The purpose of the letter is to document concerns I have with the clinical competency and professional misconduct of a surgical colleague in Brisbane, Dr William Braun. It is my belief that Dr William Braun has engaged in notifiable conduct that I am obligated to report.

As a Consultant General Surgeon and Bariatric Surgeon at both a Queensland Health Public Hospital, the Princess Alexandra Hospital, and a Ramsay Healthcare Private Hospital, Greenslopes Private Hospital, for approximately 10 years, I have personally managed patients of Dr William Braun and am aware now of a number of patients of Dr William Braun managed by my surgical colleagues, that constitute reasonable grounds to support the belief he has practised the profession of medicine and surgery in a way that constitutes a significant departure from accepted professional standards placing the public at risk of harm.

I have also been directly informed in the last 48 hours by a female nurse of several instances of sexual misconduct in connection with the practice of the practitioner's profession as a doctor and surgeon towards her that require mandatory notification to AHPRA(Australia Health Practitioner Regulation Agency).

I, I have personally had to manage 2 patients with serious complications following elective Bariatric surgery performed by Dr William Braun. Both patients required several subsequent emergency operations to manage their complications and after several weeks and in one circumstance, months in hospital, are now discharged from hospital.

I do appreciate after practicing in Brisbane for more than 10 years as a General Surgeon and Bariatric Surgeon that certain procedures carry a small risk of complications, the incidence of complications following elective surgery is not necessarily my concern with Dr William Braun. My specific concerns with both of these two patients that I had to personally manage were as follows.

In one case of a patient that presented to the Princess Alexandra Hospital days following elective Sleeve Gastrectomy Surgery for obesity, it appeared that the patient suffered a post operative haemorrhage and subsequent leak directly as a result of surgical technique. This was then followed by a failure to diagnose the complication and manage it accordingly. I believe this demonstrates clinical incompetence and practices that are a departure from acceptable professional standards.

In the second case there was a serious complication relating to a decision by Dr William Braun to perform a 'Banded' Sleeve Gastrectomy procedure, which is unconventional unfamiliar modifications of a common Bariatric procedure for the treatment of obesity. I believe the decision to perform a 'Banded' Sleeve Gastrectomy procedure is an experimental procedure that constitutes a

significant departure from acceptable professional standards. A serious complication then followed this procedure, followed then by failure to recognize complications early and then manage them accordingly. In this particular case, the patient was uninsured and there was a lack of both adequate informed consent of the added risks of performing this unconventional procedure and a lack of informed financial consent of the added costs of the implantable prosthetic device required for this unconventional procedure.

As a General Surgeon and Bariatric Surgeon in this country there is the expectation that if patients present to their local doctor or hospital with a complication or problem following surgery, that they will be managed by their surgeon who performed the procedure or an alternative surgeon who is covering on call for their elective surgeon if he or she is on leave or unavailable. In one of these cases I was directly involved with, Dr Braun was not contactable by the patient or medical staff at our hospital as he was overseas and no appropriate cover was arranged. Again I believe constitutes significant departure from acceptable professional standards and places the public at risk of harm.

I have personally had several discussions with Dr Braun regarding some of his complications and how they may have been detected earlier and managed differently. We have also had discussions about his responsibility as a General Surgeon and the expectations to be available to manage complications, accept responsibility for managing complications and discussions regarding performing unconventional and questionable modifications to established Bariatric procedures.

I am disappointed to hear that despite these discussion, complications have continued to occur following his surgery that were not recognized and were mismanaged, leading to further life threatening consequences and the discharge from hospital of a patient with a life threatening complication, only to have her present to a nearby hospital several hours after discharge moribund and needing life saving surgery for her complications. The details of this case will be forthcoming in a letter from Dr , the Consultant General Surgeon who managed this patient at Mater Hospital, South Brisbane. I believe this again constitutes significant departure from acceptable professional standards and places the public at risk of harm. After being informed of the near death of one of his patients recently following elective Bariatric surgery, there was a failure to acknowledge that the complication was missed, failure to acknowledge the need for life saving emergency surgery required to save his patients life and a lack of understanding of appropriate postoperative care.

I am of the understanding that this occurrence of events is not an isolated incident, as some of my surgical colleagues in Brisbane have had similar experiences with his clinical management of patients recently.

My other great concern that I have with Dr William Braun is in regard to his engagement in sexual misconduct in connection with the practice of his profession as a doctor and surgeon directed towards female staff members, including nurses, junior medical staff and female medical equipment company representatives. In the last 48 hours, I have been made aware of numerous examples of Dr William Braun making inappropriate sexual remarks, touching

female staff members inappropriately, engaging in sexual behaviours in front of female staff members in a operating theatre, and attempting to use his power as a Consultant General Surgeon to coerse female staff members into sexual favours in exchange for various rewards.

I have also been informed that allegations of sexual misconduct by Dr William Braun are common knowledge amongst female General Surgical Trainees in Brisbane and Queensland and are well know by both Queensland Health and The Royal Australasian College of Surgeons of Australia and AHPRA. As a result of his alleged sexual misconduct towards junior female surgical doctors, Queensland Health and The Royal Australasian College of Surgeons Queensland Surgical Training Board have not permitted junior female doctors to undergo General Surgical Training at Queensland Health's Redcliffe Hospital where Dr William Braun is employed for fear of exposing any more female junior Surgical Trainees to his sexual misconduct, yet he continues to practice there. There is thus an acknowledgement of a problem of sexual misconduct by a powerful General Surgical Consultant at Redcliffe Public Hospital towards less powerful inexperienced junior female Surgical Trainees without obvious resolution of this serious problem thus far.

Over the last 48 hours I have been informed first hand of numerous cases of sexual misconduct by Dr William Braun towards female staff members, many of whom have been reluctant and scared to verbalize their encounters due to fear of losing their jobs and fear of damaging their careers and even threats of legal action for defamation of character directly by Dr William Braun.

I have personally been informed by an Registered Operating Theatre Nurse from Greenslopes Private Hospital, who I have worked with for approximately five years now, who is now also working as a medical equipment company representative, of her numerous personal experiences of sexual misconduct by Dr William Braun. Given her position as a single parent and sole bread winner, and for fear of losing her job as a medical equipment company representative, who's greatest customer is Dr William Braun, she has decided not to report Dr William Braun to AHPRA, or North West Private Hospital were the encounters of sexual misconduct took place. She has however shared her experience of sexual misconduct by Dr William Braun with her medical equipment company employer, who also chose not to make a formal complaint about Dr William Braun due to the obvious imbalance of power and need of the company for Dr Braun's business.

This one particular female was inappropriately touched from behind between the buttocks by Dr William Braun, was offered invitations for sexual encounters by text message at night by Dr William Braun while he drove past her house at night, was asked to give oral sex to Dr William Braun in theatre with a nurse witnesses present(who heard the offer for oral sex and reported Dr William Braun to North West Private Hospital administration), and was informed by Dr William Braun that she 'knew what she had to do if she wanted to improve her business".

I was also informed that Dr William Braun lowered with pants in an operating theatre at North West Private Hospital on one occasions in front of both nurses

and medical equipment representatives and remained standing in his underwear whilst another male proceeded to measure his waist circumference and leg length for a suit fitting.

I am horrified by these multiple allegations of sexual misconduct towards Dr William Braun that I have been informed of over the last 48 hours, and although I have not personally witnessed any of these examples, my understanding is that these behaviours constitute notifiable conduct according to the Medical Board of Australia.

I am even more disappointed and saddened, a little surprised and disheartened by the failed attempts of Queensland Health, The Royal Australasian College of Surgeons, North West Private Hospital and Ramsay Health Care as well as AHPRA, who are all aware to some degree of various other instances of sexual misconduct by Dr William Braun over the last few years, in preventing these examples on sexual misconduct and preventing the public from being exposed to the risk of harm due to the way Dr William Braun practices medicine and surgery which is in significant departure from acceptable professional standards.

I am hopeful that this information provided will assist in prompting further action by the above mentioned professional parties.

Sincerely

13/2/19

To Whom it May Concern:

I would like to document my experience of working for Dr William Braun , at Redcliffe Hospital in 2017.

My term at Redcliffe was the first term that there was a general surgical Fellow appointed for the hospital, who in my opinion worked primarily covering for Dr Braun and Dr in many aspects.

However, in my dealings with Dr Braun, there were a few things that were apparent and consistent throughout my time at that hospital.

The most obvious thing was his absence. At his scheduled operating lists and clinics (for which I assume he was being paid for by QLD health), if he came at all he would usually arrive late and leave early (often this would be covered by the Fellow to both start and finish operating lists and clinics). I clearly recall that the majority of his clinics (the clinics that he actually attended) he refused to see any patients, but instead spent his time in the "tea room" on his mobile phone and the more junior staff (Fellow and registrars) would need to go to the tea room to discuss patients with Dr Braun.

His behaviour in the operating theatre also left a lot to be desired. He frequently used foul language and obscenities, especially when the operative procedure may not be going smoothly. This was usually just generalized cursing and swearing, but occasionally was directed at a specific individual. For example if the laparoscope was not in the ideal position or the retraction was not adequate, the abuse would be directed at the surgical assistant. If there was incorrect or insufficient equipment in the operating theatre at the time he wanted it, it would be directed at the nursing staff. Occasionally it was also directed towards the anaesthetic staff. I also felt that he was constantly rushing his procedures in order to be able to leave the hospital as soon as possible. This was evidenced by both his actions and his words and in my opinion may have occasionally impacted on the quality of the procedure (e.g. lack of ensuring adequate haemostasis, rushing to put in laparoscopic ports with inadequate vision etc).

One specific negative interaction with Dr Braun that is burnt into my memory is as follows.....

I received a call from a regional northern QLD centre regarding a private patient of Dr Braun's who clearly had a complication of their surgery. At the time Dr Braun was overseas and uncontactable. Both the northern QLD hospital and myself tried multiple times to unsuccessfully contact Dr Braun. As a result, I accepted the patient to be transferred to Redcliffe hospital for further assessment. Upon assessment of the patient and discussion with the consultant on call for Redcliffe hospital at the time, it was clear that the patient had a "leak" from their sleeve gastrectomy. After further discussion with the consultant on call for Redcliffe hospital it was decided that since Dr Braun was still uncontactable and there was no upper GI/bariatric surgeon to deal with this matter at Redcliffe that the patient should be discussed with and transferred to the upper GI/bariatric unit at RBWH. At this point, I discussed the case with Dr from RBWH who agreed to have the patient transferred to RBWH for further management. My understanding is that the RBWH subsequently operated on this patient and they made a full recovery. However, my main issue with this situation is that once Dr Braun returned from overseas, he obviously found out about this patient who had a

complication from surgery and was eventually transferred to RBWH. At my next encounter with Dr Braun at Redcliffe hospital he broached this subject by putting his face intimidatingly close to mine and told me to "never, ever transfer one of my patients to the f@#$ing RBWH again". At the same time he was saying this he poked his index finger into my chest several times which I felt was a gesture of aggression and intimidation. I brushed this off, as I knew he had done much worse things to registrars before me and I knew that I was doing the best thing for the patient at the time. Interestingly though, within the next couple of days, I was pulled up by Dr for a conversation. The conversation indicated that if I ever have a phone call or a problem with one of Dr Braun's patient's ever again, and Dr Braun is not available, that I am not to call or transfer the patient to RBWH, but I am to admit the patient under Dr at Redcliffe hospital and speak to Dr directly to manage that patient.

Overall, in my opinion, I feel that Dr Braun:

- Was not in the hospital for the time that he was paid/contracted/supposed to be at work for Redcliffe hospital;
- Did not give adequate attention to his patients in the outpatient clinics and he rushed many of his operative procedures;
- Provided inadequate consultant level cover for his upper GI/bariatric patients whilst he was overseas and unable to be contacted; and
- Physically intimidated me when he realised that I had transferred one of his patients who had a post-operative complication to the appropriate tertiary level hospital who could manage this complication.

From: [redacted]
Sent: Saturday, 16 February 2019 9:04 AM
To: [redacted]
Subject: Supporting statement

[redacted]

In 2018, whilst operating at Northwest Private Hospital at Everton Park, I overheard a conversation involving my scrub and scout nurse and an additional nurse from an adjacent theatre, whereby they were discussing an observed behaviour by Dr William Braun. The comments overheard alledged that the representative from the company, 'Baxter,' which supplies bougies used in bariatric surgery, had arrived late to Dr Braun's scheduled operating list. Upon apologising to Dr Braun for her lateness, his witnessed response included words indicating that she could repay the concern with sexual favours.

This incident caused much discussion amongst the theatre staff for the rest of my operating session. Nurses in my theatre, in the tearoom and in recovery were all appauled with what had occurred. Of interest to me was the fact that it appeared as though this was a routine behaviour displayed by Dr Braun and that the staff, whilst upset, appeared dejected at the realisation that previous similar incidents had been ignored and that it was likely this new event would again fall on deaf ears.

With this in mind, as a consultant surgeon with operating and admitting rights at Northwest Private Hospital I felt I should discuss this incident with the hospital's Chief Executive Officer, Dr [redacted]. I advised him of the concern that I had witnessed in the operating complex amongst the nursing staff that day, and stressed that although I had not been a direct witness of the alledged event involving Dr Braun, the level of disgust displayed by the nursing staff warranted review by himself and Ramsay Health of the incident. To date I have not received any feedback, and the involved surgeon continues to operate at the facility.

Regards,

Dr Judy Graves
EDMS
Royal Brisbane and Women's Hospital
Butterfield Street
Herston Qld 4129

5th May 2018

Dear Dr Graves,

As requested, I hereby submit my recollection of the cases of 2 recent Bariatric Surgery cases transferred from Redcliffe Hospital for further management. In the interests of timely submission, I have not trawled through the RBWH case notes. They will provide accurate details of transfer to RBWH and of dates of return to theatre.

My notes are based on my recollection of consults with patients and are as factually accurate as possible.

Case 1

This patient had a sleeve gastrectomy in mid 2017 with Dr . Due to poor subsequent weight loss, the patient underwent a laparoscopic conversion to single anastomosis gastric bypass, with fixed minimiser ring, with Dr William Braun at Peninsula Private Hospital (?) in late December 2017. I understand Dr Braun went on extended leave the day after surgery and that the patient's subsequent management was with Dr ; at Redcliffe Hospital. After initial problems with dysphagia necessitating contrast swallows during the first few postoperative days, the patient was discharged.

He was readmitted with severe abdominal pain and sepsis via the Gold Coast Hospital, due to its proximity to his residence, back to the Redcliffe Hospital. He returned to theatre there for washout of gastric pouch leak and removal of the fixed ring. Following failure to progress after this intervention, his wife contacted me personally requesting transfer to the RBWH for further management.

When I reviewed the patient shortly after arrival at the RBWH he had low grade tachycardia and fevers with bile bubbling out his epigastric port wound. I therefore took the patient back to theatre on 4/1/18 and performed a laparoscopic washout and conversion to Roux-e-Y gastric bypass, the standard salvage maneouvre for a leaking single anastomosis bypass. His gastric pouch leak subsequently resolved and the patient was discharged home a few weeks later.

Case 2

This patient underwent a laparoscopic Roux-en-Y gastric bypass with fixed ring at the Peninsula Private Hospital (?) in mid December 2017. The patient was then discharged.

The patient was readmitted with severe abdominal pain and sepsis to the Redcliffe Hospital. She returned to theatre on multiple occasions for laparotomy, removal of fixed ring, washout and placement of drains for a large gastric pouch +/- gastrojejunostomy anastomotic leak. She was severely unwell with multiorgan failure.

The patient thereafter developed adhesive bowel obstruction with large volumes of bilious fluid regurgitating back up the alimentary limb of the Roux-en-Y bypass. This was being managed by Dr ; at the Redcliffe Hospital with nasogastric VAC (negative pressure) dressings. These were being changed every couple of days via serial endoscopies.

I was contacted directly by Dr ' ; after management (EDMS) of the Redcliffe Hospital asked that the patient be moved to the RBWH for further management.

When I met the patient following RBWH transfer she was 4 weeks post-op following her laparotomies and ICU stay at Redcliffe. She had on ongoing adhesive bowel obstruction with large volume bilious NG aspirates and ongoing abdominal sepsis with multiple drains containing purulent output.

Due to the time frame being 4 weeks after her laparotomies, and the fact that this falls in the zone (post-op weeks 2 to 6) where abdominal adhesions are very dense and any subsequent reoperation associated with a very high risk of creating major bowel injuries, along with the fact that the patient was relatively well (stable heart rate, blood pressure and inflammatory markers; no fevers), I elected to avoid further surgery at that time. As our department always attempts to do, I discussed this management decision with consultant colleagues who concurred with this management.

The patient was managed with 2 - 3 returns to endoscopy (Dr and Dr Gastroenterologists) where the drains were repositioned to optimize drainage from the leaking gastric pouch, and the NG tube VAC sponge was exchanged for a simple NG tube.

The patient subsequently improved without further operative intervention, due to her adhesions spontaneously softening, and was able to resume a full diet and be discharged home.

During this stay on ward ' 1 at the RBWH, the patient was visited by Dr William Braun out of hours on a weekend. Despite the patient expressing her strong upset at this visit and requesting to not be visited again, Dr Braun returned with his wife, a Psychiatrist at the RBWH. According to the patient, during this visit Dr Braun expressed his view that the patient should have retuned to theatre for more surgery. This clearly upset the patient further, undermining her confidence in the RBWH care she was receiving.

Finally, I understand that 2 surgeons at the RBWH have previously attempted to raise concerning outcomes from the aforementioned surgeon and were gagged legally from proceeding with this.

Please don't hesitate to contact me if you need further information.

Yours sincerely,

Document 5

Thursday, 26 April 2018

Dr Judy Graves
Executive Director, Medical Services
Royal Brisbane and Women's Hospital
Cnr Butterfield St and Bowen Bridge Rd
HERSTON 4029

Dear Dr Graves

I

I would like to draw to your attention what I consider to be a notifiable incident at the Royal Brisbane and Women's Hospital. I met recently at the Surgical Weight Loss Clinic at the Royal Brisbane and Women's Hospital. She has a very complicated surgical history in a number of different Brisbane institutions under the care of Dr Will Braun. Initially she had a sleeve gastrectomy in 2015 at the Holy Spirit Northside Hospital. Septic complications were subsequently managed at the Redcliffe Hospital and a number of endoscopic procedures were taken place then at North West Hospital.

The complicated issue to me that requires notifications is that ultimately as a Redcliffe Hospital patient, she was then transferred to Sydney for reasons that were not well explained to her. She transferred under the care of Dr , a bariatric endoscopic surgeon in Sydney, well known to all of us in Brisbane.

When I met she was visibly upset and emotionally somewhat of a wreck. She had been plagued with abdominal pain for the last twelve months and given that she had no further follow up in Sydney and she was no longer able to attend the Redcliffe Hospital she was really confused and anxious and I would even suggest she was fearful. She explained to me in that first consultation how she had felt that the entire hospital system was not to be trusted and took a great deal of convincing that I would take her problem seriously and indeed had very little faith that I would improve the situation.

Given how fragile she was at the time I did arrange expeditious review with Dr gastroenterologist, and we went to quickly have that drained that remained in situ removed and that did lead to quite significant improvement quickly.

The reason for me writing to you, Judy, is that I believe that there is a pattern of behaviour related to Dr Will Braun that needs notification both to the AHPRA as well as to the Redcliffe Hospital. There is no circumstance in which a patient at the Redcliffe Hospital would normally be transferred interstate as all clinically and technical procedures that she went through in Sydney can be undertaken by the Royal Brisbane and Women's Hospital upper GI team. My real concern here is that she was sent to Sydney to avoid any exposure to her problem profile by Dr Braun. As I have mentioned to you before, Judy, we have been a recipient of a number of what we all believe to be fairly poorly managed complicated GI problems caused by Dr Braun at Redcliffe and other surrounding hospitals. I certainly see a

pattern here, that he is constantly moving patients between institutions to avoid exposure and I suggest to you, this also enables him to avoid scrutiny at any morbidity and mortality meeting. Although I do agree that it is sometimes reasonable to seek attention interstate, the reason for this interstate transfer was never at any stage explained to the patient and to this end, I don't believe served any role other than concealing his problem from his local colleagues.

The exact details of her surgical management are again only familiar to me from her own personal history and only the documentation from Redcliffe Hospital, Holy Spirit Hospital, North West Private Hospital and the Sydney institution could help actually define exactly what has occurred here and exactly whether the treatment was reasonable. I do however think it is a notifiable incident where a patient is transferred interstate without a very sound clinical reason.

It is probably relevant to inform you that I am aware has already made contact with a private solicitor and to that end that solicitor has already sought a medicolegal opinion. I declined to provide that opinion given that I am one of the treating clinicians.

Judy, please be aware Dr Braun has previously taken legal against surgeons at this institution who have identified his poor surgical performance. To that end, I believe it would be far more appropriate for the hospital executive to take this on suggesting that her case has been discussed at our MDT meetings, which it has, and that we feel this represents a notifiable occurrence. I am happy to discuss this with you at any time.

With kind regards
Yours sincerely

Document 6

28th February 2017
Kellee Slater
Deputy Chair of Board in General Surgery
General Surgeons Australia
270 Spring Street
Melbourne Vic 3001

Dear Dr Slater,

I am writing to you to make a formal complaint regarding the behaviour of William Braun as my Consultant during my SET rotation at Redcliffe Hospital in the last five years. I am encouraged by the progress in which the college, which I am a Fellow of, is making toward fairer treatment of our colleagues and trainees. William Braun is well known amongst Trainees, Consultants and QLD Health as having significant issues with his behaviour. Dr Braun bullied me in his capacity as my Consultant, his behaviour was not acceptable, I am writing this complaint out of concern for future trainees placed under his supervision and in the hope it will provide a safer workplace in which to train.

In this complaint I would like to initially note why I am speaking now. I had the mentality during my training that if I could simply wait out six months and get through the rotation then it would be finished. Regrettably what I felt was the easiest option was not the right one. I am concerned that he will be placed in a position of trust with future trainees and more importantly non accredited (non protected by a college) Registrars. It is not an easy decision for me to take, however I am absolutely confident in my recollections, corroborating witnesses, existing evidence held by QLD Health and my stance as being in the right.

William Braun's behaviour ranged from daily subtle unacceptable treatment of me for example, whispering in my ear whilst I was trying to operate ' you operate like a retard, don't you' on many occasions, to outright verbally abusive behaviour.

I can illustrate with many examples what I thought was appalling treatment of me, I will list a couple:

-One patient on the ward who I did not believe required an Intercostal Catheter, Dr Braun thought they should have one. I tried to convey to him why I believed it to be the case. He immediately told me to come to the public cafeteria (he would make it fairly routine to belittle me in front of general public and staff). He immediately with much profanity in a loud manner including using 'f .' many times yelled at me in front of the general public that if I did not put it in the next ten minutes I would immediately fail my whole rotation. He subsequently went straight to the ward and told every nurse if they don't see me up there in ten minutes to let him know and I would be failed. This is noted in the record, and in my evidence to QLD Health. I placed the ICC against my better judgement, I gave the patient a pneumothorax. Dr Braun came to the ward the next day and apologized to the patient for me harming her, in a manner that completely gave

the impression to the patient that I was independent in my decision making and action.

-There was a major retroperitoneal vascular injury during an optical entry. The patient had a haemodynamic collapse. I was not involved at all in the entry, I was heavily involved in looking after the patient. A trainee subsequently told me that Dr Braun has been telling people that I was the one who did the injury. I reject this absolutely. I informed the Director at Redcliffe Dr what I had heard. He assured me that he would follow it up, Dr Braun denied saying this to anyone. Dr Braun contacted me on the phone to deny ever saying this. His primary purpose of the call was to find out if I was involved in the QLD Health investigation of him, clearly against the rules of the investigation. I stated I was asked to be interviewed, he told me to only say good things about him. Having completed my fellowship exam and no longer feeling that he was in a position of power over me I told him that he was indeed not good to me and I would like to never be contacted again by him.

I am very concerned as to the discomfort I saw on a daily basis from women in the workplace around him. His interaction with women is not professional, he is well known amongst female trainees and nurses as having highly inappropriate behaviour. I would not entrust him with the care of any of my relatives or people I care about.

Dr Braun creates a chaotic unpredictable and verbally abusive environment and he appears to relish in it. It was a very stressful time. I was significantly depressed and simply wished for the rotation to end. I am glad my college is now implementing positive steps with action to rectify mistreatment of people.

It is not in my nature to draw attention to myself or complain, this is a difficult step for me to take, however I know I am right. I think there are definite further steps RACS and the Board in General Surgery need to take to give trainees the confidence that we have their welfare at the forefront of our decisions when we place them in these positions.

William Braun is a well known problem in Queensland and in other states. I have heard many stories about his behaviour. Female trainees who I have spoken to feel uncomfortable in his presence. I would encourage the college to write to QLD Health to uncover their investigation into William Braun and why it was a confidential process which placed subsequent Junior Doctors into unsafe positions.

I wish to remain anonymous in this complaint as I am concerned about reprisals.

Sincerely,

Cc.

Thank you for accepting my statement on the issues surrounding Redcliffe hospital - particularly in relation to the surgeon Dr Will Braun.

To let you know my background, I am a ı at Royal Brisbane and Womens' Hospital and have been there since . Part of my role as is to allocate the 24 Northside trainees to their posts each year.

I am writing to the board with concerns over a surgeon who supervises our trainees at Redcliffe hospital in Queensland. Redcliffe had previously always been one of our popular training posts with excellent exposure to General surgery. The trainees used to love the job because of the teaching and the hands-on experience it gave them. In July 2016, it was brought to my attention that this was not the case anymore. Good trainees were now willing to leave surgery rather than return to Redcliffe with complaints from poor medical judgement to belittling and harassment to inappropriate contact with female trainees. Unfortunately, all these issues were centred around one consultant surgeon, Dr Will Braun.

Professionally I have never worked with Dr Braun or at Redcliffe Hospital except supervising a different surgeon in a colorectal operation on a single occasion. I have met Dr Braun only occasionally at events such as conferences or other surgical meetings.

When I became aware of these issues, I was naturally concerned and contacted 10 of the previous trainees who had worked in the hospital. 9/10 did not have anything positive to say about this surgeon. The 10th trainee was aware there had been issues but had not experienced them himself but also felt he should tell me that he was Dr Braun's private assistant prior to starting the term.

Allegations from the trainees ranged from discrimination - female trainees being told that they "would never be a decent, stand-alone surgeon as they were a girl", to belittling which I heard from almost everyone, that he lacked the patience to teach - with trainees being told on the first day that "if you can do the operation, it's yours but if you can't I'll do it", to poor clinical decision making and trying to hide complications from other hospitals. There were many issues of unprofessional behaviour including ringing the trainees in the middle of the night, drunk and swearing at them. Most trainees stated that the only reason he worked in a public hospital was to have a place to dump his private complications on a Friday. One trainee recalls managing complications from 5 different private hospitals at once in the public setting and found him uncontactable on many occasions. Many of the trainees described Dr Braun as a "sociopath".

One male trainee recalled him constantly whispering profanities in his ear when he was operating and kept telling him how hopeless he was. He recalls a particular incident when he was called to the public cafeteria and told to put in a chest drain of questionable need. When the trainee questioned Dr Braun, he was yelled at, sworn at in the public cafeteria which continued onto the ward where Dr Braun continued the swearing in front of the nursing staff, then told the trainee that he would fail his term if he didn't do as he was told. He also recalls an incident where Dr Braun put a laparoscopic port into the IVC. The patient subsequently struggled for weeks after, being managed by the trainee without support. Later, the trainee then finds out that Dr Braun had been telling subsequent trainees how "his f***ing useless registrar had stuck a port into the IVC and I (Dr Braun) had to come in and save the day". this trainee generally felt bullied, belittled and unsupported.

Another female trainee had many issues with Dr Braun. I asked her to describe her worst situation. She recalls that Dr Braun used to teach her colonoscopy by standing behind her and putting his arms around her to show her how to scope. She felt so uncomfortable that at one stage she had to "accidentally" elbow him in the groin to get him away from her. This was not an isolated incident with another female trainee also describing the same "method of teaching colonoscopy".

The first trainee was also just newly married at the time and Dr Braun would ask her why she was doing surgery and that she should be going off and having babies. He eventually found out that she had been having fertility issues and spent the rest of the term saying things like "you're too fat to get pregnant" or if she said anything that did not agree with him he would reply "no wonder you're not pregnant"

A further, more experienced, male trainee stated that as a trainee you accept that your get shouted at from time to time. He was a more senior and more confident trainee but could see that if you were more junior, the way you got treated there would really undermine your confidence. He also felt that care of public patients was compromised in preference to private patients, yet he was constantly managing private complications on the weekends when they had been transferred to Redcliffe on Fridays. The trainee was also so concerned about patient selection that he would just tell the patients to get in their car and drive to Brisbane or if they were an inpatient, he would take it upon himself to arrange a transfer to RBWH directly.

Another male trainee described Dr Braun as a sociopath. That he took great pleasure in getting under your skin. He was handed over not to let Dr Braun know anything personal about yourself as he would use it against you. He also stated that Dr Braun would call you in the middle of the night swearing at and cursing you. The trainee found Dr Braun very belittling but stated that he thinks he was lucky because he actually thought Dr Braun liked him in comparison to other trainees.

In discussion with another male trainee, who was the previous trainee rep to QBIGS, he described Dr Braun as a massive egomaniac. That he's rude, swears and carries on a lot, can't teach, lacks judgement and does stupid things. He believes that the only reason Dr Braun keeps his public appointment was to have a place to dump his private complications. He said from a trainee's perspective that it depends on how thick skinned you are as to whether you survive the term. "if you can ignore the harassment, you will be OK". This trainee felt he was put in many difficult situations, for example, he was doing an acute gall bladder for Dr Braun and having difficulty. He called Dr Braun for help and was told that Dr Braun "was leaving the hospital and feel free to cope". He ended up being bailed out by one of the other surgeons who was actually on leave at the time but had come into the hospital for other reasons and heard that there was an issue in theatre. This trainee also listed a number of situations where he felt bad clinical decisions were being made for monetary reasons including operations that should not have been done but the patients were private and hence getting one. Again, this trainee thinks that Dr Braun actually liked him and treated him like a mate so would say things to him like that he "doesn't think women can be surgeons" etc. This trainee thinks that Dr Braun is ruining the job. It was a job that people used to request. Now no trainees want to go there.

In summary, I am concerned about sending Northside trainees to a hospital where they have to works with a surgeon like this. I feel like I'm sending lambs to the slaughter. I have stopped allocating female trainees there already, but I think he bullies the male trainees as well and I hesitate to send any trainee. Currently, if possible, I will only allocate a more confident, "blokey" male but I do not think that this surgeon is fit to be supervising any trainee. In the age of operating with respect, I urge the board in General Surgery to investigate this situation further.

23/1/2019

To Whom It May Concern,

I write this letter as an account of my experience working at Redcliffe Hospital i
l. I worked for Dr William Braun. I felt traumatised after this rotation and do not wish for future trainees to have a similar experience.

On my first day at Redcliffe Hospital, I was taken aside by the head of the general surgery department and was told that Dr William Braun, who I had not yet met, could be difficult to work for.

I felt bullied and harassed. I had concerns for Dr Braun's professional conduct towards me as well as his clinical conduct.

- I can recall one specific instance when I was was standing in the operating theatre, about to start a case. He told me that he thought I would never make a successful, independently practicing surgeon as I was female and he did not know of any such females that were successful. I was shocked and humiliated by this statement and kept quite at the time as I did not know what to say.
- I felt uncomfortable doing endoscopy lists with him. His concept of personal space was non existent and he would repeatedly take the scope off me while rubbing up against me from behind. I was embarrassed by this and felt violated.
- I would assist Dr Braun for private lists performed in the public hospital as per the term requirements. I found these lists extremely stressful; during one particular Friday list, by the end of the first case I was in tears. He had spent the entire case telling me off and chastising me. I then refused to scrub for the remainder of the day and for any of his private lists thereafter. He then had to organise his own private assistant for these lists. This was not a one off instance; this private list was near the end of the term and I had

had enough of being treated in this way in the operating theatre. I was often made to feel belittled and inadequate.

- When performing colonoscopies, sometimes I would write the report while he performed the procedure. The procedure start, end and withdrawal times were recorded by the nursing staff. He asked me on a number of occasions, when the withdrawal time was less than seven minutes, to change the notes to state he had taken longer than seven minutes (this is the recommended withdrawal time).
- On the 10th April 2014 he had a patient booked on his list for excision of multiple large abdominal wall lipomas). I had examined her notes in the days prior to the operating list and called Dr Braun to inform him that she was booked first on the morning list. I told him I had concerns about excising these lipomas as they were reportedly very large (>10 cm each) and I would likely need senior help. I politely requested that he be there to assist me. He brushed this off. On the day of surgery, he arrived to the operating theatre an hour late as I was finishing off this first case. He berated me for taking so long. This was exasperating; I felt unsupported given I had clearly expressed my concerns to him the day prior. I thought it a reasonable request that he should arrive on time to his own operating list to assist a junior trainee with a difficult case.
- I was on call on the night of the 12th June 2014 with Dr Braun. An elderly nursing home patient was brought to the emergency department) with a new painful groin lump. This was suspected to be a incarcerated/strangulated hernia. As a trainee I had not seen many of these before. I was unable to reach Dr Braun by phone for an hour, and tried on numerous occasions to call his mobile phone. I spoke to his wife via his alternative number and was told he was playing tennis. He called me back eventually and I asked him to evaluate the patient before going to OT as I had concerns my clinical assessment was incorrect given my inexperience. He refused to do this and instead insisted that I book the patient for OT. I had the patient transferred to the operating theatre. Dr Braun arrived and sat in the tearoom while the patient was going off to sleep, all the while knowing I wanted him to clinically assess the patient. He then came into the operating theatre once the patient was anaesthetised and assessed the lump. He told me that it wasn't an acute hernia and chastised me for getting it wrong. Instead the patient had an infected abdominal wall haematoma adjacent to a chronic hernia. Dr Braun repaired the hernia and drained the haematoma. The patient had delayed wound healing requiring ongoing inpatient assessment. Dr Braun made fun of me during the ward round for getting the diagnosis wrong and therefore the wound issues must be my fault.

- At the end of term assessment, I was told by the hospital supervisor that seeing as I had only cried a handful of times, I must have performed well.

Yours Sincerely

22 February 2019

Dear

Further to our conversation regarding Dr W Braun, I wish to bring to your attention my own experience when working at St Vincent's Private Hospital Northside (formally known as Holy Spirit Northside). I had the occasion to attend one of Dr Braun's patients at his request. (Specific dates and names are available if required). This patient had undergone a gastric sleeve procedure which was complicated by a chronic persisting gastric perforation high on the greater curvature of the stomach remanent, considered inoperable. This rendered the patient in need of hospital-based care for a period of approximately 2 months. During this time, he was attended by specialists in the field of gastroenterology, infectious diseases, intensive care, myself and Dr Braun.

During this time the patient was admitted under Dr Braun, as appropriate, those of us that were also attending the patient were doing so to assist the primary clinician – Dr Braun. None had to my knowledge had been asked nor had agreed to take over the patients care from Dr Braun at any stage.

While the patient was in hospital during this episode of care, Dr Braun undertook travel to Europe. He did not arrange adequate surgical cover for the patient. In fact, many of the clinicians involved were unaware that Dr Braun had taken leave. This left the patient in hospital with no primary doctor looking after him. When I realised that the patient was not being seen every day and had not been surgically reviewed for several days, I reported this to hospital executive who contacted Dr Braun.

Dr Braun contacted me directly and was verbally aggressive – In fact angry that I had taken this course of action. He arranged surgical cover from his overseas location with a colleague who although a surgeon I believe is not a gastric surgeon.

The issues I raise here, I believe relate to Dr Braun's ethical and moral duty to the patient which I feel he failed in this case. He did not display any insight to his actions, specifically to, the potential harm which could have come to a seriously ill patient. I am not contending that the complication was in any way caused by negligence or incompetence. I am not able to evaluate surgical competence and have never done so.

Should you require further specific details, given the appropriate legal frame work these can be supplied.

Regards,