Our Ref: H19/11191 : DD20/34213

PROFESSIONAL STANDARDS COMMITTEE INQUIRY

Constituted under Part 8 of *the Health Practitioner Regulation National Law (NSW)*
to hold an Inquiry into a Complaint in relation to:

Dr Paul Joseph Cozzi
MED0001149458
254240

Date/s of Inquiry:	6, 7 & 8 July and 2 September 2020
Committee members:	Ms Diane Robinson (Chair) Dr Alexander Grant Dr Marcela Cox Ms Jennifer Houen
Appearance for Health Care Complaints Commission:	Ms Emma Bayley, Legal Officer
Appearance for Dr Paul Joseph Cozzi:	Ms Eva Elbourne of counsel, instructed by Ms Lauren Biviano from Meridian Lawyers
Date of decision:	3 November 2020
Decision	The Committee made findings of unsatisfactory professional conduct and determined to reprimand the practitioner and impose conditions on his registration.
Publication of decision:	Refer to page 28

REASONS FOR DECISION

INTRODUCTION

THE COMPLAINT

1. Dr Paul Cozzi is a specialist urologist. On 11 December 2019 the Health Care Complaints Commission (the Commission) made a formal complaint alleging that Dr Cozzi is guilty of unsatisfactory professional conduct. The Complaint is now being prosecuted before this Professional Standards Committee. At the commencement of the proceedings the Complaint was amended without objection and with the leave of the Committee.

2. In summary, the Amended Complaint alleges that in November 2015 Dr Cozzi left a trainee urologist unsupervised to perform several surgeries at St George Hospital (SGH). Secondly, it is alleged that he breached the legislative and NSW Health policy requirements in relation to the production of medical records, by signing blank count sheets prior to the completion of surgery and making medical records when he was not present for the patient's surgery. Thirdly, it is alleged that Dr Cozzi made false and misleading statements to the South Eastern Sydney Local Health District (LHD) and the Commission, when these matters were investigated.

3. The Amended Complaint contains several Particulars and is set out in full in Annexure A to this decision.

LEGISLATIVE PROVISIONS

4. Unsatisfactory professional conduct is defined in section 139B of the *Health Practitioner Regulation National Law NSW* (National Law (NSW)), as, amongst other things, conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

5. It is also defined to include a breach of Regulations and improper or unethical conduct relating to the practice or purported practice of medicine.

6. Section 139B of the National Law (NSW) and other relevant legislative provisions are set out in Annexure B to this decision.

STANDARD OF PROOF

7. The Commission bears the onus of establishing that Dr Cozzi is guilty of unsatisfactory professional conduct.

8. The standard of proof required to establish the Complaint is the civil standard so the Committee must be reasonably satisfied on the balance of probabilities of the matters alleged against Dr Cozzi. Given the seriousness of the allegations and the nature of their consequences, the Committee needs to be comfortably satisfied that the Complaints have

been established on the Briginshaw principles (see *Briginshaw v Briginshaw* (1938) 60 CLR 336).

ISSUES

9. The issues to be determined by this Committee are:

   a. Which, if any, of the Particulars of the Complaint are proven to the comfortable satisfaction of the Committee.

   b. Whether the proven conduct overall amounts to unsatisfactory professional conduct. The Committee can look at all the conduct found proven either separately or cumulatively when making a determination as to whether the conduct amounts to unsatisfactory professional conduct (*Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 at 545, 546 and 547).

   c. If such a finding is made the Committee must decide whether orders or directions made pursuant to Part 8 Division 3 Sub-division 3 of the National Law are appropriate.

EVIDENCE

10. In addition to the documentary material provided by the parties, the Committee heard evidence from the following people:

- Dr Cozzi, the Respondent
- Dr X, Urologist (urology trainee in 2015)
- Dr Malouf, Head of Urology Department, SGH
- Dr Hutton, VMO and Supervisor of Urology Training, SGH
- RN Beames, Scout/scrub nurse, SGH
- RN Davies, Nurse Manager, Perioperative Services, SGH
- Dr Wong, Urological surgeon and expert witness for the Commission.

BACKGROUND

Dr Cozzi

11. Dr Cozzi graduated Bachelor of Medicine Bachelor of Surgery from the University of New South Wales in 1990. He worked as an intern and resident at SGH and began his surgical training there in 1992. He completed his specialist fellowship training at Nepean Hospital, Royal Prince Alfred Hospital and SGH. He has been a Fellow of the Royal Australian College of Surgeons since 1999. He practices as a specialist urologist, often dealing with urologic oncology.

12. In November 2015 Dr Cozzi was a Visiting Medical Officer at SGH. He was also a Visiting Specialist at the Mater Private Hospital (Mater) in Crows Nest. On 12 November 2015 Dr Cozzi had a surgical list at SGH. He also had a surgical list at the Mater.

13. There were five patients on Dr Cozzi's list at the Mater. He attended the Mater between about 7.40am and 9.10am and performed surgery on three patients. He then left the Mater and drove to SGH. During the morning Dr

Cozzi left SGH and drove back to the Mater. He did not return to SGH on 12 November 2015. At the Mater he was involved in the surgery for the two other patients on his list.

14. Dr X, a trainee urologist, operated on the patients on the SGH list. Patient A, who is not the subject of any Particular of the Amended Complaint, was operated on between about 9.30am and 10.26am. Patient B was operated on between about 11.05am and 11.44am. Patient C was operated on between about 12.28pm and 12.57pm. Patient D was operated on between about 13.22pm and 14.21pm and Patient E was operated on between about 14.30pm and 14.54pm.

Particular 1 - Supervision

15. Particular 1 of the Amended Complaint alleges,

Between about 1035 and 1454 on 12 November 2015, the practitioner left Doctor X unsupervised to perform four surgical procedures at St George in circumstances where:

a. Doctor X was a SET 5 Urology Trainee;
b. at about 1035, the practitioner left the grounds of St George;
c. the practitioner did not tell Doctor X where he was going;
d. the practitioner did not tell Doctor X how to contact him in the event of an emergency;
e. Doctor X performed surgical procedures at St George for Patient B, Patient C, Patient D and Patient E between about 1105 and 1454;
f. the practitioner performed surgical procedures at the Mater for Patient I and Patient J between about 1105 and 1633;
g. the practitioner was not physically available at St George to assist Doctor X in the event of an emergency.

Particular 1a

16. There is no dispute that Dr X was a SET 5 Urology trainee. Dr Cozzi admits Particular 1a.

Particular 1b

17. Dr Cozzi agrees he left SGH during the morning of 12 November 2015 to drive to the Mater. He does not accept that he left SGH at about 10.35am. He thinks it may have been later. Dr X's evidence is that Dr Cozzi was present for 15 – 20 minutes during the surgery on Patient A. That surgery commenced at 9.30am and SGH records show Dr Cozzi entered the Operating Theatre (OT) at 10.10am. RN Beames gave evidence that she saw Dr Cozzi in theatre during Patient A's procedure but when she retuned from a break at 10.30am he was gone.

18. E-Toll records show that Dr Cozzi's vehicle was on the Eastern Distributor at 10.57am. Mater car park records show that he entered the Mater car park at 11.03am. The Committee is satisfied that the available evidence indicates Dr Cozzi left SGH at around 10.35am on 12 November 2015.

Particulars 1c and 1d

19. Dr Cozzi denies Particulars 1c and 1d. He said he told Dr X where he was going the day before the surgery and Dr X had his mobile number so he could call or text him.

20. Dr X says that at some time before 6 November 2015 Dr Cozzi called him and asked him to send him an email stating that he was happy to do the 12 November list unsupervised. Dr Cozzi denies making such a call. Dr X said he was aware that as a SET 5 trainee he is not permitted to perform surgery unsupervised. He felt uncomfortable about Dr Cozzi's request and spoke to Dr Hutton and Dr Malouf.

21. Dr X said that Dr Cozzi had not told him why he wanted the email or its purpose. He said Dr Cozzi had not told him about his surgery at the Mater. He became aware of Dr Cozzi's list at the Mater when he saw email communication between Dr Cozzi and Dr Hutton. He said he was also told about the Mater list by Dr Namdarian, Dr Cozzi's assistant at the Mater.

22. In his correspondence with the Commission, dated 9 April 2018, Dr X said, *"I was later informed by others (never by Dr Cozzi) that he was planning to perform robotic radical prostatectomies at the Mater but I had no idea at the time of our phone call and email exchange."*

23. However, Dr Hutton's evidence is that Dr X rang him to express concern about operating independently and indicated that Dr Cozzi was not available as he was operating elsewhere. Certainly the email Dr Hutton sent to Dr Cozzi (see paragraph 37 below) shows Dr Hutton was aware Dr Cozzi had a list at the Mater on 12 November 2015.

24. In any event, Dr X says that when Dr Cozzi left the SGH OT he did not state where he was going. In his 9 April 2018 letter, Dr X states, *"I was not aware of Dr Cozzi's whereabouts after he left the theatre. He did not inform me of his whereabouts prior to, or during, the case."* This is in part corroborated by RN Russell's statement, dated 23 October 2017, which states that Dr Cozzi *"left after the first procedure and said words to the effect of, 'I am off for the rest of the day."*

25. Dr X agreed that he did have Dr Cozzi's mobile number and could contact him by phone. In his interview with the PPU on 17 March 2016, Dr X said that when Dr Cozzi left the OT he said he was *"happy that the operation was going fine, he was leaving and if there were any problems to give him a call."*

26. In relation to Particular 1c, there may be some inconsistency between the evidence of Dr Hutton and Dr X, but Dr X has maintained throughout that Dr Cozzi did not tell him about the list at the Mater and that when Dr Cozzi left the OT there was no discussion of where he was going. The Committee accepts Dr X's evidence on this point and finds on this basis that Particular 1c is proven.

27. However, Particular 1d is not proven as there had been communication between Dr Cozzi and Dr X by text message on the morning of 12 November 2015, Dr X did know how to contact Dr Cozzi and Dr Cozzi told him to call if necessary.

<u>Particular 1e</u>

28. There is no dispute that Dr X performed the surgery for Patients B, C, D and E. Dr Cozzi admits Particular 1e.

Particular 1f

29. Dr Cozzi acknowledges that he was involved in the surgery for Patients I and J at the Mater. He does not accept the time frame alleged. Dr Cozzi accepts that he arrived at the Mater at 11.03am. He says he cannot recall exactly what he did on arrival. However, he says that his assistant at the Mater, Dr Namdarian commenced the surgery on Patient I before he attended the OT.

30. His evidence about the time he joined Dr Namdarian in the OT has varied considerably. In his interview with the PPU on 16 September 2016, Dr Cozzi said he arrived one and a half or perhaps two hours after the surgery began.

31. In his oral evidence on 8 July 2020 Dr Cozzi said he arrived at the Mater just after 11am, he went to the OT, then to the day surgery to check on the patients he had operated on that morning and then returned to the OT at 11.30am or 11.40am. He later said he scrubbed in after midday.

32. The documentation from the Mater indicates that Dr Cozzi was the operating surgeon for Patient I whose procedure commenced at 11.05am.

33. In his interview with the LHD on 23 March 2016 Dr Namdarian stated that he left SGH mid to late morning on 12 November 2015 to travel to the Mater where he was assisting with Dr Cozzi's surgical list. When asked what time Dr Cozzi arrived at the Mater he stated, *"I can't estimate that but the case I started with Dr Cozzi was late morning roughly."*

34. Dr Cozzi has recalled various times for when his involvement in Patient I's surgery began. Given Dr Cozzi's partial admission and the available documentary evidence, the Committee is comfortably satisfied that Particular 1f is proven.

Particular 1g

35. Dr Cozzi denies Particular 1g. He says that he was physically available to supervise the morning list at SGH. He asserts this despite the fact that he left SGH around 10.35am and was at the Mater from 11.03am where he was involved in complex urological surgery. The surgery that began at the Mater at 11.05am was a robotic assisted nerve sparing radical prostatectomy with lymph node dissection.

36. Dr Cozzi said he was available because he moved his robotic cases at the Mater back to the afternoon, so he could supervise the morning list at SGH.

37. Both Dr Hutton and Dr Malouf had raised concerns about an unsupervised list with Dr Cozzi. At 7.41am on the morning of 11 November 2015, Dr Hutton wrote to Dr Cozzi,

> *"I understand you are planning an unsupervised list tomorrow at SGH. Although I have no doubt Dr X is more than capable, it is a stipulation of the USANZ Board that all SET 3-5 are fully supervised.*

If you could either cancel your operating list at the Mater or arrange alternative consultant cover for the St George list, then obviously the list will be able to go ahead. Otherwise it will have to be cancelled.

If you could respond to this as quickly as possible especially if the list needs to be cancelled so that Wendy can make the appropriate arrangements."

38. In his reply to Dr Hutton's email, on 12 November 2015, Dr Cozzi stated,

"……. I made arrangements to be here this morning for my part of the list and moved my Mater robot cases to the afternoon."

39. In his Statement to the Committee, dated 15 June 2020, Dr Cozzi stated that at his request his practice manager arranged to move his robotic cases at the Mater to the afternoon. There is no documentary evidence of this request and the letter from the CEO of the Mater to the Commission, dated 28 February 2017, states that no correspondence was received from Dr Cozzi related to the rescheduling of his surgical cases on 12 November 2015. The letter states, "*He didn't reschedule, he operated from 7.33am in a regular operating list."* There is no dispute that Patient I's robotic procedure at the Mater started at 11.05am.

40. Despite Dr Cozzi's apparent belief or understanding that the robotic cases had been moved back to the afternoon, he left SGH around 10.35am and was present at the Mater from 11.03am. When asked why he had done this, he stated he was comfortable with Dr X performing the SGH surgeries and he could return if there were problems.

41. Dr Cozzi also stated that he received a text from Patient I's anaesthetist, when the anaesthetic was started, to ensure that he was close by and ready to proceed. Patient I's anaesthetic started at 10.10am and Dr Cozzi estimates he received the text around 10.45am. He believes it is likely he received this text while driving from SGH to the Mater.

42. On the available evidence, it is difficult for the Committee to accept Dr Cozzi's assertion that he had moved or attempted to move his robotic cases at the Mater to the afternoon of 12 November 2015.

43. In addition, Dr Cozzi told the Committee that his assistant at the Mater, Dr Namdarian was a SET 6 trainee and could be left to perform the robotic surgery independently, if necessary. He said he could leave the Mater and return to SGH to assist Dr X if required. He said he could return in 20 or 25 minutes. He acknowledged that it might take him 10 minutes to prepare and scrub in for surgery, so he could be available in 30 minutes.

44. As noted above, the documentation from the Mater indicates that Dr Cozzi was the operating surgeon for Patient I whose procedure commenced at 11.05am. The Committee is satisfied that Dr Cozzi was involved in performing surgery at the Mater from around that time (see Particular 1 f). However, Dr Cozzi asserts that he was not scrubbed in until after midday and so, until then he could drive back to SGH to assist Dr X.

45. Dr Wong, the expert witness for the Commission, stated that a supervising consultant must be available to assist in case of difficulty or emergency. Patient safety requires this. He was strongly critical of a supervising consultant leaving the grounds of SGH during an operating list, and particularly leaving to go to another OT. He said it did not matter if the other hospital was only a short drive away, if the consultant is involved with another patient in another OT, patient safety could be compromised.

46. Particular 1g alleges that Dr Cozzi was not physically available at SGH to assist Dr X in the event of an emergency. Dr Cozzi left SGH around 10.35am and travelled to the Mater where he was involved in complex robotic surgery. He did not return to SGH on 12 November 2015. The distance between SGH and the Mater, the time involved in travelling between the two hospitals and most importantly, the fact that Dr Cozzi was responsible for patients undergoing surgery at the Mater meant that he was not physically available to assist Dr X. The Committee is satisfied that Particular 1g is proven.

Dr Cozzi's credibility.

47. It is convenient at this point to comment on Dr Cozzi's credibility. These comments relate to the Committee's assessment of Dr Cozzi's evidence in respect to all the Particulars of the Complaint.

48. The Committee did not find Dr Cozzi to be a credible or trustworthy witness. In his evidence to this Committee, and to the PPU and the Commission, Dr Cozzi gave inconsistent and contradictory information about his conduct and activities on 12 November 2015.

49. In his oral evidence to the Committee, Dr Cozzi had difficulty responding in a clear and direct manner to questions asked of him. His responses were often tangential. Many answers were vague. The Committee considered that many of his answers were designed to obfuscate and deflect attention from the relevant issues. He did not make a genuine attempt to answer questions in a frank or open manner.

50. The Committee heard oral evidence from Dr X, Drs Hutton and Malouf and RN Beames and RN Davies. In contrast, these witnesses presented as honest, forthright and credible. When the evidence of Dr Cozzi was in direct conflict with that of the other witnesses, the Committee was unable to place significant weight on Dr Cozzi's statements and preferred the evidence of the medical and nursing staff, who in the Committee's view gave consistent and reliable accounts of the events in issue.

Unsatisfactory Professional Conduct

51. Having determined that Particulars 1a, b, c, e, f and g are proven, the Committee considered whether the proven conduct amounts to unsatisfactory professional conduct (UPC).

52. Dr Cozzi denies that his conduct is unsatisfactory professional conduct. He says Particular 1 is misconceived as it is based on a false assumption that a supervising surgeon must provide direct supervision at all times. Dr Cozzi says supervision could be direct or remote.

Remote supervision.

53. Dr Cozzi was the Supervisor of Training in the Urology department at SGH until early 2013. Dr Malouf took over this role from February 2013 until 2015, when the current Supervisor of Training, Dr Hutton was appointed.

54. In 2013, following an inspection by the Urological Society, the supervision provided to trainee urologists at SGH was strongly criticised, giving rise to a risk that accreditation may be lost. Dr Malouf stated that there was extensive discussion in the department at the time about the findings of the 2013 report and about supervision.

55. Dr Hutton said that from 2013 on there was a consensus in the Urology Department about the level of supervision required and direct supervision, with consultants in attendance at SGH, was the agreed approach. In his interview with the PPU Dr Hutton stated,

> *"One of the criticisms was in the past that consultants had been scheduling private operating lists at the same time that public had lists on….. and that was obviously, I think everyone in the department was told that that was unacceptable."*

56. Dr Hutton said supervision might involve the consultant being present in the OT or being present nearby, perhaps doing a ward round or having a tea break, so he can attend if needed. The supervisor must be at SGH and not have competing activities or duties. Dr Malouf agreed that supervisors had to be in attendance at SGH with no competing activities permitted.

57. Dr Cozzi told the Committee that he could not recall the 2013 report or discussion of it. He asserted there was no agreement in the department about supervision. He accepted that a consultant should be in the vicinity of the hospital, but considered that being 30 minutes away satisfied this criterion. He relied on an analogy between supervising consultants and consultants on call, who might be 30 minutes away from the hospital.

58. On 22 June 2015 Dr Hutton emailed Dr Cozzi to remind him of the supervision arrangements,

> *"Recently there have been a number of examples of poor supervision of operating lists at SGH. Supervising surgeons need to be readily available and onsite for all operating lists. Consulting or operating elsewhere is plainly unacceptable. I'm sure you remember that this was a previous criticism of the department and part of the reason why we were put on probation."*

59. In oral evidence Dr Cozzi said that Dr Hutton's opinion does not reflect common practice, which is that surgeons may be operating elsewhere while a public list is underway.

60. Dr Cozzi also relied on the recognition of remote supervision by the Urology Board. The Chair of the Board of Urology wrote to the Commission in October 2017 stating that the nature of supervision depends on the complexity of the procedure and the competence of the

trainee. He acknowledged that sometimes trainees perform procedures with remote or off-site supervision. He stated,

> *"However, it is expected that even in cases of "remote supervision" the supervising consultant can be contacted for advice, and is readily physically available to assist the trainee if they find themselves out of their depth and patient care may be compromised. This may mean the consultant should not commit themselves so that they are not available."*

61. Dr Hutton agreed that the exact nature of supervision depends on the circumstances, but gave evidence that remote supervision was not routine at SGH. Dr Hutton said that a SET 5 Trainee requires direct supervision. He said that remote supervision, by telephone, was not considered to be supervision. Dr Hutton and Dr Malouf agreed that remote supervision was unacceptable and inappropriate for a SET 5 trainee.

62. Dr Cozzi also argues that Particular 1 is misconceived in so far as it refers to him being responsible for the supervision of patients after 12 noon. He says he was only required to supervise the morning list.

<u>The Morning List</u>

63. On 20 October 2015 Wendy Stone, the manager of the admissions office, sent an email asking if Dr Cozzi was available to cover an AM session on Thursday 12 (sic) November 2015. On 4 November 2015 Ms Stone sent an email to Dr X, including a two page list described as the OT list for 12 November. That list included six patients, 4 admitted under Dr Cozzi and 2 admitted under Dr Z. Dr X forwarded that list to Dr Cozzi on 6 November 2015 referring to it as the morning list.

64. The final OpSuite list for 12 November 2015 contained 8 patients, 5 admitted under Dr Cozzi and 3 admitted under Dr Z. It is described as the Urology list 09.30 – 16.30. As a departmental meeting took place on a Thursday morning, the list often commenced later than usual, around 9AM or 9.30am.

65. Dr Cozzi relies on the email from Ms Leisa Rathborne, General Manager, SGH, dated 25 October 2016, which states,

> *"Although it is not entirely clear, I have accepted that your responsibilities for the 'morning list' (despite only two of the five patients listed under your name being completed by 12.00 pm) ended at 12.00pm."*

66. Dr Hutton told the Committee that a morning list could contain 1 patient, if it was a complex surgery, or it could contain several patients having minor surgeries. Dr Hutton said that if a list was running late, the supervising surgeon may run over time or defer the surgery to a later date or organise for another consultant to take over supervision.

67. There is no dispute that Dr Cozzi had a surgical list at SGH on 12 November 2015. Having regard to the available evidence, it would appear that is was a list containing 5 of Dr Cozzi's patients. And at various times Dr Cozzi accepted responsibility for those patients.

68. Dr X emailed Dr Cozzi on 6 November 2015, referring to a list containing 6 patients, *"Attached is the morning list for 12 November as discussed. I will do these cases with you available as needed."* In his email to the PPU on 5 May 2016, Dr Cozzi stated, *"Dr X emailed me (6/11/15, attached) with a copy of the MORNING LIST that I had committed to supervise."*

69. Dr Malouf emailed colleagues on 11 November 2015 stating,

> *"I spoke to Paul Cozzi a few minutes ago. He assures me he will be there at 0900 - 0915 for a scheduled 0900 start in SGH theatres. His four or five cases will be appropriately supervis*ed."

70. Dr Cozzi denies he made that statement to Dr Malouf.

71. In his email to the PPU on 5 May 2016 Dr Cozzi accepts responsibility for Patient A, B and C on the SGH list. In the letter to the Commission dated 24 October 2017, he again accepts responsibility for the first 3 patients on the list,

> *"Dr Cozzi submits that he was present for and supervised directly or indirectly the three cases he was required to supervise until midday."*

72. In his oral evidence to the Committee, Dr Cozzi says he was only responsible for 2 patients, Patients A and B as their surgeries were completed before 12 noon. He accepts he was responsible for the morning list, but asserts that list is determined by time only. For example, 5 patients may be on a list, but if only 2 are operated on before 12 noon, they constitute the morning list and the rest are afternoon patients.

73. Dr Malouf gave evidence that pooled lists had been used for some time at SGH to ensure that OT use was optimised. Dr Cozzi said the 12 November 2015 list was a pooled list. He said that supervision was to be shared between himself and another consultant, Dr Z.

74. In both his statement to the PPU on 5 May 2016 and his interview with the PPU on 16 September 2016, Dr Cozzi said he spoke with Dr Z on 11 November 2015 and Dr Z confirmed his availability to cover the afternoon list. In his oral evidence he also said he had contacted Dr Z by telephone.

75. Dr Z's statement to the Commission, dated 9 July 2018, states that he does not recall nor could he find any record of Dr Cozzi asking him to cover any surgeries on 12 November 2015. He was working at Hurstville Private Hospital on that day from 7.30am to 13.00pm.

76. Dr Z made enquiries with SGH HR department and was informed that he was paid for 1 hour's work on 12 November 2015. He stated that if he had covered an afternoon list he would have billed for it. He regarded this an accurate surrogate confirmation that he did not cover Dr Cozzi's cases on 12 November 2015.

77. There is no documentary evidence before the Committee to establish that the urology list on 12 November 2015 was a pooled list. There is no

documentary evidence indicating the involvement of Dr Z as the afternoon consultant and it appears he did not participate as such.

The Committee's decision

78. It may be that the morning list 'morphed' into an all day list, without proper administrative follow up. It may be that too many patients were on the morning list for it to be finished by 12 noon, especially as the list had started late. In any event, Dr X and the nursing staff involved in the list understood it to be Dr Cozzi's list. And in November 2015 Dr Cozzi understood that too. He confirmed his supervision of the patients on that list with Dr X and Dr Malouf in November 2015. It is only later, when writing to the Commission in 2017 that he said he was responsible for only 3 patients on the list and then before this Committee he said he was responsible for only 2 patients.

79. The Committee considers that Dr Cozzi was responsible for the urology list on 12 November 2015. The Committee also accepts that Dr Cozzi had only agreed to be available in the morning of 12 November 2015. If Dr Cozzi's list was running late and he was not available after 12 noon, he could decide to defer procedures or ask another consultant to take over, neither of which occurred. Instead, the SGH list continued while at the same time Dr Cozzi was responsible for a surgical list at the Mater.

80. The investigation by the PPU resulted in the following finding being made by the CEO of SGH in relation to Dr Cozzi,

> *"I am currently of the view that when you realised you had two competing lists on the morning of 12 November 2015 you initially attempted to get the SET 5 Trainee to agree, in writing, to undertake the St George list unsupervised, despite knowing that this was contrary to your supervisory requirements. When it became known to Drs Malouf and Hutton that you had a competing list and you were instructed that you must supervise the morning list at St George or have someone else supervise, or cancel it, you chose to tell Drs Malouf and Hutton that you had moved your Mater cases to the afternoon but continued with both lists running on the morning of 12 November 2015."*

81. The Committee agrees with his conclusion.

82. There is no doubt that a SET 5 Trainee required supervision. The Committee accepts the evidence of Dr Hutton and Dr Malouf that at SGH after the 2013 report, direct supervision with the consultant present at SGH, not necessarily in the OT but available to assist if needed, was the agreed approach. It is difficult to accept that Dr Cozzi was not aware of this, as the 2013 report had been widely discussed and he had been the Supervisor of Training until early 2013. In addition, he had been reminded on a number of occasions of his obligations as a supervisor.

83. Dr Wong's evidence concerning the requirements for the supervision of trainees was consistent with the evidence of Dr Hutton and Dr Malouf. The Committee accepts that the nature of supervision may vary with the circumstances, particularly the complexity of the procedure and the skills and competence of the trainee. However, remote or offsite supervision,

where a surgeon is not physically available to assist, is not acceptable. The Board of Urology makes it clear that even with remote supervision a consultant must be readily available and Dr Cozzi was not.

84. Dr Wong stressed that having two lists running concurrently was not acceptable professional practice. He said a consultant cannot provide even remote supervision while he is engaged in another operating list. *"Once he is engaged in a list elsewhere that is not remote supervision, that is no supervision."* Dr Malouf and Dr Hutton agreed it was unacceptable for Dr Cozzi to have a list at the Mater at the same time he had a list at SGH.

85. The Committee is satisfied that Dr Cozzi failed to provide supervision to Dr X as alleged in Particular 1. The Committee accepts the evidence of Dr Wong that his conduct is significantly below the standard to be reasonably expected of a specialist urologist with Dr Cozzi's training and experience. Dr Wong's opinion is consistent with the evidence of Dr Malouf and Dr Hutton. The Committee is satisfied that Dr Cozzi's conduct constitutes unsatisfactory professional conduct.

Particulars 2 and 3 - inappropriate medical records

86. Particular 2 alleges:

Between about 1010 and 1035 on 12 November 2015, the practitioner made a medical record for Patient B's surgical procedure at St George in circumstances where:

a. the practitioner signed a blank Count Sheet;
b. the practitioner signed a Clinical Procedure Safety Check List;
c. Doctor X performed Patient B's surgical procedure at St George between about 1105 and 1144;
d. the practitioner was not present at St George for Patient B's surgical procedure;
e. the practitioner failed to comply with NSW Health policy directives, Clinical Procedure Safety PD2014 036 dated 20 October 2014 and Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures PD2013 054 dated 18 December 2013, in that the medical record was signed prior to the completion of the procedure;
f. the practitioner failed to comply with clause 9 of the Health Practitioner Regulation (NSW) Regulation 2010 in that the medical record was not made contemporaneously with the provision of the medical treatment.

Particular 2a

87. Dr Cozzi denies Particulars 2a. His response to the Complaint states,

"The Practitioner does not admit the facts alleged in 2(a) on the basis that the alleged Count Sheet is no longer available, the matter was not brought to his immediate attention and therefore his memory as to what occurred is limited. The Practitioner says that although RN Russell claims she saw him sign multiple count sheets…… they have apparently been destroyed and other nurses do not corroborate that."

88. The evidence of RN Russell, who was the scout nurse in SGH OT on 12 November 2015, is that *"Dr Cozzi came for one case and that was between 10:05 and 10:35 I think were the times and before he left, he signed 6 count sheets and then disappeared."*

89. In her statement to the Commission, dated 23 October 2017, she states,

> *"I reminded Dr Cozzi to sign the count sheet after the first procedure for patient A. Dr Cozzi then proceeded to sign a further 6 - 8 count sheets to surgeries that had not been performed. I remember this quite clearly because I have never seen anyone do this before given that the count sheet is an important legal document that confirms that the count is correct after a procedure has been undertaken."*

90. The evidence of RN Beames is that at the morning tea break she saw a number of count sheets, which had been signed by Dr Cozzi. She removed them from the OT and took them to RN Davis who instructed her to destroy them and file a report. The evidence of RN Davis corroborates this account of events. Dr X's evidence was that he heard nurses discussing a problem with signed count sheets.

91. The AIMS Incident report describes the incident as *"surgeon signed 5 blank count sheets and timeout sheets before the operation had starte*d." RN Davis, the nurse manager, noted, *" VMO told that we do not pre sign count sheets at STG count sheets destroyed and new ones used for each case with the appropriate person signing the count sheet and procedure safety checklist, nursing staff reminded to ensure that they check their documentation in surginet to ensure that it is a true reflection of who is present during the case."*

92. In his correspondence with the PPU on 5 May 2016, Dr Cozzi stated that he was present for the procedures he signed the count sheets for. He said*, "I signed the last patients' count sheet (Patient C) in theatre at the end of the case and then departed for the Mater."*

93. In his oral evidence to the Committee, Dr Cozzi said that he signed the count sheet for Patient A and cannot recall what happened with the other patients. He said he may have signed the blank count sheet for Patient B. It was possible. He also said that he regretted signing blank count sheets and it would never happen again. He described it as an error of judgment.

94. Dr Cozzi said that the mood in the OT at SGH was very unusual on 12 November 2015. He described it as an atmosphere of entrapment. He acknowledged he had signed the blank count sheet in an effort to document his presence at SGH.

95. Despite a discrepancy in relation to the number of pre-signed count sheets, the evidence of the medical and nursing staff present in the OT is consistent and indicates that Dr Cozzi signed blank count sheets for procedures that were not completed. The AIMS Incident report corroborates that evidence. Dr Cozzi's denial, based on the absence of the pre-signed count sheets, is tempered by this concession in oral evidence, that he may have signed a blank count sheet.

96. On balance the Committee is comfortably satisfied that Particular 2a is proven.

Particulars 2b and 2c

97. Dr Cozzi admits Particulars 2b and 2c. He signed the Clinical Procedure Safety Check List for Patient B, whose surgery was performed by Dr X.

Particular 2d

98. Particular 2d alleges that Dr Cozzi was not present at SGH for Patient B's surgical procedure. Patient B's surgery was performed by Dr X between 11.05am and 11.44am. In his formal response to the Complaint, Dr Cozzi denied Particular 2d. Despite that denial, Dr Cozzi's evidence in relation to Particular 2d is contradictory.

99. In his written response to questions from the PPU dated 5 May 2016, Dr Cozzi stated that he was present for cases 1, 2 and 3 and he discussed cases 4 and 5 with Dr X before leaving for the Mater. He said he told Dr Malouf he would be present until midday and he was, as he was outside the OT in the anaesthetic bay when he sent an email at 11:52am.

100. In his written statement prepared for the Committee, dated 15 June 2020, Dr Cozzi stated that he was present for the first two cases on the list, but not the third which commenced at 12.18pm.

101. In his reply to the Complaint dated 19 June 2020, he says it is likely he left when Patient B's surgery was well underway.

102. Dr Cozzi's submission dated 6 July 2020 states, "*at the time the respondent left, it appears that Patient B's surgery was commencing."*

103. In his oral evidence to the Committee on 8 July 2020, Dr Cozzi said that he left SGH just as Patient B was being moved into the operating theatre. He said he was present when Patient B came into theatre, but he was not present for the procedure. He said that his written statement made on 15 June 2020, referred to above, is incorrect.

104. SGH records show that Patient B entered the OT at 10.48am and his surgery started at 11.05am. As noted above in relation to Particular 1 the Committee accepts that Dr Cozzi left SGH around 10.35am on 12 November 2015. His car was recorded as driving on the Eastern Distributor at 10.57am and the Mater car park records show that his car drove into the Mater car park at 11:03am.

105. Dr Cozzi's evidence has changed considerably over time. However the eToll and car park evidence is consistent with his oral evidence to the Committee, and indicates Dr Cozzi was not present at SGH for Patient B's surgical procedure.

106. The Committee is satisfied that Particular 2d is proven.

Particulars 2e and 2f

107. The Commission submits that pre-signing safety checklists contravenes NSW Health Policy Directive Clinical Procedure Safety PD2014 035,

dated 20 October 2014. The purpose of this Policy Directive is to improve clinical care and patient safety and it sets out the process and timing for the signing of documentation before, during and after a clinical procedure.

108. The Commission submits that pre-signing count sheets contravenes NSW Health Policy Directive Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures PD2013 054 dated 18 December 2013. The purpose of this policy is to ensure the appropriate management of instruments used in surgery and it sets out the process and timing for the signing of count sheets.

109. The Commission also submits that pre-signing count sheets and safety checklists contravenes clause 9 of the Health Practitioner Regulation (NSW) Regulation 2010, which deals with when records are to be made and provides,

> *"A record must be made contemporaneously with the provision of the medical treatment or other medical service or as soon as practicable afterwards."*

110. Dr Cozzi denies he has failed to comply with NSW Health policy guidelines or the legal requirements in the Regulations relating to medical records. However, the Committee is satisfied that Dr Cozzi signed a blank count sheet before the completion of Patient B's surgery and he signed a safety check list when he was not present for the patient's procedure. Accordingly, the Committee is satisfied that Particulars 2e and 2f are proven.

111. Particular 3 alleges:

Between about 1010 and 1035 on 12 November 2015, the practitioner made a medical record for Patient C's surgical procedure at St George in circumstances where:

a. the practitioner signed a blank Count Sheet;
b. the practitioner signed a Clinical Procedure Safety Check List;
c. Doctor X performed Patient C's surgical procedure at St George between about 1155 and 1303;
d. the practitioner was not present at St George for Patient C's surgical procedure;
e. the practitioner failed to comply with NSW Health policy directives, Clinical Procedure Safety PD2014 036 dated 20 October 2014 and Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures PD2013 054 dated 18 December 2013, in that the medical record was signed prior to the completion of the procedure;
f. the practitioner failed to comply with clause 9 of the Health Practitioner Regulation (NSW) Regulation 2010 in that the medical record was not made contemporaneously with the provision of the medical treatment.

Particular 3a

112. Despite acknowledging, in his email to the PPU on 3 October 2016 that he had signed the count sheet for Patient C, in his reply to the Complaint, Dr

Cozzi does not admit that he signed a blank count sheet for Patient C. And in his oral evidence, while he accepted he may have signed the count sheet for Patient B, he stated that he did not sign a count sheet for Patient C.

113. Dr Cozzi's submissions in relation to the signing of a blank count sheet for Patient C are the same as for Patient B. The Committee refers to the evidence (see paragraphs 87 – 96 above) and reasoning set out in relation to Particular 2a. For the same reasons, the Committee is satisfied that Particular 3a is proven.

Particular 3b

114. In his reply to the Complaint dated 19 June 2020, Dr Cozzi denies Particular 3b. However, his evidence in respect of the signing of the safety check list is again contradictory.

115. In his interview with the PPU on 16 September 2016 Dr Cozzi acknowledged that he had signed the safety checklist for Patient C. He explained that there is a signing at the beginning, a signing during and a signing at the end of the case. Dr Cozzi said he would have signed it at the end of the case in the operating theatre.

116. In his statement to the Committee dated 15 June 2020, he said he was unfamiliar with the pre-operative safety check sheets as they were new and he would not normally sign them. However, he recalls signing safety check sheets handed to him by the anaesthetic nurse.

117. The safety check list for Patient C was provided by the Commission (Tab 83) and it shows Dr Cozzi's signature in all three columns.

118. In his oral evidence to the Committee Dr Cozzi agreed that he had signed the safety check list. He said he should not have done so, but was unfamiliar with the form.

119. On balance and in light of the documentary evidence, the Committee is satisfied that Particular 3b is proven.

Particulars 3c and 3d

120. Dr Cozzi admits Particulars 3c and 3d. He was not present at SGH for Patient C's surgery, which was performed by Dr X.

Particulars 3e and 3f

121. Dr Cozzi denies that he failed to comply with NSW Health policy directives or the Regulations in relation to his medical record keeping.

122. The Commission relies on the evidence and arguments presented in relation to Particulars 2e and 2f above.

123. Dr Cozzi says that the allegation is misconceived as Patient C was an afternoon patient and not his responsibility. Dr Cozzi also says that signing Patient C's safety checklist was not inappropriate or inconsistent with policy directives, as he had discussed Patient C's surgery with Dr X prior to its commencement.

124. The evidence indicates that Dr Cozzi signed a blank count sheet and a safety check list for Patient C when he was not present for any part of that patient's surgery. For the reasons given above, the Committee is satisfied that Particulars 3e and 3f are proven.

Unsatisfactory professional conduct

125. Having determined that Particulars 2 and 3 are proven, the Committee considered whether the proven conduct amounts to unsatisfactory professional conduct.

126. The Committee notes that the investigation conducted by the PPU found that Dr Cozzi pre-signed blank count sheets and pre-signed the clinical procedures safety checklist for Patients B and C *'despite not being present in theatre for either of these cases.'*

127. Following the PPU investigation, the General Manager SGH, stated,

> *"I am currently of the view that on the morning of 12 November 2015 you took a number of steps to create the appearance that you were present when you were not. Firstly, you pre-signed a number of count sheets and Clinical Procedure Safety Checklists in an attempt to show that you will present for cases you did not attend."*

128. The procedures for the signing of count sheets and safety check lists are designed to ensure patient safety by optimising clinical care and ensuring the appropriate management of surgical instruments. These procedures are not difficult or esoteric. They are in fact rudimentary.

129. Dr Wong said that from the beginning of training, medical practitioners learn that it is routine to sign a count sheet at the end of a procedure, to account for the equipment used in that procedure. He said Dr Cozzi's conduct was significantly below the accepted standard.

130. Dr Wong explained there are three sections of a safety check list which need to be signed at different stages of a surgical procedure. He said the document should not be signed unless the surgeon is actually present for the procedure and if Dr Cozzi signed a safety checklist when he was not present this goes against first principles.

131. Dr Wong said safety checklists were introduced in the 1990s and he would expect a surgeon to be familiar with a safety checklist and with the requirement that it be signed only when the surgeon has been present for the procedure. Dr Wong also said that it is not appropriate for a medical practitioner to sign a form if he is unfamiliar with it or does not know what he is signing.

132. Dr Cozzi's conduct as described in Particulars 2 and 3 has infringed basic standards of professional practice. It also breaches the *Health Practitioner Regulation (NSW) Regulation 2010* and NSW Health policy and protocols. The Committee is satisfied that Dr Cozzi's conduct constitutes unsatisfactory professional conduct.

Particulars 4, 5, 6, 7 and 8 – making false and misleading statements

133. These Particulars allege as follows:

4. *On 5 May 2016, the practitioner made false or misleading statements to the Principal Investigations Manager, Professional Practice Unit at the South Eastern Sydney Local Health District (LHD)*
    a. *to the effect that:*
        i. *he was present for the surgical procedures for Patient B and Patient C at St George on 12 November 2015,*
        ii. *he was at St George "until after midday" on 12 November 2015,*
        iii. *he arranged for Doctor Z to supervise his afternoon list at St George, and*
        iv. *he did not perform "any paid outside work between the hours of 0900 and 1230pm" on 12 November 2015;*
    b. *in circumstances where:*
        v. *he was not present for the surgical procedures for Patient B and Patient C at St George on 12 November 2015,*
        vi. *he departed St George at about 1035 on 12 November 2015,*
        vii. *he did not arrange for Doctor Z to supervise at St George on 12 November 2015, and*
        viii. *he performed surgical procedures between about 1105 and 1633 on 12 November 2015 at the Mater.*

5. *On 5 June 2016, the practitioner made a false or misleading statement to the LHD by providing a de-identified list, which he claimed was faxed by his assistant to the Mater, showing two surgical procedures commencing at 1330 on 12 November 2015, in circumstances where he performed surgical procedures from about 1105 on 12 November 2015 at the Mater.*

6. *On 16 September 2016, the practitioner made a false or misleading statements to the LHD*
    a. *to the effect that:*
        i. *he was at St George "until midday" on 12 November 2015,*
        ii. *he arranged for Doctor Z to "take over" from 1200 on 12 November 2015 at St George, and*
        iii. *he drove his friend's car from the Mater to St George and then back to the Mater on 12 November 2015;*
    b. *in circumstances where:*
        i. *he departed St George at about 1035 on 12 November 2015,*
        ii. *he did not arrange for Doctor Z to supervise at St George on 12 November 2015, and*
        iii. *he drove his own car from the Mater to St George and then back to the Mater on 12 November 2015.*

7. *On about 24 October 2017, the practitioner instructed his solicitor to send a letter to the Health Care Complaints Commission (Commission) which contained a false or misleading statements to the effect that he was present at St George on 12 November 2015 for the surgical procedure for Patient B and was present for part of the surgical procedure for Patient C in circumstances where he was not present at St George for those surgical procedures.*

8. *On about 2 November 2017, the practitioner instructed his solicitor to send a letter to the Commission which contained a false or misleading statement to the effect that he drove his friend's car from the Mater to St George and then back to the Mater and did not enter the Mater parking garage on 12 November 2015 in circumstances where he drove his own car from the Mater to St George and then back to the Mater and parked his own car in the Mater parking garage twice on 12 November 2015.*

Particulars 4, 6, 7 and 8

134. It is convenient to deal with these Particulars together. There is no dispute that Dr Cozzi made the statements referred to in Particulars 4, 6, 7 and 8. They are contained in the documentary evidence before the Committee. With the exception of Particular 4 a (iv), Dr Cozzi now concedes that the statements are incorrect.

135. Particular 4 a (iv) alleges that Dr Cozzi said he did not perform any paid outside work between the hours of 9am and 12.30pm on 12 November 2015, when he performed surgical procedures between about 11.05 and 16.33 at the Mater.

136. Dr Cozzi acknowledges that he performed paid work at the Mater in the early morning of 12 November 2015 and again *"commencing late morning…. after attending part of the SGH morning list".* He says he *"did not bill anyone for being in two places at the same time, nor while being paid by St George."*

137. However, Medicare billing information provided by the Commission indicates that Dr Cozzi charged Patient I $9999.90 for his surgery, which commenced at 11.05am at the Mater.

Particular 5

138. Dr Cozzi provided a document to the PPU on 5 June 2016. It was headed "*Mater Hospital Theatre List – Thursday, 12 November 2015 – A/Prof Paul Cozzi – FINAL – Start 1.30pm.*"

139. In his reply to the Complaint, Dr Cozzi said when he provided this document to the PPU, he believed it was the fax sent to the Mater by his staff. He also stated that he cannot say who created it or when it was created or whether it was later changed.

140. The information from the Mater indicates that Dr Cozzi's list was not rescheduled and there is no dispute that the surgery for Patient I commenced at the Mater at 11.05am on 12 November 2015.

Did Dr Cozzi make false or misleading statements?

141. The Committee is satisfied that the statements referred to in Particulars 4, 5, 6, 7 and 8 are incorrect. However, Dr Cozzi says he did not make false and misleading statements.

142. Dr Cozzi describes his statements as mistaken recollections. He says when interviewed by the PPU he did not have access to his phone records, Mater car park records or his eToll records. He says that when he was able to access various records, it became clear that his earlier accounts were not accurate.

143. It is difficult for Dr Cozzi to rely on a lack of records when he was asked to produce those records on numerous occasions and failed to do so. In October 2016, SGH General Manager made these comments in relation to Dr Cozzi's approach to producing his records:

> *"The PPU requested that you provide your telephone and toll records on multiple occasions. When you provided your telephone records, after a significant delay, it was noted that they did not contain any records after 3 November 2015…..You advised that you spoke to your phone company and they were unable to explain the anomaly. You were requested to provide verification from your phone company in writing but you have failed to do so.*
>
> *You were requested by the PPU to provide your e-toll records on multiple occasions over a period of three and a half months…..You were offered assistance by the investigators to help you get the records online…….. You have not provided your records and not provided any explanation of why you have not done so.*
>
> *Your failure to provide your telephone records for 12 November 2015 (or a written explanation for their non-appearance on your bill from your phone company) together with your inability to provide your e-toll records for the car you would driving on 12 November 2015 and your failure to provide your own e-toll records for 12 for November 2015 has significantly damaged your overall credibility as you were well aware that any one of those three sets of records could potentially have shown precisely where you were at certain times on the morning of 12 November 2015."*

144. The Commission submits that Dr Cozzi had ample time and opportunity to obtain the records needed to check or verify his statements. The Commission notes that Dr Cozzi requested and was granted additional time to respond to the PPU in May 2016.

145. Dr Cozzi says he was in a difficult domestic situation and his wife had denied him access to his eToll account. He produced evidence of a Provisional Apprehended Violence Order made by the Police for his protection in 2018. He said he was reluctant to share personal information that he felt might place him at risk, given his domestic situation.

146. Dr Cozzi submits that in relation to Particulars 4 – 8, he was not provided with nor was he able to access patient health records when responding to the PPU or the Commission. Dr Cozzi's position is that these Particulars are premised on a foundational misrepresentation, which is inconsistent with Australian privacy principles. He says he could not access patient records without patient consent.

147. Dr Cozzi also says that his responses to the PPU were honest and open and he answered questions to the best of his ability based on his recollections many months after an uneventful day.

148. Dr Cozzi may have been under stress, both personally and professionally, but 12 November 2015 was not an uneventful day. He was running two

concurrent surgical lists and he had been challenged about doing so by Dr Hutton and Dr Malouf. It is difficult to give significant weight to Dr Cozzi's assertion that he could not recollect how he managed the two lists and how his movements, and the timing of his movements, allowed him to do so.

149. On 8 July 2020, Dr Cozzi told the Committee his memory may be poor because he had suffered hypoxic brain damage. When asked about this he stated he had had an asthma attack when he was a fourth year medical student. He said he had been hospitalised and spent some time in ICU. He believes this was a significant event and that he may have been hypoxic, but he also said he wasn't sure about this. Dr Cozzi went on to pass his medical examinations, and attained a fellowship of the RACS. He said that he had not had any formal assessment of his memory, but felt that his recall of past events may not be as good as an average 52 year old. This was the first occasion on which Dr Cozzi mentioned possible memory impairment due to hypoxic brain damage.

150. Dr Cozzi said he should have taken more care in his responses to the PPU and the Commission. He said he didn't realise how serious the investigation was. He said that in hindsight he accepts that *"his guesses were reckless and inaccurate"* and his difficult personal and professional circumstances were one reason for this.

151. Dr Cozzi said he was subject to more intense scrutiny compared to other members of the urology department. He believes he has been subject to biased and inaccurate allegations, as well as bullying within the urology department at SGH. He told the PPU he was being victimised by Dr Malouf and Dr Hutton because he was in a business relationship with them, which ended badly.

152. As noted above, the Committee did not find Dr Cozzi to be a credible or trustworthy witness. In part this was due to the nature and number of inconsistent and contradictory statements Dr Cozzi made about his conduct and activities on 12 November 2015.

153. Dr Cozzi now acknowledges that some of his early statements are erroneous and presumably would argue that characterising his evidence as inconsistent is not correct. However, there are significant inconsistencies in Dr Cozzi's recent statements, made in the weeks leading up to the Committee's proceedings, and after he did have access to his records. Dr Cozzi's evidence in relation to Particular 2d is one example (see paragraphs 98 - 106 above).

154. Dr Cozzi's approach to the production of his records reveals a persistent reluctance to assist or support a proper enquiry. And at the same time Dr Cozzi was assembling his own evidence. In March 2016 Dr Cozzi was notified of the PPU investigation. Dr Cozzi told the Committee that he had discussed some of the difficulties he was having with Patient D who said he had seen Dr Cozzi at SGH and would like to help. Dr Cozzi asked Patient D to document his recollections. On 1 April 2016 Patient D signed a Statutory Declaration stating that he had seen Dr Cozzi in the operating theatre during his surgery on 12 November 2015. Patient D's surgery took

place between around 1.22pm and 2.21pm. Dr Cozzi now acknowledges this statement cannot be true.

155. On 13 January 2017 Patient C signed a statement stating that Dr Cozzi had spoken to him about his procedure in the anaesthetic bay and in recovery after surgery on 12 November 2015. Patient C's surgery took place between around 12.28pm and 12.57pm. This statement is also not accurate. Dr Cozzi gave this letter to his lawyers, but not the Commission.

156. When asked about these matters, Dr Cozzi stated that his former Practice Manager had prompted Patient C to make this statement. He said that she had undue influence on his decision-making. He regrets asking for the statement and that is why he did not submit it in evidence. Dr Cozzi said she was also involved in Patient D making a statutory declaration. He said she has a 'strong personality' and pressured him to use that declaration.

157. When asked if he tends to deflect responsibility, Dr Cozzi said that that issue had been addressed in the Communication workshop he attended. He said he had shown poor judgment in going along with the suggestions of his Practice Manager and would now be more cautious in a response to the PPU.

158. Dr Cozzi has never acknowledged any wrongdoing in relation to his surgical supervision. He has maintained that his conduct reflected common and accepted practice. In early statements Dr Cozzi provided accounts of his activities that absolved him from wrongdoing. When information was obtained which demonstrated that his account could not be true, he adjusted his version of events to again excuse or justify his conduct. For example, at 11.52am on 12 November 2015 he sent an email to RN Davis and several other colleagues at SGH. He initially said this email was sent from SGH and demonstrated his presence there until midday. When the eToll and car park records indicated this could not be the case, he then argued that the 11.52am email was sent from the Mater and demonstrated that he was not scrubbed in and so was available to return to SGH before 12 noon if needed.

159. Dr Cozzi's evidence over time has consisted of a staggering array of contradictory and inconsistent statements. The Committee does not accept that the information Dr Cozzi provided to the PPU in 2016 and to the Commission in 2017 can reasonably be accepted as 'mistaken recollections'. The changes in his evidence are not simply a reflection of him obtaining more information. The Committee considers those changes are more likely indicative of the capricious nature of Dr Cozzi's evidence.

160. The Committee is satisfied that the matters alleged in Particulars 4 – 8 are proven.

Unsatisfactory professional conduct

161. Having determined that Particulars 4, 5, 6, 7 and 8 are proven, the Committee considered whether the proven conduct amounts to unsatisfactory professional conduct.

162. Dr Wong said that a medical practitioner responding to questions as part of an investigation by the PPU should take the matter seriously and obtain all necessary material so accurate information can be provided. Similarly when the Commission is involved in a serious investigation, care must be taken to ensure all statements made to the Commission are truthful.

163. Dr Wong described Dr Cozzi as a consultant with years of experience in understanding his obligation towards trainees, the procedures around signing clinical documentation and his accountability to patients, as well as the PPU and the Commission. Dr Wong is strongly critical of Dr Cozzi's knowingly misleading the PPU and the Commission. The Committee concurs with this view.

164. Dr Cozzi's conduct is not only significantly below the standard to be reasonably expected of a consultant urologist, it is also improper and unethical conduct. For these reasons it should be considered unsatisfactory professional conduct.

Are orders or directions under the National Law appropriate?

165. Having found Dr Cozzi guilty of unsatisfactory professional conduct, the Committee must now consider what, if any, orders should be made in relation to him.

General considerations

166. It is well established that the jurisdiction exercised by a Professional Standards Committee is protective, not punitive. Disciplinary proceedings are intended to maintain proper professional standards, primarily for the protection of the public, and as the Court of Appeal held in *Health Care Complaints Commission v Do* [2014] NSWCA 307 protecting the health and safety of the public "*includes protecting the public from the similar misconduct or incompetence of other practitioners and upholding public confidence in the standards of the profession."*

167. In relation to the relevant protective orders to be made, the Committee notes that the powers available to it in this regard are set out in section146 (B) of the National Law which provides as follows:

> *A Committee may do one or more of the following:*
>
> *a. caution or reprimand the practitioner;*
>
> *b. direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;*
>
> *c. order that the practitioner seek and undergo medical or psychiatric treatment or counselling;*
>
> *d. order that the practitioner complete an educational course specified by the Committee;*
>
> *e. order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;*
>
> *f. order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.*

Dr Cozzi's evidence

168. Dr Cozzi submitted that he had already suffered professional consequences as a result of his conduct. He now works exclusively in the private sector. His employment at SGH has been terminated and he does not believe it will be possible for him to be re-employed in the public hospital system. He no longer supervises trainee urologists, as they are not trained in the private sector. He no longer has an appointment at the University of Notre Dame and is currently on leave from UNSW. There are difficulties in maintaining an academic role when he does not have access to a public teaching hospital. Dr Cozzi also said he has suffered reputational damage in the broader urological community as well as his local medical community.

169. Dr Cozzi said that throughout 2016 and 2017 he was under considerable stress both at work and at home. The acrimonious dissolution of the group urology practice led to a difficult working relationship with his former business partners, including Dr Malouf. He said he was in a tumultuous home environment when he was subject to harassment and abuse from his wife, from whom he is now divorced.

170. Dr Cozzi told the Committee that he completed a communication course through the Cognitive Institute. This involved 8 hours of training in "Mastering Shared Decision Making and Difficult Clinical Interactions". This was completed in July 2020.

171. Dr Cozzi states that he has reflected at length on his conduct and regrets that some of his actions were not compliant with NSW Health policy directives. Nevertheless, he does not accept that his conduct constitutes unsatisfactory professional conduct. He says aspects of his conduct may have been below the relevant standard, but not significantly below that standard.

172. Dr Cozzi stresses that he does not feel *"there was any risks to patients' safety as a result of his actions or any adverse impact on any patient or staff member including Dr X."*

173. Dr Cozzi provided two character references, one from Lloyd Adams, CEO of Hurstville Private Hospital and one from Dr Raj Gogia, consultant urological surgeon.

Reprimand

174. The Commission proposes that Dr Cozzi be reprimanded. The Commission pointed to the fact that Particulars 1, 2 and 3 relate to conduct which could have serious ramifications for patient safety. And Particulars 4-8 demonstrate dishonesty and a lack of integrity, inconsistent with the ethical standards expected of medical practitioners.

175. Dr Cozzi submitted that the Complaint should be dismissed but should unsatisfactory professional conduct be found, he should only be cautioned. He referred to the fact that the safety of the public had not been impacted by his conduct.

176. The Committee considers that Dr Cozzi should be reprimanded in the strongest possible terms. Dr Cozzi ran two surgical lists in two different

places at the same time. He failed to provide supervision to a trainee urologist, thereby jeopardising patient safety, he failed to follow simple and standard rules in relation to medical record keeping and he misled the LHD and the Commission in attempts to obscure his inadequate professional conduct. His conduct is reprehensible and it is only fortuitous that no patient suffered as a result of his actions.

Education

177. The Commission proposes that Dr Cozzi undertake an ethics course. The Committee notes that Dr Cozzi has completed one Communication Course. Dr Cozzi told the Committee he was willing to undertake any further courses considered appropriate.

178. The Commission submits that an ethics course is appropriate to assist Dr Cozzi to gain insight into the requirements for appropriate supervision, contemporaneous record keeping and professional ethical obligations. The Committee concurs.

Supervision.

179. The Commission proposes that Dr Cozzi be subject to category C supervision and the Committee agrees with this proposal.

180. Dr Cozzi no longer works in the public sector but has a large private practice and operates in a number of private hospitals. His ability to confer with peers and colleagues may be impacted by his lack of involvement in the public sector. Supervision will provide him with peer support and also assist him in gaining insight into the matters referred to above - requirements for appropriate supervision, contemporaneous record keeping and professional ethical obligations.

Supervision of trainees

181. Although Dr Cozzi has limited capacity to supervise urology trainees at present the Committee considers it is appropriate to place a condition on his registration which prevents him from undertaking this kind of supervision. Dr Cozzi's evidence to the Committee indicates that he has an inadequate understanding of the requirements for supervision or a lack of motivation to comply with them. Without further education and a period of supervision this is not an activity in which he should engage.

DETERMINATION AND ORDERS

Reprimand

182. Under section 146B(1)(a) of the *Health Practitioner Regulation National Law*, the Committee reprimands the practitioner.

Practice restrictions

183. To complete within 12 months of 3 November 2020, the Clinical Ethics course organised by the University of Sydney.

a) Within 3 months of 3 November 2020, he must provide evidence to the Medical Council of NSW of his enrolment in the above mentioned course.

b) Within 1 month of completing the above mentioned course, he is to provide documentary evidence to the Council that he has satisfactorily completed the course.

c) To bear responsibility for any costs incurred in meeting this condition.

In the event that the Clinical Ethics course is unavailable, he must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 3 January 2021.

184. To practise under category C supervision in accordance with the Medical Council of NSW's Compliance Policy – Supervision (as varied from time to time) and as subsequently determined by the appropriate review body:

a) The terms of the Council's Compliance Policy are varied to require the practitioner to:
   i) meet with the approved supervisor on a monthly basis for a minimum period of 1 hour.
   ii) To authorise the Council-approved supervisor to provide reports to the Council (in a Council-approved format) every 3 months.

b) At each supervision meeting the practitioner is to review and discuss his practice with his approved supervisor with a particular focus on:
   i) the requirements for appropriate supervision
   ii) medical record keeping
   iii) professional ethical obligations

c) To authorise the Medical Council of NSW to provide proposed and approved supervisors with a copy of the decision that imposed these conditions.

185. Not to undertake trainee supervision.

186. The Medical Council is the appropriate review body for the purposes of Part 8, Division 8 of the Health Practitioner Regulation National Law (NSW).

APPEAL AND REVIEW RIGHTS

Dr Paul Joseph Cozzi has the right to appeal this decision to the NSW Civil and Administrative Tribunal.

An appeal must be lodged with the Tribunal within 28 days of the date of these written reasons.

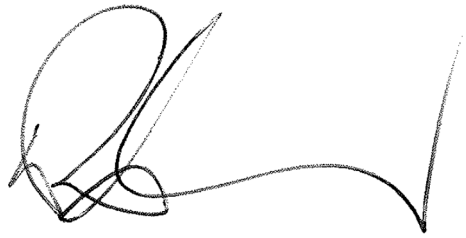
Dr Cozzi also has the right to seek a review by the Medical Council of NSW of the Committee's order to impose conditions. Should Dr Cozzi's principal place of practice be anywhere other than NSW at the time of seeking a review of conditions, Dr Cozzi may make an application for review to the National Board.

NON-PUBLICATION ORDER

A non publication order has been made so that the names, addresses or any other information which might identify the 10 patients referred to in the Complaint and two medical practitioners, referred to herein as Dr X and Dr Z, are not to be published.

DISTRIBUTION OF DECISION

A copy of this written statement of our decision will be provided to Dr Cozzi, the Commission, the National Board, the complainant.



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Ms Diane Robinson
Chairperson

3 November 2020

Attachment 1

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally [NSW]

(1) **"Unsatisfactory professional conduct"** of a registered health practitioner includes each of the following-

(a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

(b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

(c) A contravention by the practitioner (whether by act or omission) of-
(i) a condition to which the practitioner's registration is subject; or
(ii) an undertaking given to a National Board.

(d) A contravention by the practitioner (whether by act or omission) of a decision or order made by a Committee or the Tribunal in relation to the practitioner.

(e) A contravention by the practitioner of section 34A(4) of the *Health Care Complaints Act 1993* .

(f) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for-
(i) referring another person to the health service provider; or
(ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.

(g) Accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product, but does not include accepting a benefit that consists of ordinary retail conduct.

(h) Offering or giving a person a benefit as inducement, consideration or reward for the person-
(i) referring another person to the registered health practitioner; or
(ii) recommending to another person that the person use a health service provided by the practitioner or consult the practitioner in relation to a health matter.

(i) Referring a person to, or recommending that a person use or consult-
(i) another health service provider; or
(ii) a health service; or
(iii) a health product;
if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of the interest to the person before or at the time of giving the referral or recommendation.

(j) Engaging in overservicing.

(k) Permitting an assistant employed by the practitioner (in connection with the

practitioner's professional practice) who is not a registered health practitioner to attend, treat or perform operations on patients in respect of matters requiring professional discretion or skill.

(l) Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession.

(2) For the purposes of subsection (1)(i), a registered health practitioner has a **"pecuniary interest"** in giving a referral or recommendation-

(a) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a public company and the practitioner holds 5% or more of the issued share capital of the company; or

(b) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a private company and the practitioner has any interest in the company; or

(c) if the health service provider, or the supplier of the health product, to whom the referral or recommendation relates is a natural person who is a partner of the practitioner; or

(d) in any circumstances prescribed by the NSW regulations.

(3) For avoidance of doubt, a reference in this section to a referral or recommendation that is given to a person includes a referral or recommendation that is given to more than one person or to persons of a particular class.

(4) In this section-

"benefit" means money, property or anything else of value.

"recommend" a health product includes supply or prescribe the health product.

"supply" includes sell.

146B General powers to caution, reprimand, counsel etc [NSW]

(1) A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-

(a) caution or reprimand the practitioner;

(b) direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;

(c) order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order that the practitioner complete an educational course specified by the Committee;

(e) order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;

(
f) order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.

(2) If the relevant health practitioner is not registered, a direction may still be given under this section but has effect only so as to require the conditions concerned to be imposed when the health practitioner is registered.

(3) If a Committee acting under this section makes an order or directs that any condition be imposed on a health practitioner's registration, the Committee may order that a contravention of the order or condition will result in the health practitioner's registration in the health profession being cancelled.

(4) The order or condition concerned is then a
"critical compliance order or condition" .

Attachment 2

AMENDED COMPLAINT

30 June 2020

HEALTH PRACTITIONER REGULATION NATIONAL LAW (NSW)

Executive Officer
Medical Council of NSW
Punt Road
GLADESVILLE NSW 2111

The Health Care Complaints Commission of Level 12, 323 Castlereagh Street, Sydney, NSW, having consulted with the Medical Council of NSW in accordance with sections 39(2) and 90B(3) of the *Health Care Complaints Act 1993* and section 145A of the *Health Practitioner Regulation National Law (NSW) ('the National Law')*;

HEREBY COMPLAINS THAT

Dr Paul Joseph Cozzi ("the practitioner") of Level 1, Suite 9, 37 Gloucester Road
Hurstville NSW 2220, being a medical practitioner registered under the *National Law*,

COMPLAINT ONE

The practitioner is guilty of unsatisfactory professional conduct under section 139B(1)(a), (b) and/or (l) of the *National Law* in that the practitioner has:

i. engaged in conduct that demonstrates the judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience; and/or

ii. contravened a provision of the *Health Practitioner Regulation (NSW) Regulation 2010* and/or;

iii. engaged in improper or unethical conduct relating to the practice or purported practice of medicine.

BACKGROUND TO COMPLAINT ONE

On 12 November 2015, the practitioner was a Visiting Medical Officer at public hospital in Kogarah, St George Hospital (St George). The practitioner's surgical list at St George consisted of the following five patients:

- Patient A
- Patient B
- Patient C
- Patient D
- Patient E

On 12 November 2015, the practitioner was also accredited as a Visiting Specialist at a private hospital in North Sydney, the Mater Hospital (the Mater). The practitioner's surgical list at the Mater consisted of the following five patients:

- Patient F
- Patient G
- Patient H
- Patient I
- Patient J

Between about 0740 and 0910 on 12 November 2015, the practitioner performed surgery on Patient F, Patient G and Patient H at the Mater. Between about 0920 and 1010, the practitioner drove from the Mater to St George.

Between about 1010 and 1035, the practitioner performed surgery on Patient A at St George. Between about 1028 and 1103, the practitioner drove from St George to the Mater.

Between about 1105 and 1334, the practitioner performed surgery on Patient I at the Mater. Between about 1428 and 1633, the practitioner performed surgery on Patient J at the Mater.

PARTICULARS OF COMPLAINT ONE

2. Between about 1035 and 1454 on 12 November 2015, the practitioner left Doctor X unsupervised to perform four surgical procedures at St George in circumstances where:
    a. Doctor X was a SET 5 Urology Trainee;
    b. at about 1035, the practitioner left the grounds of St George;
    c. the practitioner did not tell Doctor X where he was going;
    d. the practitioner did not tell Doctor X how to contact him in the event of an emergency;
    e. Doctor X performed surgical procedures at St George for Patient B, Patient C, Patient D and Patient E between about 1105 and 1454;
    f. the practitioner performed surgical procedures at the Mater for Patient I and Patient J between about 1105 and 1633;
    g. the practitioner was not physically available at St George to assist Doctor X in the event of an emergency.

3. Between about 1010 and 1035 on 12 November 2015, the practitioner made a medical record for Patient B's surgical procedure at St George in circumstances where:
    a. the practitioner signed a blank Count Sheet;
    b. the practitioner signed a Clinical Procedure Safety Check List;
    c. Doctor X performed Patient B's surgical procedure at St George between about 1105 and 1144;
    d. the practitioner was not present at St George for Patient B's surgical procedure;
    e. the practitioner failed to comply with NSW Health policy directives, *Clinical Procedure Safety PD2014 036* dated 20 October 2014 and *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures PD2013 054* dated 18 December 2013, in that the medical record was signed prior to the completion of the procedure;
    f. the practitioner failed to comply with clause 9 of the *Health Practitioner Regulation (NSW) Regulation 2010* in that the medical record was not made contemporaneously with the provision of the medical treatment.

4. Between about 1010 and 1035 on 12 November 2015, the practitioner made a medical record for Patient C's surgical procedure at St George in circumstances where:
    a. the practitioner signed a blank Count Sheet;
    b. the practitioner signed a Clinical Procedure Safety Check List;
    c. Doctor X performed Patient C's surgical procedure at St George between about 1155 and 1303;
    d. the practitioner was not present at St George for Patient C's surgical procedure;
    e. the practitioner failed to comply with NSW Health policy directives, *Clinical Procedure Safety PD2014 036* dated 20 October 2014 and *Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures PD2013*

054 dated 18 December 2013, in that the medical record was signed prior to the completion of the procedure;

f. the practitioner failed to comply with clause 9 of the *Health Practitioner Regulation (NSW) Regulation 2010* in that the medical record was not made contemporaneously with the provision of the medical treatment.

5. On 5 May 2016, the practitioner made false or misleading statements to the Principal Investigations Manager, Professional Practice Unit at the South Eastern Sydney Local Health District (LHD)
    a. to the effect that:
        i. he was present for the surgical procedures for Patient B and Patient C at St George on 12 November 2015,
        ii. he was at St George “until after midday” on 12 November 2015,
        iii. he arranged for Doctor Z to supervise his afternoon list at St George, and
        iv. he did not perform "any paid outside work between the hours of 0900 and 1230pm” on 12 November 2015;
    b. in circumstances where:
        i. he was not present for the surgical procedures for Patient B and Patient C at St George on 12 November 2015,
        ii. he departed St George at about 1035 on 12 November 2015,
        iii. he did not arrange for Doctor Z to supervise at St George on 12 November 2015, and
        iv. he performed surgical procedures between about 1105 and 1633 on 12 November 2015 at the Mater.

6. On 5 June 2016, the practitioner made a false or misleading statement to the LHD by providing a de-identified list, which he claimed was faxed by his assistant to the Mater, showing two surgical procedures commencing at 1330 on 12 November 2015, in circumstances where

he performed surgical procedures from about 1105 on 12 November 2015 at the Mater.

7. On 16 September 2016, the practitioner made a false or misleading statements to the LHD
    a. to the effect that:
        i. he was at St George “until midday” on 12 November 2015,
        ii. he arranged for Doctor Z to “take over” from 1200 on 12 November 2015 at St George, and
        iii. he drove his friend’s car from the Mater to St George and then back to the Mater on 12 November 2015;
    b. in circumstances where:
        i. he departed St George at about 1035 on 12 November 2015,
        ii. he did not arrange for Doctor Z to supervise at St George on 12 November 2015, and
        iii. he drove his own car from the Mater to St George and then back to the Mater on 12 November 2015.

8. On about 24 October 2017, the practitioner instructed his solicitor to send a letter to the Health Care Complaints Commission (Commission) which contained a false or misleading statements to the effect that he was present at St George on 12 November 2015 for the surgical procedure for Patient B and was present for part of the surgical procedure for Patient C in circumstances where he was not present at St George for those surgical procedures.

9. On about 2 November 2017, the practitioner instructed his solicitor to send a letter to the Commission which contained a false or misleading statement to the effect that he drove his friend’s car from the Mater to St George and then back to the Mater and did not enter the Mater parking garage on 12 November 2015 in circumstances where he

drove his own car from the Mater to St George and then back to the Mater and parked his own car in the Mater parking garage twice on 12 November 2015.

The conduct in particulars 1-8 of Complaint One is repeated and relied upon in combination as a course of conduct involving the practitioner leaving Doctor X unsupervised and concealing his own whereabouts amounting to unsatisfactory professional conduct.

Dated .....December 2019

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Bree Chisholm
Director of Proceedings
Health Care Complaints Commission