Board had "no charter to examine matters such as those outlined in the documentation (I had) provided to the Board".

August 2009: My opinions here are based on Brian Martin's website articles. They have been freely available since his original publication of my views of the story 12 years ago. There have been no responses from any source since then. My personal explanations and interpretations have been edited as new information has come to hand. They, also, appear on Martin's website.

Background to publishing of "Putting a surgeon under"

Brian Martin bmartin@uow.edu.au_19 January 1998

In May 1997, I sent a draft of John Wright's article to a number of the key figures mentioned in or associated with it. My standard cover letter was as follows:

Please find enclosed a copy of a manuscript by John Wright entitled "Putting a surgeon under: a personal story of hospital politics." I plan to publish it on my web site (http://www.uow.edu.au/arts/sts/bmartin/dissent/) in the next month or so. Before proceeding, I would appreciate any comment you may have to ensure the accuracy of the story. In addition, I invite you to write a response or commentary to be published along with the manuscript. In this case, please send your contribution by e-mail or computer disc.
Please send any response to me by 16 June. If you have any queries please don't hesitate to contact me.
Until all comments are received and any necessary changes are made in the manuscript, I would appreciate your cooperation in not copying, quoting or circulating the manuscript without John Wright's permission.

Here is a summary of the responses received. Dr Wright has made alterations or additions to his article in response to some of these points.

. Professor John Beveridge sent two letters, one dated 18 May and the other undated but received 21 May. In the latter and more substantive letter, Professor Beveridge noted that his legal advice was that he should write listing errors of fact and matters which he regarded as defaming him. His points concerned Dr Wright's title, Beveridge's own vocabulary and philosophy, the issue of commercial factors, administration of research funds, and his exercise of responsibility to recommend withdrawal of Dr Wright's operating privileges.

. Dr A. C. Bowring rang me on 23 May. He said he was sorry to hear that there was some further publication concerning Dr Wright and did not wish to see him suffer any further. He challenged many points in the manuscript but declined to write anything for publication or to mention any specific points that needed to be corrected.

. Dr Matthew Crawford sent me a long letter on 3 June. In it he described his training and experience and his work with Dr Wright. He presented various statistics to show that Dr Wright's replacement by another surgeon had led to considerably improved results. He also commented on some of the personal and organisational events of the period around Dr Wright's dismissal._On 18 June I wrote to Dr Crawford offering to publish his letter, or a version of it, on the web along with Dr Wright's article. I received no reply to this offer.

. Dr B Currie did not reply.

. Dr G Davidson did not reply.

. Sir Harold Dickinson on 11 June returned a copy of my letter, having written on it "no comment."

. Dr Barry Duffy did not reply.

. Mr J Gerathy did not reply.

. Dr Dennis Kerr did not reply.

. Dr W G Lawrence sent a brief note on 11 June, saying that he wrote in case an absence of reply might be taken as agreement with Dr Wright's article. He also noted that those publishing written material should be aware of defamation law.

. Emeritus Professor Gerald F. Murnaghan wrote on 11 June that he had no comment to make.

. Dr Andrew Pybus did not reply.

. Dr Andrew Refshauge, Minister for Health, wrote on 20 May acknowledging receipt of Dr Wright's manuscript. On 16 June I received a phone message from one of Dr Refshauge's staff members requesting that staff names be removed from the chronology dealing with the Mee report, but that the minister's name could stay.

. Dr Thomas A. Torda replied on 16 May saying that he did not propose to respond to Dr Wright's manuscript. He stated that various others, including Drs Davidson, Crawford, Currie, Kerr and Professor Murnaghan, should be offered an opportunity to comment.

One of the advantages of web publication is the ease with which changes can be made and material added or deleted. It is unfortunate, in my opinion, that none of the individuals listed above chose to make publicly available their own version of the events covered in Dr Wright's article. The offer for any of them or others to do so remains open. On 19 January 1998, I posted the following letter to all the individuals listed above.

Last year I sent you a draft manuscript by John Wright entitled "Putting a surgeon under: a personal story of hospital politics". A revised version of this article, taking into account comments received, can now be viewed on my web site (see http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/Wright/). A printed version is enclosed for your convenience, plus a copy of my commentary on the background to the article. Also on the web site is Phillip Knightley's article "The doctor is out" from the June 1990 issue of The Independent Monthly.

Please send me any comments you may have to improve the accuracy of the story, if possible by 20 February. In addition, you have a standing invitation to write a response or commentary which I can arrange to be put on the web along with John Wright's article. Please send your contribution by e-mail or computer disc.

The doctor is OUT

When an eminent doctor is fired by a prominent hospital, that is almost certainly the end of his career. PHILLIP KNIGHTLEY investigates a case in which a Supreme Court judge decided that a hospital can sack anyone it wants to -- even its top children's heart surgeon -- without telling why.

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JOHN SAXON WRIGHT is a blunt, uncompromising man. A traditionalist, he believes that once a patient is referred to a surgeon's care, the surgeon should be responsible for that patient until the care is complete. In the operating theatre he believed his power was like that exercised by the captain of a ship. He gave the orders; the others were there to contribute their talents but, when necessary, obey the surgeon.

During the 1970s and 1980s this belief increasingly ran contrary to a new theory -- that the high-tech world of modern surgery and the development of new drugs had given anaesthetists an extended and more interesting role. No longer were they there only to administer the anaesthetic; they now claimed a commanding role in the management of the patient in the post-operative period, in "intensive care".

Not only did this give them extra power and prestige but additional money. In the schedule of fees, a surgeon had been obliged to include a sum for post-operative care, but many now tacitly handed over this right to the anaesthetists. Today some anaesthetists prefer to concentrate on post-operative and other intensive care. In the United States, this extended role for anaesthetists has become formalised. There, anaesthetists obtain an extra qualification in intensive care, call themselves "intensivists" and specialise in this area. This has not met with general approval among surgeons. In a recent American College of Surgeons Bulletin a professor of surgery from the Harvard Medical School urged his colleagues to take the extra qualification themselves. "Now is the time to resume responsibility and recapture our proper leadership role," he wrote.

Wright, too, objected to anaesthetists taking over a major role in the post-operative period. He did not want control to go to anaesthetists automatically, but only with the surgeon's authority and liaison. As he says, "I feared that without someone in ultimate control, the care of the patient would deteriorate to being management by a committee of several experts."

In 1983, Wright brought to a head his long-standing conflict with the anaesthetists at the Prince Henry hospital in Sydney. Wright, head of the children's heart surgery department wrote to one Prince Henry anaesthetist saying, he recalls, that "although I respected his professionalism we had such different ideas about how we should do things that it would be best for patients if we did not work together any more."

Previously Wright had clashed with Sir Harold Dickinson, chairman of the hospital board, by complaining to the administration that facilities for the treatment of children at Prince Henry hospital were "sub-standard". Wright wrote: "I find a decision to deliberately perpetuate inferior standards quite unacceptable." Dickinson replied that he found Wright's characterisation not only wrong but needlessly offensive. "While this remains your attitude the

appropriate course would be for you to resign."
Dickinson now instructed the late John Delaney, the hospital's chief executive officer, to interview Wright. According to Wright, Delaney told him that he had been making trouble and that he should withdraw the letter about the anaesthetists. Wright refused. According to Wright, the head of surgery, Professor G. F. Murnaghan, said that the anaesthetists' version was that Wright was incompetent and that this was the source of the trouble. Since Wright was not willing to withdraw the letter, Wright was told he should go on leave for six weeks -- or be stood down -- while an inquiry was conducted. At the end of the six weeks Wright went back to work with an order from the hospital that he should avoid surgical cases that could cause friction with the anaesthetists. In fact, Wright continued to operate on the most complex cases. But Wright says a colleague told him privately: "The anaesthetists haven't forgotten."

This prediction proved correct when, two years later, in mid-1985, unknown to Wright, the director of theatres, Dr George Davidson, told the chairman of the department of paediatric surgery, assistant professor A. C. Bowring, that members of his staff were no longer prepared to give anaesthetics for Wright's operations. There remains some mystery over what happened to this complaint. In any event, in November of that year Wright was formally appointed director of the new department of children's heartsurgery at the Prince of Wales.

Wright was delighted with the appointment. He had advocated for some time that the only proper location for children's surgery was in the hospital that housed them, the Prince of Wales, and that therefore it should be moved from Prince Henry. What Wright did not known was that the anaesthetists and others had opposed such a department in the Prince of Wales on the grounds that it would put an excessive strain on resources and would draw off money, staff and equipment from other departments. At Prince Henry there was concern that such a move might further weaken the status of Prince Henry and compromise a fight which had been going on for two decades -- and is still going on -- to preserve this hospital. On the other hand, a new department might well be an advantage for the Prince of Wales at a time when it was under threat of being moved to cater for the growing population needs of Sydney's western suburbs.

"Unaware of this, I spent a month on top of the world," Wright says. "Then a feeling of insecurity set in. On the orders of the head of paediatrics, John Beveridge, others took over the pre- and post-operative treatment of patients, which was against all my practice and beliefs." Wright also considered that the department had deficiencies which worried him. He told the hospital executives that some assistants, anaesthetists and intensive-care workers did not have as much experience as he would like.

"There was no response to those complaints," Wright says, "so on 27 June,1986, I went to the hospital's chief executive officer, W. G. Lawrence, and told him that my view was that some inexperienced senior and junior staff were making crucial decisions about patients without reference to me. I said that unless this situation was reviewed, the new department should shut down." Lawrence had replied that Beveridge, then a close personal and professional friend of Wright, had it all in hand. On July 10, according to Wright, Beveridge came into Wright's office and told him that two anaesthetists did not want to work with him any more. Within hours Wright was suspended from operating. Five months later he was sacked. He was 57 and retirement would not have been unusual for a medico in his high-pressure and physically-demanding job. But Wright felt that important principles were involved. For example, the hospital had not told him what the accusations against were or who had made them or given him an opportunity to respond. So he decided to fight.

When it came to a choice between one senior surgeon -- no matter how long his service -- and the whole of the department of anaesthetics, the administration chose to sacrifice Wright, according to a later judgment delivered in his case. The question was: how best to do it? It seems that the hospital at first decided to question Wright's competence. But when Wright went to the Supreme Court in August 1986 to challenge his initial suspension, the hospital was ordered to provide the doctor with details of allegations and complaints against him. Then the hospital, perhaps realising the difficulty of winning on the issue of Wright's incompetence, changed its approach and on legal advice decided to fight on its right to dismiss any employee with or without a reason. If pressed for a reason, it could simply cite the fact that some anaesthetists did not want to work with Wright.

This is, in fact, what the Supreme Court agreed with when in June 1987, in his second court action, Wright sought unsuccessfully to compel the hospital to give him back his job. The judge, Mr Justice Bryson, said his decision that Wright could not demand reinstatement was not a reflection on Wright's ability. "A decision to cease to employ a surgeon in work which retains some of the character of experiment and adventure passes no judgment on his general competence," he said.

But by then the damage had been well and truly done. During the first Supreme Court hearing, when the hospital was still using the tactic of questioning Wright's competence, its lawyer, Peter King, said on instructions that the hospital had suspended Wright out of concern for patients' lives. This accusation was widely reported.

But all the hospital provided in court by way of proof of Wright's incompetence were statistics that suggested the mortality rate in certain operations Wright had performed exceeded the average. King said of four operations Wright had performed involving aortic valve procedures, two had resulted in death, whereas the mortality rate for this operation was normally less than 10 per cent.

At that stage the hospital had still not held a formal inquiry into Wright's competence. It now moved to do so. In November of 1986 it co-opted an expert surgeon, nominated by the Royal Australasian College of Surgeons, to assist an inquiry by the non-expert laymen of the hospital's medical practices committee. This was Roger Mee, director of the paediatric cardiac surgical unit at the Royal Children's Hospital, Melbourne.

Dr Mee attended hearings of the medical practices committee and made his report in December. He came down in favour of Wright and was highly critical of the hospital's case. He said:

- in depth analysis had not been performed of each case where Wright was criticised;
- case summaries were compiled by staff members who had already stated their lack of support for Wright;
- he suspected that there were problems of lack of experience and expertise with some of these staff;
- he suspected that intensive-care management (no longer Wright's responsibility) was less than ideal;
- all complications alluded to in the case summaries were well recognised complications and each complication, taken on its own, was unremarkable.

Dr Mee concluded: "I believe that Professor Wright was working under less than ideal

conditions, that it is quite inappropriate to expect the same results from this unit as may be achieved in a much larger unit such as the Mayo Clinic, Toronto Children's Hospital, Boston Children's Hospital, or my own unit." He said he had been able to support the contention that there was a lack of confidence in Wright's competence only because he had heard this opinion expressed at the committee hearings. "But from the data examined I am unable to determine ... whether or not Professor Wright is solely responsible for the lack of confidence" (emphasis by Mee).

But the hospital board meeting at 8am on December 19, 1986, decided to turn Wright's suspension into a sacking yet not to pursue the competence issue. The medical practices committee did not make any finding on Wright's surgical competence and the hospital has not referred to it again, in court or elsewhere.

Wright himself had to take legal action to get a copy of Mee's report, only to find that it could not be admitted as evidence in his court case because the hospital had asked for the report only after deciding to dismiss him on grounds of lack of confidence. Wright was thus unable to undo the damage caused to him by the hospital's earlier allegations of incompetence. To this day Mee's report is not mentioned in the NSW health department's dossier on the Wright case and all his attempts to persuade the department to add the report to its files have failed.

The significance of the hospital's new tactic -- to fight Wright's application for re-instatement on the right of the hospital to hire and fire whom it liked -- remains generally unappreciated. In its finding, the Supreme Court ruled that a hospital doctor, no matter how eminent, was, in effect, just another employee. His contract of employment could be "terminated by either party on reasonable notice, without stating or without there being any reasonable ground."

Wright was beaten. No-one of his seniority had ever been dismissed in such a manner.
He began to pick up the pieces of his life. Many of his friends and colleagues who had read the reports of the affair found it embarrassing to meet him and, with few exceptions, fell away. Wright said: "The general feeling was that while there was smoke there must be fire."

Now Wright is back in Macquarie Street with a new and successful career as a consultant but the scars remain. "My reputation has been vandalised. It is ironic that, after I had gone, the hospital acted quickly to correct every single component of the list (of deficiencies) I compiled, and Dr Mee compiled, of what was wrong."

Two requests for the hospital's views on the Wright case -- one by letter and one by telephone -- were not answered.

TWO RESPONSES (From The Independent Monthly, July 1990)

I read with interest Phillip Knightley's article on the dismissal of Professor John Wright (IM June) from Prince of Wales Children's Hospital. The allegations by the hospital's barrister in a Supreme Court hearing that "mortality rates in certain operations Wright had performed exceeded the average" was of particular interest to me in the light of the following experience. Seven years ago, returning from a holiday in Fiji, I sat next to and befriended a Fijian woman and her one-year-old daughter, flying to Sydney for urgent cardiac surgery for her baby. The child was desperately ill, and had been referred to a cardiac surgeon. The child spent several weeks in hospital for appropriate investigations. The surgeon decided not to operate on her as she was too ill. Arrangements were made by the hospital to send her back to her village in

Fiji -- surely to die!
I knew Professor Wright socially and begged him to review the child's condition, and if possible give her a chance to live. This he agreed to do, explaining to the mother there was a less than 50 per cent chance of success.

Today that child is a wonderful healthy little girl of eight, doing well at school and even participating in school sports. Professor Wright saw the chance of a future for this poor child as more important than his mortality rate.

It would appear to me that Professor Wright is a victim of personalities and politics.
Rose Watson_Vaucluse, NSW.

In reply to Phillip Knightley's article, The Doctor is Out (IM June), I would like to express my shock that such a dedicated surgeon as Professor Wright could have his career ended in such a way.

My own association with Professor Wright began 11 years ago when he operated on my son at the age of seven months. This association continued as my son's cardiac problems were an ongoing concern.

[Professor Wright was sacked without any reason being offered to a court. The hospital (Prince Henry and Prince of Wales are jointly administered) relied on its legal right to terminate a surgeon without giving a reason.]

My son's surgery was carried out at Prince Henry Hospital and he was receiving outpatient treatment through the Prince of Wales Hospital until the time of Wright's dismissal.
At Prince Henry Hospital the sub-standard conditions of which Professor Wright complained did exist. The ward in which these children were housed was dark, damp and airless. No consideration had been given to providing for the needs of these children, physically or emotionally or educationally -- a consideration you would expect in light of the amount of knowledge available in the area of early childhood development.

Pre and post-operation patients were transported to theatre via open roadways in all types of weather. There was no intensive care unit at Prince Henry for these children.

After surgery the children would be taken to an intensive recovery area; however, they could not remain there for long periods as there were not sufficient beds, staff or equipment to allow surgery on other patients to proceed. Very sick children would be transported to Prince of Wales Hospital; others would go back to the general ward. There was no specialty staff in these wards and very little equipment to assist in the treatment and monitoring of these children.

There were always chronic staff shortages. It was not uncommon on some shifts to have only two nursing staff attempting to care for 28 heart babies. Staff were dedicated and did the best they could under the circumstances. They often cried tears of frustration at not being able to provide properly for the children in their care.

Complaints were made but there were never any changes. Parents and staff eventually gave up, such are the emotional drains which accompany such action. Professor Wright, however, did not. Along with Wright we were elated when we learnt that after a fight which stretched

over several years our child would be able to share in the benefits of a hospital (Prince of Wales) which was designed to cater for the needs of small children. We assumed that when our son's medical condition required further surgery he would return to the Prince of Wales Hospital. Professor Wright, however, was dismissed before this eventuated so my son's recent surgery was carried out elsewhere.

We did, however, from previous visits to Prince of Wales experience problems mentioned in Knightley's article. On several occasions we were forced as parents to make complicated medical decisions which we did not have the knowledge to make. The experts could never agree on the treatment they thought my son should receive. Eventually, in an attempt to retain some sanity, we chose to have only Professor Wright treat our son.

Our son is a happy, contented child who bears no emotional signs of the ordeal he has undergone. I attribute this to the emotional support which Professor Wright has offered to our family, and to his expert medical care.

Over the years we have met many families who share the same admiration and gratitude for Professor Wright as we do. His sacking is a sad loss to these children and to many children who now will never be given the chance that our children have been given.
P. McKensey_Budgewoi, NSW.