

Chapter Two – Base hospitals, recruiting doctors, and Area of Need Registration

'It's...easy to connect a few points together to understand that if over the last 20 years...in Queensland the supply of graduates has remained ...the same, during which period of time [the] population has grown each year equivalent to the size of a city of Rockhampton, we were inevitably heading for a railroad crash.'

Dr Lennox, Rural Medical Advisor

Administrative structure of base hospitals

- 2.1 The legislative framework for public health in Queensland is provided by the *Health Services Act* 1991. It provides that the Governor in Council may, by gazette notice, declare an area of the State to be a Health Service District, and may assign a name to the District.² Pursuant to that power, the State of Queensland has been divided into 38 different districts, each named according to its location.³
- 2.2 The Act provides that there be a District Health Council for each district. It provides that the Governor in Council is to appoint council members,⁴ and it charges the District Council with a role that is, essentially, advisory.⁵ For instance, the Council is to 'identify and assess the health service needs of people living in the district'; 'monitor the quality of public sector health services delivered in the district', and 'advise the manager for the district about the development of health service agreements for the district'. Curiously, the Act does not confer upon the Council any powers for the performance of its functions.
- 2.3 The legislation also provides that there be a manager for each district.⁶ That manager is to be a public service officer or a health service employee and, subject to the control of the Director-General of Queensland Health, is to manage the delivery of public sector health services in the district.⁷ There is a requirement that the District Manager 'consult and liaise' with the district council but, as will be gleaned from the discussion, the Council has very little power to give directions.⁸

² *Health Services Act* 1991 s6

³ <http://www.health.qld.gov.au/wwwprofiles/default.asp>

⁴ *Health Services Act* 1991 s10. The section provides that the Council may have as many as 10 members

⁵ *Health Services Act* 1991 s8. The council is to identify the health needs of the district, to monitor compliance with budgets, and to provide advice and recommendations for the delivery of services, amongst other things⁵

⁶ *Health Services Act* 1991 s22

⁷ *Health Services Act* 1991 ss2,22 and 24; and see *Acts Interpretation Act* 1954 s33(11)

⁸ T1832 line 30 - 50, T4380-3, T581 line 50; T1833

- 2.4 Unlike some Australian jurisdictions,⁹ Queensland has a public health system which is effectively run by one organisation, namely Queensland Health through layers of administration¹⁰ with its head office in Brisbane. For administrative purposes, Queensland Health divides the State into three zones (southern, central and northern), and those zones are divided further into districts. The various districts, however, are not autonomous. The staff at the various health facilities¹¹ within each district are accountable to the District Manager who, in turn, is accountable to the Director-General (pursuant to the provisions set out above). The staff at the hospitals, and indeed all public health facilities, effectively contract with, or are employed by, the Director-General,¹² and the assets and liabilities utilised in the running of the hospitals vest in the State.¹³ In short, the Director-General, based in Brisbane, has very real control over the various public hospitals in the districts and they are operated in accordance with the policies and procedures of Queensland Health.
- 2.5 It was not always so in Queensland. The *Hospitals Act* 1936¹⁴ provided for a very different system of administration. The Governor in Council was to establish districts throughout the State. The districts were matched with a local 'hospitals board' and the board effectively ran the hospitals in its district.¹⁵ The board would comprise 5 to 9 members, namely a representative from the local government authority, together with such members as the Governor in Council might appoint. Each board was a body corporate with the attendant capacity at law. It had the power to enter into contracts and to accept gifts and bequests.¹⁶ It was charged with the 'treatment of the sick' and with 'the good rule and government of the district in relation to such function'. It had the power to receive property and, in practice, it is understood, all real and personal property associated with its enterprises, was vested in the board.¹⁷ The power to frame the budget for the hospitals in the district (through various prescribed funds) was conferred on the board.¹⁸ Further, the board employed the staff of

⁹ There has been a strong centralising tendency in recent re-structuring so that all states and territories, except South Australia and Victoria, have a central governing agency. See the comparative tables in 'Australian health system restructuring – what problem is being solved?', Judith Dwyer, *Australia and New Zealand Health Policy* 2004 1:6 available at: <http://www.anzhealthpolicy.com/content/1/1/6>

¹⁰ T577 line 8

¹¹ These facilities may include centres for immunisation, dental clinics etc

¹² *Health Services Act* 1991 ss24 - 28

¹³ *Health Services Act* 1991 s72

¹⁴ There was a similar decentralised regime pursuant to the *Hospitals Act* 1923. The Hospital Boards received funding from the Government, the local authority and the patients: Exhibit 159

¹⁵ *Hospitals Act* 1936 s12 In practice, there were 11, and later 12, districts: *Triumph in the Tropics, An Historical Sketch of Queensland*, Sir Raphael Cilento and Clem Lack Snr, Smith & Patterson Pty Ltd, 1959 p445

¹⁶ *Hospitals Act* 1936 s13

¹⁷ At least the *Hospitals Act* 1936 s12 gave the Boards power to receive such property and it is understood that, in practice, the property was so vested

¹⁸ *Hospitals Act* 1936 s21

each hospital in its district subject, in certain cases, to the approval of the Director-General.¹⁹

- 2.6 The Act also gave the Governor in Council power to designate certain facilities within a district as 'base hospitals', and those hospitals were to act as the primary referral centre for the other facilities.²⁰ In practice, there were 11, and later 12, districts, 'each with a base hospital strategically located, and with as adequate a staff of medical officers and specialists as could be found locally, striving towards complete provision'.²¹
- 2.7 When the *Health Services Act* 1991 was initially enacted, a large measure of decentralisation was retained. Although the old hospitals boards were dissolved,²² they were replaced by Regional Health Authorities responsible for designated regions, with members again largely appointed by Governor in Council.²³ The regional authorities were subject to the control and direction of the Minister²⁴ but their primary functions were substantive ones. They were charged, amongst other things, with ensuring that health services were of a high quality; ensuring that there was adequate access to health services; making available to the public reports, information and advice concerning the services in the region; and providing training and education to the service-providers.²⁵ The authorities were given power to do all things reasonable and necessary in the performance of their functions.²⁶ They were given specific power to hold property,²⁷ to enter into contracts²⁸ and to receive gifts.²⁹ The property, previously vested in the hospitals boards, was vested in the regional authorities.³⁰
- 2.8 There was some testimony³¹ before the Commission that appointments to the Regional Health Authorities was politicised (and it seems entirely probable that this was the case), and that this interfered with their performance. It seems clear, however, that the regional health authorities and the hospitals boards before them, were attentive to local issues and that planning was firmly focussed on the clinical needs of the immediate population.³²

¹⁹ *Hospitals Act* 1936 s18. It should be noted, however, that the appointment of a medical superintendent, a medical officer or a matron required the approval of the Director-General: of the *Hospitals Act* 1936 s5

²⁰ *Hospitals Act* 1936 ss12A, 12B

²¹ *Triumph in the Tropics*, p445

²² *Health Services Act* 1991 (Reprint No. 1) s1.4

²³ *Health Services Act* 1991 (Reprint No. 1) ss3.1 - 3.5

²⁴ Interestingly, there was an exception namely in relation to the contents of a recommendation or report made by the Authority to the Minister: s3.8

²⁵ *Health Services Act* 1991 (Reprint No. 1) s3.18

²⁶ *Health Services Act* 1991 (Reprint No. 1) s3.19

²⁷ *Health Services Act* 1991 (Reprint No. 1) s3.24

²⁸ *Health Services Act* 1991 (Reprint No. 1) s3.27

²⁹ *Health Services Act* 1991 (Reprint No. 1) s3.25

³⁰ *Health Services Act* 1991 (Reprint No. 1) s8.2(1)

³¹ T1834 line 40, T1835 line 20 (Dr Thiele)

³² T1834-5 line 20 (Dr Thiele)

- 2.9 In 1996, the *Health Services Act* 1991 was amended so that the regionalisation provisions were removed and the current, corporate model (with the structure described above) was introduced.³³ Queensland Health grew into one of the largest employers in Australia with a staff of 64,000 people, engaged across a range of departments. Patients became known as 'clients', Medical Superintendents became known as Directors of Medical Services, and hospitals tended to be run by managers who were career public servants rather than local officials or health professionals.³⁴ The drive for centralisation had the admirable goals of ensuring that health resources could be effectively distributed through the State, that services and competency levels could be standardised (to the extent that is possible in a State as diverse as this one), and that certain economies of scale could be achieved. It also worked to diminish inefficient competition between centres and to facilitate co-ordinated planning of State-wide issues.³⁵ Queensland was able, for instance, to develop a well-resourced, centralised renal unit and a burns unit, rather than presiding over a proliferation of lesser units in various regions.³⁶
- 2.10 In this endeavour, of course, there is a real need to ensure a proper balance between the logistical benefits of a centralised approach and the encouragement to initiative and ownership which comes with local autonomy. The evidence given before the Commission, and canvassed later, suggests that such a balance is yet to be achieved in Queensland.

The role of the base hospital

- 2.11 Queensland Health operates just over 100 hospitals in Queensland, the smallest being ten bed/one doctor facilities in places such as Augathella and Julia Creek, and the largest being tertiary hospitals in Brisbane, such as the Princess Alexandra, with more than 700 beds and 4000 staff. In all of Queensland's large regional centres including Toowoomba, Dalby, Mackay, Rockhampton, Townsville and Cairns, there is a 'base hospital' or, if the old language is not used, a central public hospital which serves as the primary referral facility for smaller centres in the area.³⁷ The base hospitals provide certain core functions to their catchment areas and, in particular, they treat most, or all, of the emergency cases in the district, either as a primary admission or a referral.³⁸ Each of the bases has a Director of Medical Services who is the 'line manager' to the doctors. Each also has a Director of Nursing who is 'line manager' to the nurses³⁹ and who, like the Director of Medical

³³ *Health Legislation Amendment Act* (No2) 1996; T1847 (Dr Thiele)

³⁴ T2942 line 5 (Dr Nankivell); T3257 line 10, T3296 line 50, T3270 line 10 (Dr Strahan); T4163 line 30, T4146 line 20 (Dr Nydam)

³⁵ T2871, T2879 (Dr Young)

³⁶ T2879 (Dr Young)

³⁷ For ease of reference, I will use the title 'base' to denote all such primary referral hospitals in regional areas

³⁸ This occurs simply because most private hospitals do not offer Accident and Emergency facilities. See, for instance, the situation at Bundaberg, explained by Dr Brian Thiele: T1830 line 10

³⁹ Exhibit 180 paras 17-19, 31-33, T2540, 2555-6 (Ms Mulligan)

Services, reports directly to the District Manager. That triumvirate of District Manager, Director of Medical Services and Director of Nursing together with the Director of Corporate Services, essentially constitute each base's senior leadership.

- 2.12 Each base incorporates a number of different medical departments (eg, Surgery, Medicine, Emergency, Anaesthetics and Obstetrics) and, for each department, there is a director. The directors are clinicians who take on certain administrative duties in addition to their clinical work. They sit below the District Manager and the Director of Medical Services in the hospital hierarchy.⁴⁰
- 2.13 Each of the bases employs doctors, nurses, and other medical staff across its departments. The doctors are known as Interns (who have not yet been fully registered with the Medical Board of Queensland as medical practitioners), Junior House Officers (being medical practitioners in their first year of service after full registration), Senior House Officers (being doctors in their second or subsequent year of practise who have not been appointed as a Principal House Officer, and who are not Registrars), Principal House Officers (being medical practitioners who are not undertaking an accredited course of study for a higher medical qualification, and have been appointed to this position), Registrars (being doctors who have been accredited by a specialist college as part of a recognised specialist training programme) and Staff Specialists (being doctors recognised as having qualifications in a given specialised area).⁴¹
- 2.14 It should be said that the term 'Senior Medical Officer' has different meanings in different contexts.⁴² In its strict sense, it refers to any senior medical practitioner within the hospital, and would include Medical Superintendents, specialists⁴³ and Principal House Officers. In its more colloquial use, it refers to a senior doctor who is not a specialist or a trainee for an accredited course.⁴⁴ In this report, the term will be used in the latter sense, unless otherwise indicated.
- 2.15 The base hospitals often employ, in addition to the staff set out above, a number of Visiting Medical Officers. These officers are doctors – usually specialists – who maintain practices away from the base but choose to work for a certain number of hours, or sessions, at the base per week. Traditionally, in Queensland, they have worked for remuneration which barely covers the cost of running their rooms for the time spent.⁴⁵ That arrangement has been acceptable, it seems, because of the goodwill enjoyed between the doctors and the public hospitals, and the doctors' inclination towards public service,

⁴⁰ Exhibit 448 para 13, DWK2 p9 Division of Medical Services

⁴¹ T5969; Also the *Regional Health Authorities – Senior Medical Officer's Interim Award* (No. R7-3/1992)

⁴² T4118, line 50

⁴³ T5969, line 15; T4118, line 48

⁴⁴ See, for instance, the way the term is used by Dr Molloy at T573, Dr Baker at T6357, Mr Demy Geroe at T439 line 10 and T448 line 35, Dr Mullen at T5774 line 50, Dr North at T3456.

⁴⁵ T612 line 40 (Dr Molloy)

teaching and the collegiate atmosphere which has existed in those facilities.⁴⁶ It has been particularly attractive to specialists who are junior or newly arrived to an area, because it serves as a vehicle for gaining experience and forging relationships in the medical community.⁴⁷

- 2.16 Visiting Medical Officers often provide important stability in that, whilst regional centres may have difficulty in retaining full time staff specialists, a Visiting Medical Officer is often somebody who has made a long-term commitment to the town.⁴⁸ Moreover, where a town relies on a number of Visiting Medical Officers, it is less likely to suffer the disruption which comes from complete reliance on a lesser number of staff specialists.⁴⁹
- 2.17 Traditionally, the engagement of Visiting Medical Officers has been very beneficial to the base hospitals.⁵⁰ Whilst staff specialists provide much needed continuity of service,⁵¹ the demands of a regional population may mean that the need fluctuates, that only a part of a specialist's time is required,⁵² or that the employed specialist needs to be relieved on a regular basis.⁵³ In all or any of these ways, the Visiting Medical Officers supplement the employed base staff, and, in particular, the Staff Specialists. Further, the Visiting Medical Officer may bring a certain amount of vigour and independent thought as an outsider,⁵⁴ and may perform a supervisory, or mentoring, role. In some cases, the Visiting Medical Officer has assumed a position as director of a department.⁵⁵

Recruitment of doctors

Past recruitment of doctors

- 2.18 There has been, until recently, only one medical school in Queensland⁵⁶ so that regional hospitals have drawn doctors from that school, from the existing State workforce, from interstate, and from certain overseas countries, particularly the United Kingdom, Ireland and South Africa.⁵⁷ The hospitals tend to advertise positions locally or nationally and, if that does not yield a suitable

⁴⁶ T1824-6 (Dr Thiele)

⁴⁷ T186, T2751-2, T2782-3

⁴⁸ Exhibit 118 para 30, Dr Mullen, Dr Anderson, Dr Strahan, Dr Theile and Dr Jelliffe (discussed later) were all examples of this

⁴⁹ T1826 line 40 (Dr Thiele)

⁵⁰ T1824 (Dr Thiele), Exhibit 118 paras 28 - 32, T2856 (Dr Young), T2936 line 10 (Dr Nankivell)

⁵¹ T2934 (Dr Nankivell)

⁵² The hospital may not be able to sustain a full time neurosurgeon, or it may need 1.5 full time Emergency Medicine specialists

⁵³ T1825 (Dr Thiele), T558 (Dr Molloy)

⁵⁴ T556

⁵⁵ eg, Dr Martin Strahan, T3257 line 40; Exhibit 232

⁵⁶ This is the University of Queensland at St Lucia, Brisbane, but as appears later in this report, there are courses in medicine now offered at James Cook University at Townsville, Griffith University in Brisbane and Bond University on the Gold Coast. The first graduates will emerge in 2006 and the total number of Queensland graduates will double by 2010/11: T825, T943 and see T776

⁵⁷ T880

applicant, they approach private, or in-house, recruiting agencies to find candidates overseas.⁵⁸ In recent years, Queensland hospitals have tended to recruit more and more doctors from the international market. Moreover, those doctors tend to be drawn now from developing countries rather than those identified above. This trend is more pronounced in the regional healthcare facilities than it is in urban, tertiary hospitals and the circumstances surrounding that trend are described below.

- 2.19 In passing, it should be noted that public hospitals also recruit doctors through a 'rural scholarship' system of longstanding.⁵⁹ Queensland Health pays an allowance to medical undergraduates for a period of time during their studies, and the scholar is then bonded to work for Queensland Health for an equivalent period.⁶⁰ Those doctors are required to work out the majority of that bonded period in a rural location, but they are usually assigned, first, to a larger hospital so that they can gain and develop relevant skills and knowledge.⁶¹

Staffing shortages

- 2.20 There has been much evidence that there is an international medical workforce shortage,⁶² that such a crisis affects the Australian states and that the staff shortages are more acute in Queensland than other parts of Australia.⁶³ These shortages are more evident in the public sector than the private sector. In Queensland, at least, it seems that this situation has been brought about by some or all of the following factors:

- (a) Over the last 30 years, the population of Queensland has almost doubled⁶⁴ but the number of places at the University of Queensland medical school has remained static at approximately 225;⁶⁵
- (b) The mean age of the Queensland population is steadily rising⁶⁶ and, with that rise, there is a greater need for healthcare;
- (c) The public has higher expectations of the public health sector;⁶⁷
- (d) On a *per capita* basis, Queensland spends considerably less than the Australian average on general health funding and on public hospitals,⁶⁸

⁵⁸ Exhibit 41 (Dr Bethell) para 29; Exhibit 51 S(Dr Nydam) paras 8-14

⁵⁹ T3012 line 50 (Dr Cook); T2804 (Dr Risson)

⁶⁰ T2829 line 20 (Dr Risson), T2049 line 15 (Dr Athanasiov), T900 (Dr Lennox)

⁶¹ A Dr David Risson, who had received such a scholarship, gave evidence that there were 30 recipients of the scholarships in his year: T2829-30

⁶² T824 line 10; Dr Jeanette Young, Chair of the Australian Medical Workforce Advisory Committee – Exhibit 209, T2861, T2863; Dr Molloy T515; Dr Lennox T876; Exhibit 28, paras 55 – 64 (Mr O'Dempsey)

⁶³ T700-702 (Dr Bethell); T899 (Dr Lennox); T2864 line 18, T2871-2 (Dr Young)

⁶⁴ The Queensland population increased from 2 million to 3.9 million between 1975 and 2005 and it continues to grow at 1.9% per annum (Australian Bureau of Statistics)

⁶⁵ T824 line 40 (Dr Molloy); T876-8, T899 line 50 (Dr Lennox); T2857 (Dr Young)

⁶⁶ See the *Queensland Government's Submission to the Productivity Commission Study of the Health Workforce*. July 2005

⁶⁷ T878 (Dr Lennox)

⁶⁸ Exhibit 34 page 11; Exhibit 35; T565, T589 line 10; T596 (Dr Molloy)

and much of that money is spent on administrators rather than service providers;⁶⁹

- (e) Australian rates of pay for doctors are low by first world standards, and Queensland Health specialist rates are low by Queensland and Australian standards;⁷⁰
- (f) Doctors are graduating later,⁷¹ their HECS debt⁷² and family circumstances make them less inclined to work in the public sector⁷³ and they are committed to working shorter hours for lifestyle reasons;⁷⁴
- (g) There are many more women graduating from medical schools than before,⁷⁵ but in the course of their careers, and as a group, they tend to work significantly fewer hours;⁷⁶
- (h) The shortage of doctors places an extra burden on those working within the public system, making the private sector even more attractive;⁷⁷
- (i) Queensland and Australian medical graduates are well-regarded and can readily obtain work overseas;⁷⁸
- (j) Even when adequate numbers of medical graduates are produced, the professional colleges restrict entry unnecessarily;⁷⁹
- (k) Doctors leave the public system because they see major compromises in the quality of care, and do not wish to be part of that, or because they are aware of intrusions into clinical autonomy⁸⁰ and a culture of bullying.⁸¹

2.21 Whatever the causes, there are, in fact, fewer doctors per head in Queensland than in any other state or territory,⁸² and the statistics for nurses are similar.⁸³ It is also clear that the state's needs are not nearly satisfied by the local graduates,⁸⁴ or even from interstate sources because other States or territories suffer from similar – but mostly, less critical – shortages and because doctors are inclined to make their career where they trained.⁸⁵ Concurrently, it has become much more difficult to recruit from countries with comparable medical

⁶⁹ T590, 515,577 (Dr Molloy)

⁷⁰ Exhibit 34 paras 6, 9; Exhibit 35; T575-6; T846 line 20 (Dr Molloy)

⁷¹ T2939 (Dr Nankivell)

⁷² T2957 (Dr Nankivell)

⁷³ T1826 line 45 (Dr Thiele); T2864 line 42 (Dr Young)

⁷⁴ T2859 line 30 (Dr Young); T850 (Dr Molloy); T4105 (Dr Nydam)

⁷⁵ Dr Young gave evidence that the proportion in the UK is approaching 70% and that Australia tends to follow the UK workforce trends: T2859

⁷⁶ T2861, T2859 (Dr Young); T2939 (Dr Nankivell); T850 line 20 (Dr Molloy)

⁷⁷ T2864 (Dr Young)

⁷⁸ T880 (Dr Lennox)

⁷⁹ This theory is highly contentious (and, in any case, does not seem to be a current problem): T888 - 891, T924-5 (Dr Lennox); T776-80 (Dr Molloy); T2938 line 40; Exhibit 57 (Dr Nankivell)

⁸⁰ T592-5 (Dr Molloy) and see the evidence of Baker, Thiele, Jelliffe

⁸¹ T562, T577; T584-8; T818-20, T859-60 (Dr Molloy)

⁸² T2864 line 18, T2871-2, T2887 (Dr Young); See *Queensland Health Systems Review*, Final Report, p13

⁸³ T2887 (Dr Young); See *Queensland Health Systems Review*, Final Report, p14

⁸⁴ T879 line 15 (Dr Lennox)

⁸⁵ T2857 line 25 (Dr Young)

systems⁸⁶ because those countries are experiencing shortages, because some countries have introduced measures to ensure that they retain their graduates,⁸⁷ and because such doctors can command better remuneration elsewhere.⁸⁸

- 2.22 In consequence, Queensland has become highly dependent for a number of years on doctors from developing countries.⁸⁹ This state employs well more overseas trained doctors than any other Australian state⁹⁰ and, at least by 2003, the proportion of Resident Medical Officers who were overseas trained doctors across the State was approaching 50 per cent.⁹¹ Whereas in 1997-08, the United Kingdom and Ireland accounted for 70 per cent of the temporary working visas issued to overseas trained doctors (known as the subclass 422), by 2002-03 that share had fallen to 43 per cent.⁹² Over the same period, the proportion of doctors originating from India, Pakistan, Sri Lanka, Malaysia, the Philippines, Bangladesh and 'other'⁹³ increased from 9.6 per cent to 37.3 per cent. Queensland authorities often know little about the training standards at particular medical schools in those countries⁹⁴ and, in any case, the training may address quite different conditions from those operating in this State.⁹⁵ The practice is also problematic from a moral point of view: it deprives developing countries of doctors in circumstances where those countries may have paid for their education and are likely to have at least an equal need for their services.⁹⁶
- 2.23 The *Medical Practitioners Registration Act 2001* prohibits people from taking or using certain restricted titles, including 'medical practitioner', unless they are registered by the Queensland Medical Board.⁹⁷ It might be thought, against that background, that any concerns about varying standards of training between overseas trained doctors, are allayed in the course of the registration process. In practice, that has not always been the case.
- 2.24 Doctors can obtain general registration from the Medical Board if they have completed an appropriate course accredited by the Australian Medical Council or passed an examination set for that purpose by the Australian Medical Council.⁹⁸ They are eligible for specialist registration if they are members of a

⁸⁶ T2863 line 50 (Dr Young)

⁸⁷ T424 (Mr Demy Geroe); T2863 line 20 (Dr Young)

⁸⁸ T424 (Mr Demy Geroe); T679 (Dr Bethell)

⁸⁹ T2863 (Dr Young); T880-1 (Dr Lennox). Exhibit 28 para 55, Exhibit 34 para 3, T701 (Dr Bethell)

⁹⁰ T459 (Mr Demy Geroe); In the article cited below, figures gathered by Professor Birrell show that for 2002/03, of the subclass 422 nominations, 37 per cent emanated from Queensland

⁹¹ Exhibit 55, DR12 p5; It is assumed that Dr Lennox uses the term 'resident medical officers' as it is used in the award R7-3/1992 so that it includes junior house officers, senior house officers, Principal House Officer, and registrars. Also Queensland Health Systems Review (Final Report) p13

⁹² Professor Birrell of Monash University has published a number of articles on this issue including 'Australian policy on overseas-trained doctors', *Medical Journal of Australia* November/December 2004, p635

⁹³ According to Professor Birrell's table, 'other' excludes Canada, South Africa, the USA, and, of course, the UK and Ireland. In all cases, the country identified is the practitioner's country of birth

⁹⁴ T2863-4 9 (Dr Young), and especially T880 (Dr Lennox)

⁹⁵ T881 (Dr Lennox); T2863 line 50 – T2864 (Dr Young); Exhibit 24 para 17

⁹⁶ T567 (Dr Molloy)

⁹⁷ s161

⁹⁸ s44; Exhibit 28 para 33

College prescribed by the regulations or the Board considers they have sufficient qualifications and experience, having regard to the advice of the relevant College and the Australian Medical Council.⁹⁹ To the extent that doctors gain general or specialist registration, the community can be assured that they have met stipulated Australian standards.

Special purpose registration for an area of need

2.25 There is, however, another path to practice in Queensland, namely 'special purpose' registration. Sections 131 to 144 of the Medical Practitioners Registration Act provide various circumstances in which the Board might allow registration of a doctor notwithstanding non-compliance with the regime set out above. They include post-graduate study,¹⁰⁰ medical research or teaching¹⁰¹ and practice in the public interest.¹⁰² The most commonly invoked circumstance, however, relates to 'area of need'. It is contained in s135 which provides that:

- (1) The purpose of registration under this section is to enable a person to practise the profession in an area the Minister has decided, under subsection (3), is an area of need for a medical service.
- (2) A person is qualified for special purpose registration to practise the profession in an area of need if the person has a medical qualification and experience the board considers suitable for practising the profession in the area.
- (3) The Minister may decide there is an area of need for a medical service if the Minister considers there are insufficient medical practitioners practising in the state or a part of the state, to provide the service at a level that meets the needs of people living in the state or the part of the state.
- (4) If the Minister decides there is an area of need for a medical service, the Minister must give the board written notice of the decision.

2.26 Special purpose registration must be for no more than one year¹⁰³ and the Act goes on to provide in s141 that::

- (1) The board may decide to register the applicant as a special purpose registrant on conditions the board considers necessary or desirable for the applicant to competently and safely undertake the activity the subject of the application.
- (2) If the board decides to register the applicant as a special purpose registrant on conditions, it must as soon as practicable give the applicant an information notice about the decision.

2.27 In addition, s143A provides that:

⁹⁹ s111. The second path, in practise, has required that the candidate pass specialist exams set by the AMC

¹⁰⁰ s133

¹⁰¹ s134

¹⁰² s137

¹⁰³ s140

- (1) This section applies to a registrant who is registered, under s135, to practise the profession in a specialty in an area of need.
- (2) While the registrant is registered to practise the profession in a specialty in an area of need, the registrant is taken to also be a specialist registrant in the specialty.
- (3) The registrant's deemed specialist registration under subsection (2) is taken to be subject to any conditions of the registrant's special purpose registration under section 135.
- (4) Part 3, division 9¹⁰⁴ does not apply to the registrant while the registrant is taken, under subsection (2) to be a specialist registrant.
- (5) Also, Part 3, division 11¹⁰⁵ does not apply to the registrant's deemed specialist registration under subsection (2).

2.28 The Commission received evidence that, at least as at May 2005, the Minister for Health had delegated the power given by s135(3) to three Queensland Health officers.¹⁰⁶ Where District Managers or directors of medical services considered that there was a shortage of some service in their district, they made application to the Minister's delegate for a decision to that effect in relation to a particular position.¹⁰⁷

2.29 If the approach was successful, an overseas trained doctor could then make application to the Medical Board of Queensland, seeking that he or she be given special purpose registration in relation to the identified position.¹⁰⁸ The Commission received evidence that the following would be submitted to the Board on a prescribed form on behalf of the overseas trained doctor,¹⁰⁹ another form on behalf of the nominating employer, together with a fee of approximately \$416.00,¹¹⁰ and certain supporting documents (including the area of need determination, a certificate of good standing – issued by the medical authority in the applicant's jurisdiction - and a certified photograph) as prescribed by the Board's Policy for Special Purpose Registration.¹¹¹

2.30 When the application came to the Board, it would be 'case-managed' by a registration officer, the officer would use a checklist to confirm that the application contained all documents prescribed by the Board's policy,¹¹² and liaise, if it was considered necessary, with the doctor concerned about any outstanding matters.¹¹³ Unless the registration officer considered that the application was clearly non-compliant,¹¹⁴ he or she would provide it to a

¹⁰⁴ This Part deals with specialist registration generally

¹⁰⁵ This part deals with general provisions about registration

¹⁰⁶ T957 (Dr Huxley)

¹⁰⁷ Exhibit 24, MDG14; T476 line 18 (Mr Demy Geroe); T954-5 (Dr Huxley)

¹⁰⁸ Exhibit 24, para 27; T414 (Mr Demy Geroe)

¹⁰⁹ I have used the past tense to describe this process, not because all elements have ceased but because I understand that changes are being made, currently, by an incremental approach

¹¹⁰ T443 (Mr Demy Geroe)

¹¹¹ Exhibit 24, MDG14

¹¹² Exhibit 24 para 26

¹¹³ T471 lines 20 - 30 (Mr Demy Geroe)

¹¹⁴ T418 (Mr Demy Geroe)

standing subcommittee, the Registration Advisory Committee,¹¹⁵ which made recommendations for confirmation by the Board.¹¹⁶ In this process, the Committee did not 're-process the application or check individual documents'. Instead, it tended to focus its attention on the forms completed by the doctor and the hospital, and the doctor's *curriculum vitae* together with the area of need certifications, with a view to considering whether the skills matched the position.¹¹⁷ Where the applicant was a non-resident, a temporary working visa with the Department of Immigration also needed also to be arranged. In effect, then, there were three obstacles that needed to be navigated for an overseas trained doctor to fill an area of need: the area of need decision to be made by Queensland Health, the registration to be secured from the Medical Board, and the subclass 422 visa to be issued by the Department of Immigration. In practice, the Commission heard it was common for recruitment agencies to co-ordinate the paperwork for all three applications.¹¹⁸

- 2.31 The process, in short, allowed overseas trained doctors to be registered for practise in Queensland in circumstances where they had not met the standards set by the Australian Medical Council and were not members of any relevant College. The intent of the legislation was that the process could be invoked only where there was an inadequate supply of Australian-trained doctors to provide the relevant service in the stipulated area.
- 2.32 Almost any medical position available in Queensland might be the subject of an area of need decision and be secured by an area of need applicant who adheres to the process. It follows that overseas trained doctors, through this route, might fill positions as general practitioners, Junior House Officers, Principal House Officers, Registrars and Directors of specialist departments in base hospitals,¹¹⁹ and possibly even directors of medical services in such hospitals.
- 2.33 The extent to which the process allows area of need applicants to practise as specialists is more problematic. Section 143A was introduced by s85 of the *Health Legislation Amendment Act 2001*. The explanatory notes for that Act usefully set out the background to the provision:

Area of Need

The Commonwealth Government, in consultation with the medical profession, has recently developed a national scheme for the assessment of overseas-trained specialists seeking registration to practise in an area of need (ie. an area where there are insufficient medical practitioners to meet the needs of people living in the area). The scheme is a response to national concerns about the need to improve the current assessment processes.

¹¹⁵ T415 (Mr Demy Geroe) s33 of the *Medical Practitioners Registration Act 2001* provides for the establishment of committees and the Registration Advisory Committee is one

¹¹⁶ T545-546 (Dr Cohn)

¹¹⁷ Exhibit 24 paras 34, 35; MDG 3

¹¹⁸ T468-9 (Mr Demy Geroe)

¹¹⁹ T431 line 48 (Mr Demy Geroe), T6659 (Dr Jelliffe)

The Medical Practitioners Registration Act 2001, which has yet to be proclaimed into force, enables the Medical Board of Queensland (the board) to register overseas trained practitioners to practise in the area of need if the board considers the applicant's qualifications and experience are suitable to practise in the area.

Under the proposed national scheme, the board will consider, applications for Area of Need Registration having regard to the recommendations of the relevant Specialist College and, once registered, registrants will be subject to periodic assessment by the relevant Specialist College...

[An obstacle] to the implementation of the scheme exists in that the Act allows area of need specialists to be granted special purpose registration but not specialist registration. Without specialist registration, these practitioners would be disadvantaged. For example, specialist registration is required for appointment to public sector specialists positions and for specialist recognition under the Health Insurance Act 1973, to enable payment of Medicare benefits at the higher specialist rates.

The Bill overcomes this problem by providing that area of need specialists who have special purpose registration are deemed to also have specialist registration. Such deemed registration will be subject to the same conditions as the registrant's special purpose registration.

- 2.34 When the legislation itself is considered,¹²⁰ it will be seen that there were two features to the path introduced by s143A. First, an important safeguard was introduced: where the Board was considering registering an overseas trained doctor 'to practise ... in a specialty in an area of need' under s135, it would, first, have regard to the recommendations of the relevant college pursuant to the national policy. That policy was published by the Australian Medical Council, in concert with the state medical boards and other parties. It is in evidence before the Commission and is entitled: *Assessment Process for Area of Need Specialists*.¹²¹ Secondly, and presumably on the basis that the safeguard would ensure quality, if such registration was granted under s135 then, by operation of s143A(2), the overseas trained doctor was deemed a specialist in the specialty. That deeming provision would provide certain benefits to the practitioner including, of course, the right to be held out as a specialist.
- 2.35 In effect the amendment permitted the Medical Board to register area of need applicants as specialists without complying with the process that would be required of an Australian-trained doctor.
- 2.36 In my view, the implementation of the area of need scheme – both in relation to general applications, and those that might attract the operation of s143A - has not been faithful to its purpose. I describe the shortcomings below.

¹²⁰ In a strict legal sense, the Explanatory Note is probably irrelevant because it is only a legitimate tool for construction in the event of ambiguity, and the legislation seems plain: *Acts Interpretation Act* 1954 s14B

¹²¹ Exhibit 36

Defects disclosed by implementation of Area of Need Registration

2.37 There are, of course, many overseas trained doctors who have come to Queensland under the auspices of s135 and who are gifted and committed practitioners. The Commission certainly became aware of or heard evidence from many such doctors. Some of them had, soon after arrival, proceeded to obtain a fellowship in the relevant college or taken the relevant Australian Medical Council examination, so that their qualifications were indisputably the equivalent of their Australian colleagues. The way in which the special purpose registration has been implemented, however, leads me to doubt the benefits of the legislative scheme, at least in its present form. It seems that no genuine attempt has been made either to give effect to the evident purpose of s135(3) in identifying areas of need nor in ensuring that, by qualifications and experience, overseas trained doctors are suited to particular area of need positions. For this reason, and perhaps others, the scheme has resulted in large numbers of overseas trained doctors practising in this State without meeting the standards required of Australian-trained doctors. That consequence is particularly worrying. It allows those doctors to work in senior positions in, say, an orthopaedic department or an internal medicine department (and usually in a regional area), without informing the public that they have not satisfied the same criteria as those required of their Australian-trained counterparts.

Defects in deciding that there is an area of need

2.38 There are a number of troubling features to the Minister's approach, to date, in exercising the discretion granted by s135. First, one of the Minister's delegates, Dr Suzanne Huxley, gave evidence that she had worked full-time in the area of need classification since October 2003, that she had received some 1700 applications,¹²² and that she had never refused any applications for public hospitals. This, obviously, makes one question the extent to which the delegate has considered the statutory task.¹²³ Secondly, and more specifically, Dr Huxley gave evidence that, in making the area of need decisions, she had never made any enquiries to ascertain whether, in fact, the precondition for s135(3) was made out.¹²⁴ Rather, she had proceeded on the assumption that hospital administrators would prefer an Australian-trained doctor so that, it seems, if they were making application for an area of need application, that was itself proof of a need.¹²⁵ Dr Huxley disclosed in her testimony that there were no protocols for making determinations because 'our data is not good

¹²² T945 line 50

¹²³ T938-9

¹²⁴ T958-960

¹²⁵ T958-9; Dr Bethell of Wavelength Consulting did give evidence that employers 'always prefer' an Australian candidate for a number of reasons: T703

enough'.¹²⁶ Thirdly, Dr Huxley disclosed that, in making decisions, the Minister's delegates would have regard to a ministerial policy on area of need which was some four years old (when the *Medical Act 1939* was in force) and which preceded the proclamation of the *Medical Practitioner's Registration Act 2001*. Fourthly, it was the practice for the Minister's delegate to renew the area of need classification automatically every year until the incumbent chose to leave, despite the terms of the legislation. No checks were made to ascertain whether the pre-conditions in s135(3) prevailed at the time of renewal and, in consequence, there was no impetus for the overseas trained doctor to satisfy the Australian standards required for registration.¹²⁷ Although the (outdated) ministerial policy stipulated that area of need doctors should proceed to general or specialist registration after four years, that was not enforced until recently.¹²⁸ As a result, there have been overseas trained doctors who have practised for many years in Queensland pursuant to the area of need concession.¹²⁹

- 2.39 It emerges, perhaps as a natural consequence of these matters, that the number of overseas trained doctors working on temporary visas in Queensland is in the order of 1,760 and, as mentioned earlier, well more than any other state.¹³⁰ It seems clear that neither the Minister's delegate nor Queensland Health has attended to their role as statutory gatekeepers with any degree of vigilance.

Defects in Area of Need Registration by the Medical Board

- 2.40 There are, in addition, related shortcomings in the manner of registration of applicants under the provisions and its consequences. First, neither the Medical Board nor Queensland Health has carried out any examinations – theoretical or practical – to test the competence of the overseas trained doctors.¹³¹ Indeed, until May 2004, the Board did not even satisfy itself that the candidate could speak English proficiently.¹³² This is in contrast to other jurisdictions including Canada, the United States, the United Kingdom and, to some extent, New South Wales, where the overseas trained doctor must establish competence in English, medical knowledge and clinical skills.¹³³

¹²⁶ T957 line 55

¹²⁷ T942 (Dr Huxley)

¹²⁸ T942 (Dr Huxley)

¹²⁹ T887 line 25 (Dr Lennox)

¹³⁰ Exhibit 28 para 62; T899 line 50 (Dr Lennox); T459 line 15 (Mr Demy Geroe); T3182 line 45 (Dr FitzGerald); 'Australian Policy on Overseas Trained Doctors', Robert Birrell, [2004] *Medical Journal of Australia* 635

¹³¹ T491 (Mr Demy Geroe)

¹³² T419 line 45 (Mr Demy Geroe)

¹³³ T491 (Mr Demy Geroe); *Australian Policy on Overseas Trained Doctors*, Robert Birrell, *Medical Journal of Australia*. Professor Birrell notes that in New South Wales the Medical Board 'assesses candidates by means of a face to face interview covering clinical skills and conducted by clinicians familiar with the relevant area of practice'

- 2.41 Secondly, perhaps for a number of reasons, the Medical Board's scrutiny of the qualifications of overseas trained doctors has been inadequate.¹³⁴ As was conceded by the Deputy-Registrar of the Board, the Board simply did not have the resources to carry out comprehensive background checks.¹³⁵ It met fortnightly¹³⁶ and considered an average of 50 to 100, and sometimes 200, applications at a sitting so that it relied almost entirely on the registration officers to peruse documents.¹³⁷ In January 2003, (a relevant date for purposes below), there were four registration officers dedicated to *all* special purpose registration processing, and 1.4 full time employees dedicated to area of need applications.¹³⁸ In January 2003, the registration officers considered 233 applications for Area of Need Registration alone.¹³⁹ At the same time, it seems, they would deal with the distraction of agencies, applicants and employers seeking to expedite applications.¹⁴⁰ Moreover, the registration officers were not professionals but rather clerical staff. They were employed at the level of 'Administrative Officer 3'¹⁴¹ (which is the level expected of a filing and serving clerk). They should not have been expected to shoulder such a large part of the quality monitoring for overseas trained doctors.
- 2.42 Neither the registration officers nor anyone else within the Board would, as a matter of practice, contact the referees nominated by the applicant or even satisfy themselves that this task had been carried out by others,¹⁴² nor would they make contact with the issuing authority for the Certificate of Good Standing. Whilst the resources may have been inadequate for such inquiries, it is difficult to see why – given that the registration fee paid on behalf of the overseas trained doctor was only \$416.00, and that it was intended that the fee fully cover the costs of registration¹⁴³ - the fee was not increased to allow for more comprehensive checks. It was incumbent on the Board to ensure that it had adequate resources to fulfil its statutory duty of considering whether candidate's qualifications and experience rendered them 'suitable for practising the profession in the area'. In the circumstances, there was great potential for discrepancies in applications to be overlooked and, as will be seen later, such an oversight had a very real impact in the events which led to this Commission.

¹³⁴ T467 line 40 (Mr Demy Geroe); Consideration is given later in this report to specific cases including Keith Muir, Jayant Patel, Vincent Berg, and the Hervey Bay situation

¹³⁵ T467 line 45 (Mr Demy Geroe)

¹³⁶ T417 (Mr Demy Geroe)

¹³⁷ T417 (Mr Demy Geroe). Exhibit 24, MDG3, para 5.3; Exhibit 28, especially para 29; Exhibit 24, paras 31 - 36; Exhibit 421, paras 5 - 8. The Board meetings considered three broad issues in equal measure, of which registration was only one: T546 (Dr Cohn)

¹³⁸ Exhibit 24, MDG3, para 5.6: this is despite the fact that July/August and December/January were the peak times: T417 (Mr Demy Geroe)

¹³⁹ Exhibit 24, para 47; Note also T415 (Mr Demy Geroe) to the effect that only one and a half staff members were dedicated to area of need applications

¹⁴⁰ Exhibit 24, MDG3, para 5.6

¹⁴¹ T418 (Mr Demy Geroe)

¹⁴² T467 (Mr Demy Geroe)

¹⁴³ T443 (Mr Demy Geroe); The fee is prescribed by Schedule 2 to the *Medical Practitioners Registration Regulations* 2002

- 2.43 Thirdly, neither Queensland Health's area of need staff¹⁴⁴ nor the Medical Board¹⁴⁵ had any system for monitoring the performance of area of need doctors in the course of their registration.
- 2.44 Fourthly, of the persons registered pursuant to s135, those who are most in need of supervision tend to be in areas where supervision is least likely to be capable of being provided.¹⁴⁶ In the competition to fill positions, the large tertiary hospitals, such as the Princess Alexandra in Brisbane, almost invariably obtain better qualified registrants than the regional hospitals or the small one-doctor centres.¹⁴⁷ The Director of Medical Services at that hospital testified:
- We have got a lot of advantages at PA. We're a large hospital, we're well-known internationally, we have had a lot of doctors come to us over the years and they go back and talk about us. So we sort of get a lot of recruitment through word of mouth, and also we don't employ a lot of overseas-trained doctors as a percentage of our total staff.
- 2.45 There are a range of 'enticements' the tertiary hospitals can offer including research facilities, proximity to an urban centre and fixed hours of employment. Further, practitioners are not paid any additional sum for working in a more remote setting, and (if they are seeking higher, or Australian, qualifications) they will find it difficult to carry out further study from rural posts where the workload is high and the access to colleagues and courses is low.¹⁴⁸
- 2.46 Fifthly, the Medical Board assumed – notwithstanding the features of the area of need policy set out above and of which the Board should have been apprised - that, if doctors were employed in a hospital as a Senior Medical Officer or in a more junior position, they would be carefully supervised.¹⁴⁹ They were not required to identify any supervisor,¹⁵⁰ and there appears to have been no process in place for the Board to confirm, during the period of registration, that overseas trained doctors – particularly those working in regional locations – were receiving supervision commensurate with their backgrounds.¹⁵¹ That omission occurs in a legislative context where, as discussed above, the Board might have imposed a condition that the registrant be supervised. It also occurs in a context where overseas trained doctors may be acting as Directors of specialty units in some hospitals.¹⁵² Indeed, when it was put to one witness that the Medical Board was entitled to expect that area of need practitioners in

¹⁴⁴ T941 line 30 (Dr Huxley)

¹⁴⁵ Exhibit 33 para 32

¹⁴⁶ The evidence of Dr Thiele and others suggests that, in most regional hospitals, it is normal to have well more than 50% of the doctors employed on an area of need basis; also T884-5 (Dr Lennox) especially T2854-5 (Dr Young)

¹⁴⁷ T939 line 40 (Dr Huxley); The tertiary hospitals are able to offer more alluring positions because they have better resources, more fixed hours of employment and of course proximity to an urban centre. The rates of pay are no higher in the regional facilities and it is almost impossible for an overseas trained doctor to carry out the necessary study whilst holding a position in a regional hospital, T6651 (Dr Jelliffe)

¹⁴⁸ T6650 (Dr Jelliffe)

¹⁴⁹ T435, T492 lines 30 – 50 (Mr Demy Geroe); T627-8 (Mr O'Dempsey); T940 line 45 (Dr Huxley)

¹⁵⁰ T492 line 32 (Mr Demy Geroe)

¹⁵¹ T470 line 32, T471 line 20 (Mr Demy Geroe)

¹⁵² There was, for example a Director of Anaesthetics at the Bundaberg Base in 2001, namely Dr Martin Wakefield, who was not a fellow of the College: T6659 (Dr Jelliffe). Also T4120 line 30 (Dr FitzGerald)

hospitals would be supervised by the directors of their specialty unit, he responded:

...with due respect to the Medical Board, they ought to get in the car and drive around the country and see what's going on...there's an ideal, isn't there? There is an ideal that every director should be an Australian-trained, Australian-recognised specialist. That unfortunately has not been the case in Queensland for years at every hospital.

- 2.47 Sixthly, many doctors who are approved under s135 tend to come from countries with different cultures and languages from ours and sometimes with a medical and hospital system which is less developed or complex than ours. The language difficulties¹⁵³ will be particularly frustrating when taking a history from a patient or when explaining the patient's history by telephone to, say, a patient retrieval expert.¹⁵⁴ Some face cultural challenges and difficulty in understanding systemic matters, such as the impact of Federal/State cost arrangements, and the interaction of regional and tertiary hospitals. There has not been any attempt to date in Queensland to co-ordinate the induction or integration of overseas trained doctors into the system¹⁵⁵ in any of these respects.
- 2.48 Seventhly, evidence was given about a further serious concern about the scheme and its administration.¹⁵⁶ The terms of Area of Need Registration usually require that they work at a specific hospital or at the direction of a particular person. Moreover, the temporary working visas¹⁵⁷ usually include a condition that the holder is not permitted to change employer;¹⁵⁸ they cannot join the private sector and, if their employment is terminated, it is likely they may be compelled to return to their country of origin.¹⁵⁹ There was a widely-held perception amongst doctors that, in the circumstances set out above, overseas trained doctors working within the public health sector are more compliant, and more accepting of conditions and directions, than their Australian-trained counterparts.¹⁶⁰ It was considered that the differential was increased when overseas trained doctors are compared with Visiting Medical Officers.¹⁶¹ There was a view expressed by some doctors that Queensland Health, as both a major employer and the 'gatekeeper' for s135(3) applications, was unduly ready to invoke the area of need policy on the basis that it made for more

¹⁵³ In 2003, the Board did not have an English language policy and, although interviews would be conducted, this was after registration was approved and the interviewer were not in the position to assess language proficiency:

T419 – 421 (Mr Demy Geroe)

¹⁵⁴ T2907-8 (Dr Rashford)

¹⁵⁵ T554-5 (Dr Molloy); Miller Report Exhibit 129 p14

¹⁵⁶ Exhibit 34, p8; T959 (Dr Huxley)

¹⁵⁷ Commonly, the Medical Practitioner Visa Subclass 422.

¹⁵⁸ Exhibit 448 para 31, Exhibits 450, 451

¹⁵⁹ T2753 line 30 (Dr Anderson); T885-888 (Dr Lennox)

¹⁶⁰ T886 (Dr Lennox); T2753 (Dr Anderson), T6660 (Dr Jelliffe); Exhibit 34, p9

¹⁶¹ Many doctors have suggested that Queensland Health is actively chasing away Visiting Medical Officers – eg Dr Molloy at T557, Dr Nankivell at T2970. The evidence of the Queensland Health Systems Review Final Review is that, whilst medical numbers have increased by 49 to 59 per cent since 1989, Visiting Medical Officers numbers have decreased by 41 per cent. Also Exhibit 34, p10; T1826 line 1 (Dr Thiele); T2936 line 30 (Dr Nankivell); Exhibit 34 Statement Molloy p10

accepting and malleable employees.¹⁶² That view was given some support by evidence that the policy would be invoked in circumstances where – despite the alleged dearth of available doctors – private hospitals in the same area had filled their equivalent positions with Australian-born practitioners.¹⁶³ It was also given support from the Chief Health Officer, Dr FitzGerald, when he testified before the Commission. When he was asked whether it was the case that news of things ‘going wrong’ would spread quickly through a hospital, he replied, ‘...that’s an expectation, from our experience in hospitals such as [Bundaberg] where today things, particularly in hospitals such as this with the number of overseas-trained doctors and their degree of anxiety about their employment, et cetera, that things are different.’¹⁶⁴ It has the disturbing consequence that the area of need policy has been used to buttress poor working conditions in public hospitals rather than to supplement a dearth of medical practitioners in a particular location.

- 2.49 Finally, it is noted that there are grounds for concern about the way that the Medical Board interpreted and administered s143A. The purpose of the legislation seems to have been significantly thwarted in two respects. First, it seems that, whether by design or through poor advice, the Board may have inadvertently registered people as specialists. It will be seen later that Dr Patel was registered as a ‘Senior Medical Officer – Surgery’. A perusal of the Medical Board register shows that it was not unusual for the special purpose registration to record that the applicant was to fill an area of need ‘as a Principal House Officer in Obstetrics & Gynaecology’ or as ‘a Principal House Officer in Paediatrics’. At least in the last two examples, the doctor fulfils the criteria in s143A(2): he or she is ‘registered to practise the profession in a specialty in an area of need’ because obstetrics and gynaecology, on the one hand, and paediatrics, on the other, are each defined, when the Act and the regulations are read together, as specialties.
- 2.50 I understand that the Board took the view that s143A only had its deeming effect where the doctor was registered to practise the profession as a *specialist* in an area of need. The legislation, however, does not speak in those terms. On the contrary, the draftsman makes clear that a distinction is drawn between a specialty and a specialist when it is said later in s143A(2) that the registrant is taken to be a ‘specialist registrant in the specialty’.
- 2.51 In my view, the Board has registered many area of need applicants on terms that would deem them to be specialists, but without invoking the safeguards set out in the national guidelines, namely consultation with the relevant College. I say more about this in Chapter Six.

¹⁶² Exhibit 34 Statement Molloy p8; T3059 (Dr Nankivell)

¹⁶³ This skepticism was articulated by a number of witnesses including Dr Nankivell at T2935 line 30 – 2936, T2973 line 15

¹⁶⁴ T3227

- 2.52 The second matter in which the purpose of the legislation was thwarted was that the process of obtaining deemed specialist registration was largely circumvented. The Commission has been informed that, where Area of Need Registration was sought for a specialist position, it was the practice of the Board to apply the Australian Medical Council national guidelines and require the involvement of the relevant specialist college and the Australian Medical Council¹⁶⁵ before granting registration. The colleges, for their part, normally examined the applicant's history, required that the applicant work under supervision, and stipulated that the person undergo training towards obtaining a fellowship¹⁶⁶ so that there was significant quality protection in the process. In effect, the overseas trained doctor would satisfy the Australian college that his or her qualifications were substantially equivalent to the Australian fellowship but would also agree to work for a time under supervision, and would take steps towards a full fellowship.¹⁶⁷
- 2.53 Unfortunately, the reality is that this path has not always been taken. Instead, even if Queensland Health anticipates that an overseas trained doctor will perform the role of a specialist in a department, it might seek an area of need declaration only for a Senior Medical Officer position or as a senior medical in a designated specialty. The then President of the Australian Medical Association in Queensland, Dr David Molloy, gave evidence, which was not contradicted, that Queensland Health 'mostly avoided' the two pathways for ensuring quality, namely fellowship or deemed specialisation.¹⁶⁸ Mr O'Dempsey of the Medical Board lent some support for this view when he gave evidence that, in April 2005, of the 1760 overseas trained doctors who had received special purpose registration, only 94 had obtained 'deemed specialist' positions.¹⁶⁹
- 2.54 Dr Molloy gave evidence that there were a number of reasons for the avoidance of the quality control measures contained in the Australian Medical Council Specialist Guidelines. They included that Queensland Health could pay Senior Medical Officers considerably less than deemed specialists,¹⁷⁰ that it was not always easy to obtain a college's approval for a particular candidate, that the college would almost always impose a condition that supervision be provided and this could be awkward for Queensland Health, and that colleges would also require continuing medical education, which might be inconvenient for Queensland Health.¹⁷¹ Rather than accept those quality control measures that go with the deemed specialist position, it was simply easier to obtain an area of need declaration, and registration, for a Senior Medical Officer and then

¹⁶⁵ Exhibit 36, T572 (Dr Molloy); T430, T480-481 (Mr Demy Geroe); Exhibit 34 para 5; T543 line 10 (Dr Cohn)

¹⁶⁶ Exhibit 34 para 5-6

¹⁶⁷ Exhibit 36; T572 (Dr Molloy); T480-1 ((Mr Demy Geroe)

¹⁶⁸ Exhibit 34 para 5;

¹⁶⁹ Exhibit 28 paras 62-3; The case of Dr Patel, set out below, provides one example, and the Hervey Bay situation, explored below, another, where overseas trained doctors were, at the very least, held out as senior doctors in specialised areas, without any application being made for 'deemed specialist' status. Exhibit 448, para 46-47

¹⁷⁰ Exhibit 34 para 5; T573 (Dr Molloy); T5969 line 25 (Dr Jayasekera); T6660 (Dr Jelliffe)

¹⁷¹ T573-4 (Dr Molloy)

assign the doctor activities in a specialty area.¹⁷² The circumstances of the appointment of Dr Patel and of Dr Chris Jelliffe would appear to be illustrative of this practice.

What these problems reveal about the scheme

2.55 These problems show that the legislative scheme for special purpose registration in areas of need has been implemented in a way which assumes, or at least accepts, that those who live in some areas of the State must suffer a substantially lower standard of medical care than that enjoyed by those in other areas; in particular, that those who live outside the metropolitan area of Brisbane must suffer a substantially lower standard of such care than those who do not. This is a morally untenable approach.¹⁷³ It is a self-perpetuating process in that, if regional health is expected to operate as an inferior system, it becomes harder and harder to attract good quality doctors and the system declines further. It is all the more disturbing because the evidence disclosed that the major stakeholders – Queensland Health, the Medical Board and the Australian Medical Association – have been aware, at least since late 2002, that the registration system for overseas trained doctors was in crisis.¹⁷⁴ I shall discuss later the possible solutions to these problems.¹⁷⁵

¹⁷² T571 line 35, T837-40 (Dr Molloy); T618 line 30 (Mr O'Dempsey); T837-40

¹⁷³ Unfortunately that approach is revealed in some other aspects of the administration of public hospitals.

¹⁷⁴ T893-4 (Dr Lennox); T3198-9 (Dr FitzGerald)

¹⁷⁵ Chapter 6