Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 31/05/2005

..DAY 6

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THE COMMISSION RESUMED AT 2.17 P.M.

COMMISSIONER: Just a couple of things before the evidence resumes. Firstly, the Secretary to the inquiry has received a letter - Mr Ashton, you're there - from your instructing solicitor.

MR ASHTON: Yes, Commissioner.

COMMISSIONER: I'll have it marked as an exhibit, but just so that everyone follows this discussion, it refers to the fact that the inquiry has proceeded so far on the basis that the witnesses who were to give evidence in the CMC inquiry would not be cross-examined at this inquiry until the CMC evidence had been given.

> "We understand that this practice is now to change because of the announced postponement of the CMC proceedings. We are not entirely clear on the reasons for the original approach which had been said to be based on offers, presumably by the inquiry, to the CMC.
>
> We think it necessary in our client's interests that we be very clear on these arrangements, their original basis, how they are now to change and why."

Perhaps in response to that I can explain briefly what has happened.

Before this inquiry was announced by the Premier, the Commissioners at the CMC had decided to conduct their own inquiry. That created a potential area for duplication and a potential for public resources to be wasted by going over the same area twice.

At a very early stage I had a meeting with Mr Needham, the chairman of the CMC, with a view to avoiding any form of duplication or wastage, and a number of matters were agreed. One was that our senior counsel, Mr Andrews SC, would also be the CMC senior counsel, so as any knowledge he acquired at this inquiry could be used for the benefit of the CMC inquiry and vice versa.

Another arrangement was entered into to share information gathered in the field. The CMC already had a team of investigators in Bundaberg, and it seemed pointless having our staff reinterview the same people, quite apart from the fact that it would have been potentially disturbing for the patients involved to go through more than one interview on the same subject matter.

Our primary concern was the risk of prejudice to witnesses who were under consideration in relation to allegations of official misconduct, that they should not be put to the tribulation of being cross-examined at this inquiry by parties with adverse interests before they had given their evidence at

the CMC inquiry, and the arrangement agreed between myself and Mr Needham was that such witnesses would be called to give evidence here, could give evidence under questioning by counsel assisting and, of course, the bench, and by the party's own legal representative, but would not be exposed to cross-examination by other parties which might have adverse interests.

Given that the CMC inquiry has been postponed, that last element of the arrangement is no longer in place, with the result that any witness called henceforth will be exposed to cross-examination from all parties, and when the witnesses who have already been called and been stood down - which includes Ms Hoffman, Dr Miach and also your client, Mr Ashton, and also Dr Keating - when those witnesses are recalled, they will likewise be exposed to cross-examination from everyone concerned.

That is really the only change that has taken place, with the arrangement to preserve witnesses, or to insulate them from cross-examination until the CMC inquiry was completed is no longer in effect, and that, as happened yesterday, and will continue to happen through the rest of the week, all witnesses called will be exposed to cross-examination at large.

Is that sufficient, Mr Ashton-----

MR ASHTON: Absolutely, thank you, Commissioner.

COMMISSIONER: -----to answer those concerns?

A second thing that I wanted to mention very briefly is that my attention has been drawn to a report in The Age newspaper of yesterday's date, the 30th of May, headed "Abbott rejects tests for overseas doctors", and part of the report reads:

> "Victoria's Health Minister, Bronwyn Pike, wrote to Mr Abbott last week urging him to adopt a Victorian model that tests doctors using a multi-choice test and clinical exam before they work", and so on.

I should mention two things about that. One is that at the very outset of this inquiry I wrote to Mr Abbott and his opposite number, the opposition health spokesman in the Federal Parliament, inviting each of them or their representative organisations to provide any submissions to this inquiry that they think appropriate. Neither of those letters has received a response.

However, in light of this article, I will be inviting counsel assisting to contact the Health Department in Victoria and obtain details of the Victorian model referred to in the article promoted by the Health Minister in Victoria to see whether that would be of assistance in Queensland in establishing a formal model for the testing and examination of overseas trained doctors before they commence work in Queensland, and also to explore the views of the Victorian Minister and Department regarding the establishment of a

national system which may eradicate this problem throughout the country.

The third thing which I wanted to mention very briefly is that the Court attendant handed me as I came in a bundle of envelopes provided by a member of the public. Let me say I have no objection if people feel that they want to have things handed to me personally, but I can give the clearest assurance that counsel assisting and staff of the inquiry are totally reliable, totally trustworthy, and if anyone has any information to come to the inquiry, it is most convenient to deliver it through the inquiry officers so that it can be copied and recorded and copies can be distributed both to the members of the bench - myself and the two Deputy Commissioners - and also to counsel assisting to give them an opportunity to examine the issues that are raised and see whether any evidence needs to be called.

So whoever the member of the public was who presented that, I thank you for your interest in making it available, but I would urge anyone who has similar information for the inquiry to provide it through the secretary. Needless to say, I will be looking at this and take it in whatever direction it needs to be taken.

Are there any other preliminary matters anyone wants to raise? Mr Allen?

MR ALLEN: Yes. There is one, if the Commission pleases. It arises from some comments made and directed to counsel for Mr Leck and Dr Keating by the Commission yesterday at pages 404 to 405 of the transcript. Those comments have been reported in some detail in today's Courier-Mail. Those were the provisional comments in relation to any questions regarding findings relating to official misconduct on the part of those two gentlemen.

COMMISSIONER: Or indeed criminal conduct.

MR ALLEN: Yes. I expect that I will have instructions to make submissions at an appropriate stage that there is sufficient evidence for the Commission to refer matters regarding both Mr Leck and Dr Keating-----

COMMISSIONER: Well, Mr Allen, you will, of course, have the opportunity to make those submissions at the appropriate stage. I think it would be inappropriate, and possibly unfair even to foreshadow what those submissions are at this stage when the evidence is still taking its course.

I would only emphasise that those comments were made for the assistance of Mr Leck and Dr Keating based on the evidence heard to that point, and needless to say, they are very provisional views, and one might say even some of the evidence yesterday might call for some reconsideration of those views. I'm not saying that that will be the case, but needless to say, we all need to keep an open mind as things go on.

I think it's undesirable that you foreshadow any details of what your final submission will be.

MR ALLEN: I don't propose to, but it would be unfortunate if any members of the public, including patients or members of my client, misunderstood the comments as indicating that it was no longer a live issue.

COMMISSIONER: Well, I'm sure if anyone has that impression, it can easily be rectified. I certainly wasn't expressing a concluded or final position. I was simply indicating for the assistance of those two witnesses, that when they come back to give evidence there are particular things which their evidence should focus on and other things that may not be so important for them to focus on at that stage.

MR ALLEN: Yes. Thank you, Commissioner.

COMMISSIONER: But it was intended to be no more than that, and I'm sure, Mr Ashton and Mr Diehm, that's how it was taken and understood.

MR ASHTON: Yes, thanks, Commissioner.

MR DIEHM: Yes.

MR ASHTON: Those remarks were made in the context of - or as part of them we were given an invitation to make a statement at some stage in the course of the week, and we at that stage propose availing of that, but not at this point.

COMMISSIONER: Do you have in mind a time when you'd be ready to do that?

MR ASHTON: I had thought it probably most convenient at the end of the week, before we rise.

COMMISSIONER: Indeed, Mr Ashton, that would be extremely convenient.

MR ASHTON: I wonder might be I heard on a matter which you raised yesterday afternoon in relation to Sir Llew sitting today.

COMMISSIONER: Yes.

MR ASHTON: In my submission there are some complications in this proposal, but I hasten to say immediately, I'm making no application, and I'm not even objecting, but I respectfully want to draw attention to these complications.

Commissioner, in your ruling of 29 April 2005 you concluded that there was no "conflict of interest" in the colloquial sense or, as you explained it in correct legal phraseology, any reasonable apprehension of bias in respect of Sir Llew and the Medical Board. I should pause to mention that I do want to just make very brief reference in what I have to say to some matters of evidence that Sir Llew, because he couldn't

sit - or didn't sit yesterday, hasn't heard. I have certainly no objection to his hearing them now, but I just mention that.

COMMISSIONER: Well, can I ask what this is leading to? You're not asking Sir Llew to leave the bench for the rest of the day?

MR ASHTON: No, I'm not, Commissioner.

COMMISSIONER: So what's the point of this submission?

MR ASHTON: Well, there are matters of unease, frankly, that I feel obliged in my client's interests to register.

COMMISSIONER: And can you say in a nutshell what those matters of unease are?

MR ASHTON: Yes, I can, Commissioner. I think I can best do it by the two examples.

COMMISSIONER: Certainly.

MR ASHTON: Sir Llew was sitting on last Thursday when it was put to Mr Leck that he - and I'm quoting - "effectively sneaked Dr Patel past" - he or someone else "effectively sneaked Dr Patel past the Medical Board". Now, Sir Llew was present for that evidence. He wasn't present for yesterday's evidence from Mr Demy-Geroe which, in our submission, indicates that Mr Leck had no role in that process at all. This is an example, and perhaps it's one of the ones that you had in mind, Commissioner, when you were referring yesterday to the awkwardness that's arising.

The second example I mention is in relation to Dr Patel's departure and the airline ticket. Now, Sir Llew was present when questions were put to Mr Leck about that, but not present yesterday when, through Mr Demy-Geroe, there was evidence that Mr Leck advised the Board in writing before Dr Patel left the country that he was going to do so. In due course, Commissioner, we'd be wanting to adduce evidence that Mr Leck similarly advised a senior Health Department official of his intention to leave the country - that is Patel's intention.

Immediately it might be said well, those matters are in Mr Leck's interests and so it would be great that Sir Llew heard them. We can't say that this will necessarily be so of whatever comes, but we say simply this, Commissioner: as happened in the Carruthers and Connolly/Ryan thing, as Justice Thomas put it, it's very difficult to unscramble - to use his word - the intellectual and procedural processes which the team approach necessarily produces, and so this sounds a note of caution.

Commissioner, you've already ruled in your written ruling that there is no apprehension of bias or, colloquially, conflict of interest. That, as a legal matter, should be the end of it.

COMMISSIONER: Yes.

MR ASHTON: The fact is though, Sir Llew's exclusion to date has been on the basis of an informal arrangement. I know it's not particularly helpful, Commissioner, to have me simply register my unease, but I don't want to fail my client by comfortable resort to silence either.

Perhaps, Commissioner, if your judgment is - you see, we don't know who made submissions, or if anyone did, and what renewed submissions might be made in view of any change of the arrangements. We certainly didn't, and we don't propose to. But it comes down to, I think, Commissioner, with respect, a judgment now whether the considerations which warranted the arrangement for Sir Llew's exclusion in the first place are outweighed by the value now seen in his being present for this sort of evidence.

For our part, we don't presume to make a submission about that. We simply, respectfully - in fact for our part it seems to us, in so far as that judgment is made that those considerations are now outweighed, perhaps the combined vigilance of counsel assisting and Mr Devlin can help us avoid any difficulty. But I simply want to advert to the difficulty potentially, Commissioner, and reserve my client's position in so far as a difficulty might arise with respect to particular evidence.

Now, I understand that in a sense it's unnecessary for me to even raise that, because I know you would hear me, Commissioner, in relation to particular evidence, but on the other hand, these are very serious matters. I don't want to be at risk of neglecting my client by, as I put it, resort to comfortable silence.

COMMISSIONER: Thank you, Mr Ashton. I'm actually very grateful that you've raised that, and you've done so in such a clear and cogent way, and I should stress that to this stage you've done everything proper to protect your client's interests and it's most appropriate that you've raised those matters in your client's interests.

At a personal level, I can say that nothing would delight me more than to be able to have the assistance of Sir Llew in relation to all aspects of the Terms of Reference. I have said on a number of occasions, and I still say, that his wealth of knowledge, not only as a qualified medical practitioner, but also as someone who has been involved at the very highest levels in the administration of public health in this state is a huge benefit to this inquiry.

At the same time, I feel that I have a duty to do two things. One is to prevent this inquiry from miscarrying. A lot of public funds are being spent on this inquiry and it would be a tragedy after all of this work and all of this money has been spent if someone were to say, perhaps weeks or months down the track, well, the whole thing has miscarried because of Sir Llew's presence. That's one thing I want to avoid, and that's why specifically yesterday afternoon I raised the

question whether anyone had any objection to Sir Llew's presence on the bench during this evidence, and as I understand it there was no objection.

The other thing I want to avoid is any hint of a suggestion or perception that Sir Llew's extremely tenuous connection with the Medical Board will in any way influence the independence of the ultimate findings and recommendations of this inquiry. Personally, I feel that that is so remote a possibility as to be almost laughable, but it has been raised by prominent people in the community, parliamentarians and people in the press and media, and in the interests of public confidence in this inquiry, I reached the view that it was better for Sir Llew to absent himself from any issues where there might even be a suspicion, however unjustified, of any so-called conflict of interest.

Now that you've raised the matter, Mr Ashton, I would be happy to reconsider my earlier ruling, and if it were the situation that nobody who has been given leave to appear has any objection to Sir Llew's continued involvement in all aspects of the inquiry, then I would, on that footing, take the recommendations of senior counsel assisting and, if appropriate, revise my earlier decision.

MR ASHTON: For our part we make no objection and no application, and it just seemed to me that the question whether there was an objection, as it was put yesterday, was, in the totality of the circumstances, a bit too complicated for a simple no answer.

COMMISSIONER: That's a very useful suggestion. I guess this most affects the Medical Board. I wonder if I can ask Mr Devlin whether you have any views on that.

MR DEVLIN: The Medical Board's view is very clear. The public interest will be served if Sir Llew does not deliberate on any recommendation or any finding directly in which the Medical Board is concerned or named.

COMMISSIONER: Yes.

MR DEVLIN: Now, that's a very simple solution. The Board has never raised any objection to Sir Llew sitting in on the evidence, simply the formulation of any findings or recommendations which directly concern the Medical Board.

COMMISSIONER: Well, that is a very useful and very clear and succinct way of dealing with the matter. Does anyone else wish to be heard or wish to make comments in relation to this aspect? Mr Allen?

MR ALLEN: No. Thank you, Commissioner.

MR DIEHM: No.

COMMISSIONER: Mr Boddice? No?

MR ASHTON: Well, Commissioner, I just say it underlines the awkwardness because it's one thing to say that there may be some evidence directly affecting the Medical Board, but it's another thing to understand the complications that emerge in the kinds of examples that I gave.

So, for example, there may be evidence which is positive for a particular party coming from the Medical Board and negative for a particular party coming from the Medical Board, but incapable of being unscrambled, to use Justice Thomas' words, from the totality of the evidence and from ultimately the decision-making process.

COMMISSIONER: But, Mr Ashton, it seems to me, with the deepest of respect, that Mr Devlin's suggestion really overcomes that because what it would mean is that Sir Llew hears all of the evidence, including the evidence relevant to Medical Board issues, but then when it comes to preparing a report, making findings and writing recommendations, Deputy Commissioner Vider and I will take sole responsibility for any findings or recommendations relating to the Medical Board. Sir Llew will have heard that evidence, but it will have no impact on him-----

MR ASHTON: I'm sorry, I didn't quite understand that that's what Mr Devlin was saying. I'm sure it was very clear, but I probably wasn't listening properly.

COMMISSIONER: Mr Devlin, that's the effect of it?

MR DEVLIN: Absolutely. I don't know how much clearer I have to be for Mr Ashton.

MR ASHTON: I just have to listen harder. I just have to listen harder. The issue is it's all in or all out so far as the evidence is concerned.

COMMISSIONER: That's very helpful. Mr Andrews, do you wish to be heard about this?

MR ANDREWS: Mr Devlin's solution seems extremely practical.

COMMISSIONER: All right. Well, I will amend the direction which formed part of ruling number 1 to this effect: Sir Llew will be permitted to be present at all stages of the public and private sittings of the inquiry and to hear and receive all evidence, whether given orally or in a documentary form.

It will, however, remain the case that on any issues directly affecting the Medical Board, Sir Llew will not participate in the deliberations between myself and Deputy Commissioner Vider, and the two of us will take sole responsibility for any findings in relation to those issues and any recommendations which we make in relation to those issues.

Is that sufficiently clear for everyone's purposes?

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Thank you. Welcome back, Sir Llew. Anything else? Mr Devlin-----

MR DIEHM: I was making sure the housekeeping matters were out of the way. Mr Commissioner, on behalf of Dr Keating, having had the advantage of seeing the witness statements for the witnesses who are proposed to be called today, as I apprehend it it does not appear as if there is any matter arising out of that that concerns my client sufficiently to warrant my remaining here for the balance of today's hearings.

COMMISSIONER: Yes.

MR DIEHM: I just wanted to raise that in open Court to give anybody who thinks that there might be something that does come up or is going to come up the opportunity to say so, otherwise I'll make my leave, though I will be contactable if the need arises.

COMMISSIONER: Thank you, Mr Diehm. I think I said on day one that everyone at the Bar table should feel at liberty to come and go having regard to the interests of the parties that they represent, and there's no need to seek leave before you get up and leave the room.

There is a potential problem that if something is going to come up that affects your client out of the blue, you may not be here, and all I can say is if that sort of situation arises, I will be astute - and I'm sure counsel assisting will be astute - to make a note of it and to either make contact with you immediately or to bring it to your attention so it can be addressed as soon as possible. I'm afraid I can't guarantee that things won't come up as a matter of surprise. That's the way oral evidence works, unfortunately, but I think your assessment is right, that there's unlikely to be any evidence affecting your client for the balance of today, and you should feel yourself being free to go if you feel comfortable with the sort of arrangement I've suggested.

MR DIEHM: Yes. Thank you, Mr Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Right. Mr Devlin?

MR DEVLIN: I'd hope to complete Mr O'Dempsey's evidence, and I also have Dr Mary Cohn available, and her evidence-in-chief that I would propose to lead, if I'm permitted to, would be relatively brief, and I'm conscious that Dr Molloy is scheduled to be here at 4.30.

COMMISSIONER: Well, given that Dr Cohn's in private practice.

MR DEVLIN: She's here present now.

COMMISSIONER: Given that she's here, unless anyone feels differently, I think it would be the most efficient use of time to get through her evidence in the two hours available and-----

MR DEVLIN: Could I suggest this though: the evidence of Mr O'Dempsey will deal with a number of issues at the operational level. Her evidence will deal with a couple of discrete Board issues.

COMMISSIONER: Yes.

MR DEVLIN: It might best be received after Mr O'Dempsey's given the detail.

COMMISSIONER: All right. So we finish Mr O'Dempsey's evidence-in-chief, stand him down and then have Dr Cohn's evidence.

MR DEVLIN: That would be entirely appropriate, thank you.

COMMISSIONER: Does anyone again have any difficulty with that approach? All right. Thank you, Mr Devlin. We'll ask Mr O'Dempsey to return to the witness box.

JAMES PATRICK O'DEMPSEY, CONTINUING EXAMINATION-IN-CHIEF:

MR DEVLIN: Mr O'Dempsey, at pages 5 and 6 of your statement, you introduce the various annual reports for the Medical Board. I think the one that we have left out is 2004, so you produce that now, do you?-- I do.

Thank you. I will hand up two copies of the 2004 report - three, sorry. I have a couple more for any party who requires it.

COMMISSIONER: Thank you.

MR DEVLIN: Mr O'Dempsey, you had drawn attention in paragraph 13 to one aspect of the 30th of June 2003 report, namely that there was particular reference in that report - that is, for 202, 203 - to the question of registration processes and a proposed integrated registration policy and procedure, correct?-- I have.

What other aspects of the reports do you say would emerge on the Commission studying them over that time continuum from about 2001 to the present? Just give us them in dot point form, if you would?-- Planning for improving the services that we provided to the Boards and delivering on those plans; the complexity of the work under the new legislative model, not only for the office, but for the Boards; the delivering on establishing a financial infrastructure where we could actually understand what our costs and funding needs were going to be, and two particular project outcomes, being looking at how we delivered services in our Complaints Management Unit, introducing systems, and our policies and procedures to actually deal with a backlog of investigations that was to the tune of approximately 300 investigations that were-----

When was that - when was that backlog?-- 2002.

What's the backlog now?-- I expect to report at 30 June that the backlog will be dealt with completely; that our turn-around time for an investigation report will be six to eight months.

Will that include the more complex cases, though, that the Board has to tackle?-- The more complex cases will depend on expert evidence and how long it takes to actually get reports for that. So, I'm talking about 80 per cent of our investigations finished in six months.

Thank you. Any other points that you say emerges from those four or so reports?-- The registration project, we did an initial project where my project officer recommended a single registration team, however it did not look in any depth at the registration processes being used or the information technology system we had in support of those processes. Because of that, I couldn't accept a recommendation to

establish a single registration unit because we need to get the processes right and the information technology support right in order to make sure that a single registration team could work effectively.

So, that's a work in progress, is it?-- We have actually partnered with a government department, used their business process review methodology and all 13 Boards have considered my report, which is an attachment to my submission. In fact, the last Board considered that report only last week. They have all endorsed that direction. We have sourced a non-repayable - sorry, a repayable grant from Queensland Health to fund our information technology, and we will have the outcomes of that project implemented by 30 June next year.

Is the registration review project the report there annexed as Exhibit 6, paragraph 15?-- I will have to go to another volume, Mr Devlin. Yes.

And at paragraph 11 of that report, did you tabulate the problems in relation to the registration system?-- I did.

And these are not responses to the matters exercising this Commission, are they? They are things that have been developing over the number of years that you have been there?-- Yes, that's correct.

Is there anything you wanted to highlight then for the Commissioners in paragraph 11?-- Only the high cost and management inability to intervene when you have got 130 different ways of doing 20 key registration processes.

Just explain that again? What registration system did you inherit when you came in in 2002?-- In terms of the processes, we inherited 10 different Boards over two decades having their own ways of doing things, and that's why we end up with 130 ways of doing 20 key procedures that are provided for under the new registration act.

Do we take it, then, you have added three Boards as well along the way?-- Yes.

And so how many steps are you down to in your-----?-- We think up to 20, and our processes have been drafted for those 20. The test will come for that as we develop the information system to support us in those processes.

Okay. Anything else you want to point out in that Exhibit 6?-- That the registration information system - and that's how we manage our registrations - software - proprietary software built in 1994, not really touched until 1999 when the licences were upgraded, it was built on a premise of those 130 processes being in existence and 10 different legislative models. It really has not been built for the template legislation that we now have providing for 20 key registration processes.

By "template legislation", you are talking about, now, the

legislation governing the 13 Boards is similar in its format, is it?-- I'd hate to be quoted on this, but seven or eight of the acts are exactly the same act with different Boards named in them. There are a number of Boards that have slightly different processes; for example, the Medical Board has a specialist register and interns, an area of need registration, whereas other Boards don't have those. The Dental Board has specialist registration and a new auxiliary registrant group that have just been regulated in the last 12 months. So, there are some slight variations, but the processes and the legislation are exactly the same under the same parts, under the same divisions; there's just more provisions within those divisions for some of the Boards.

Thank you. Now, in paragraphs 18 onwards, you draw the attention of the Commission to a review required by statute of your office conducted in June 2003 and the outcomes?-- I do.

Thank you. I want to move now to a matter that you address in some detail in paragraph 21. Can you favour the Commission with information based on this paragraph about how a member of, for example, the nursing profession, or a member of the public knows that he or she can complain to the Medical Board about perceptions of clinical malpractice, or sub-standard practice?-- We have published continually on a website for the Medical Board and for the Office the complaints mechanism quite clearly, and that was from 1999 - clearly identifies who can complain, what they can complain about and how to complain and the civil protections provided. That was updated in 2000 when the Professional Standards Act was introduced, just in terms of the text, but there is available on my office's website, on the Medical Board's website and on the other 12 Boards' websites - we have introduced access to the public register by the Internet since August 2002 where any member of the public can go in and search on that register to check the details of the doctor, including the disciplinary details, and there is a specific heading in the public register of "Disciplinary Decisions". Aligned to that is the Health Practitioners' Tribunal, which publishes its decisions on the District Court website, generally in full. A general overview was provided of the new legislation in the Medical Board Bulletin back in 2000, and we published in the consultation document seeking submissions to the Board's strategic plan to help us build that strategic plan. We publish the Boards' functions under the Professional Standards Act. That went widely to the profession in terms of the organised profession, their colleges, the AMA and so forth, but it also went to a range of consumer groups, such as the Brisbane Consumers Association, Q-Cost, the Queensland Council of Social Services, the Rural Women's Network-----

Let's take just a practical example here. I'm mindful that this Commission will go to Bundaberg?-- Mmm.

Why wouldn't a patient or his family/her family, on entry to any hospital in Queensland, for example, be given a leaflet saying, "If you have a complaint, complain to us."? Is there some reason why that doesn't happen? I presume it doesn't

happen?-- It is not a matter of policy for the Medical Board to distribute those type of leaflets because the expectation is that Queensland Health has a complaints management policy where there is a complaint coordinator appointed within the organisation who is there to advise people on their mechanisms of complaint.

So, in terms of hospital admission, it would be cutting across Q Health policy, as the Board would see it. Would that be a fair response?-- I believe that's correct. Within the private sector, for example, the GP sector, GP's are required, as part of their accreditation, to actually give pamphlets to their patients about how to complain. They all mention the Health Rights Commission because that should be the primary complaint by a health service user. They should primarily go to the Health Rights Commission, who then consults with us about it.

COMMISSIONER: Mr O'Dempsey, I have two issues about all of this: one is that when you look at section 47 of the HPPS Act - the Health Practitioners' Professional Standards Act - it lists a group of people that can make a complaint, but the very example given by Mr Devlin doesn't appear to be there. It can be the user of the service - which is, I take it, the doctor's patient - an entity acting on behalf of the service user - I take to be the patient - and another registrant, meaning another registrant in the same register?-- Yes.

So, a doctor can make a complaint about another doctor?-- I'm not quite sure if that would be the case, given the Professional Standards Act applies across all professionals.

It wouldn't apply to nurses, for example, because they are under the-----?-- Separate-----

They are under the Nursing Council?-- Yes.

The Chief Executive, the Minister, or foreign regulatory authority, but nothing in there to say a nurse can make a complaint?-- I have always read section 47 and I'm just going to it as they were examples rather than a conclusive or exclusive list.

Yes. I'm sure you are right about that, but it is funny that the examples given don't include at least one of the most obvious sources for complaints about medical practitioners. The other difficulty, and perhaps it is a related one, is that it seems to me there would be a lot of advantage in having, as it were, a one-stop shop for people wishing to make complaints about health matters. I know when this Inquiry was formed, a lot of people I spoke to just socially had never heard of the Health Rights Commission, didn't know it existed, didn't know what its functions were. I was fortunate because, having had some previous professional experience, I knew what it did and how it operates, but I suspect you would find, if you did a poll in this room, that a fair proportion of people either hadn't heard of it or didn't know what it did before they became involved in this Inquiry. You would agree with me,

wouldn't you, that there would be a lot of advantage in having a central contact point that people can go to if they have complaints about health issues - whether it is public sector or private sector, whether it is hospital or GP, whether it is the sort of striking-off matter that might traditionally come to the Medical Board, or a different kind of matter that would go to the Health Rights Commission - just one identified source; you know, if you have to have a terminology, call it the Health Sector Ombudsman, or something like that, where everyone knows if they have got a problem, that's who they go to?-- The only model I know of like that, Commissioner, is the Health Care Complaints Commission in New South Wales, and I believe they have had some significant problems with that model.

Do you know why that is?-- I can only say that I have met with the Parliamentary Chair of the Commission that oversights that and they had problems in terms of - from - and this is knowledge from two years ago - in terms of assessment of complaints, investigation of complaints, and the assessment was in terms of whether they were dealing with complaints about individuals or complaints about the health service generally. They had a significant backlog of investigations that hadn't been addressed. In fact, he did recommend in a report to Parliament that the model that I had established in Queensland, establishing a panel of contract investigators, should be investigated for them, but they got the luxury of the government giving them - I think it was up to $5 million to clear their backlog. So, I can only say that that's the model that I'm aware of in Australia, but it would be of benefit if there was a one-stop shop. My only concern from a professional standards viewpoint would be that there would be that consultation about what action would be appropriate on that complaint.

I think we are really, perhaps, talking about two different things here: one is the public interface, the counter that people come to with their complaint, and that's where I think we need to have a one-stop shop. It may be that at an investigational level or a decision-making level, the complaints then have to be farmed out, and, you know, to take the most - or perhaps the most trivial example, if a patient has a complaint about the quality of food at a hospital, you would hardly want to be troubling an organisation like the Medical Board or the Health Rights Commission to deal with that, but the advantage of a one-stop shop is that when the patient makes their complaint, it can be received, logged, recorded, and then sent to the appropriate sector-----?-- A triaging.

A triaging, precisely?-- Mmm.

And the other thing with that, as it seems to me, is that my experience, not just in the health sector, but in all areas of dealing with both public authorities and private organisations, is that the most frustrating thing for many people is not knowing what's happening to their complaint, and it seems to me that if you have that one stop shop, that

central registry, it would be at least part of their function to have a call-up system. If they refer a complaint to the Bundaberg Hospital which is a complaint about the quality of food, or a complaint about a doctor talking about private health matters when other members of the family are present, or one of those sorts of things - which is not, you know, at the highest level of seriousness, but which is nonetheless important to the person involved - then there would be a system that the hospital has to report back in 30 or 45 or 60 days and say, "This is what we have done about the complaint. This is the response. We consider the matter is now resolved.", or, alternatively, the patient or the complainant would have the opportunity to escalate the complaint if he or she chose to do so. That's really what I'm-----?-- It would be an interesting model to explore, and it would help streamline that receipt. I know with the Queensland Nursing Council we did market research on recognition of the Council and other regulatory authorities and the focus groups that researchers tapped into all had general knowledge that Boards existed, didn't always know the specific name, but they knew there would be a body like that to receive complaints about practitioners.

Well, to take one concrete example, there was at least a potential witness at this Inquiry who has provided a statement, and it hasn't yet been distributed, so I won't go into the names or details, but according to that witness, a complaint was made to Queensland Health about an incident at a particular hospital, Queensland Health said, "That's a matter for the Health Rights Commission.", the Health Rights Commission sat on it for some length of time and then said, "Well, that's not really within our parameters.", and they were moved on to the - I think it actually went to the Medical Board as well, but eventually ended up where they started at Queensland Health, and that's a disaster. Everyone here knows I'm very keen on transparency, and it seems to me the most transparent system is one where there is a central person - an ombudsman is as good a word I can think of to describe the person - who receives the complaints and farms them out to the appropriate authority to deal with and ensures that they are dealt with. Do you have any difficulty with that sort of model?-- I don't have any difficulty with that sort of model.

D COMMISSIONER EDWARDS: Many years ago there was a trial program called "A Patient's Friend" in hospitals. I think it fell by the wayside, but it seemed at the time from reports from that patient friend, who would hear minor complaints and try to solve them as quickly as possible, there was some advantage in that, rather than going into the formal complaints to the Medical Board or the Health Rights Commission. Do you have a view on any such persons in major hospitals particularly?-- My experience with them have been limited to the psychiatric hospitals, Commissioner. I think that local resolution by someone that is an advocate for that complainant rather than seen as an employee responsible within the system worked well within psych services. So, that's the only experience that I can tap into. But looking at that type of model, so that there is some local resolution - you know,

you might stop an ombudsman, Commissioner, from being inundated with-----

COMMISSIONER: Perhaps I should disclose I have also had some discussions about this at a very general level with Mr Needham and Mr Forbes-Smith from the Crime and Misconduct Commission and, of course, their problem is that they get so many complaints they can't deal with all of them, and I guess that they are at least part of the source for the suggestion that if you are having one central complaints organisation, the important thing is that that central organisation is able to farm out the complaints to the appropriate entities for investigation or resolution, and even the sort of patient friend model that Sir Llew is talking about could be integrated into that so people can be told, "Well, you first discuss it with the patient's friend. If you can't get a resolution that way, come back and see us and we can move it on to another organisation."?-- Mmm.

Gentlemen, just so that the documents are in order, I should give some exhibit numbers before we go on. I'm sorry to interrupt the evidence in that way. I referred earlier to the letter from Mr Ashton's instructing solicitors, Hunt & Hunt. That letter of 31 May 2005 will be Exhibit 29.

ADMITTED AND MARKED "EXHIBIT 29"

COMMISSIONER: I referred also to an article in The Age newspaper - The Melbourne Age - of 30 May 2005. That will be Exhibit 30.

ADMITTED AND MARKED "EXHIBIT 30"

COMMISSIONER: There's another document that I think should go into evidence; that's a letter from the Minister for Health, Mr Nuttall, to myself, dated 26 May 2005, but only received today, and Mr Boddice, that raises a question about Queensland Health staff, particularly doctors, taking overseas travel whilst this Inquiry is on foot, and Mr Nuttall very helpfully raises the concern that it might inadvertently inconvenience this Inquiry if he approves travel whilst the Inquiry is going on. I appreciate you are not appearing for the Minister, but can you convey to the Director-General our appreciation for that concern having been raised? We would not wish to stand in the way of anyone travelling overseas for professional reasons. The letter mentions doctors travelling overseas for clinical conferences and matters of that nature. We certainly wouldn't stand in the way of that, and my suggestion would be that if there are any doctors who are likely to be involved in this inquiry, either from Bundaberg or within Queensland

Health Corporate Office, you would be in a position to let the Director-General know who those are likely to be, and if there are any that are the subject of any doubt, you might liaise with Mr Andrews about that.

MR BODDICE: That's so.

COMMISSIONER: I think it is unlikely that anyone will be going overseas for more than a few weeks anyway, so it doesn't present as a big problem.

MR BODDICE: No, and we are fortunate that we have a rough timetable in terms of sittings as well to be able to know whether, in fact, there could be potential difficulties.

COMMISSIONER: Having said that, of course, I will reply formally to Mr Nuttall, but I do appreciate his concern about that matter and, despite his having raised it, I don't see it as being problematic in any way. Thank you, Mr Boddice. Sorry, Mr O'Dempsey, to interrupt your evidence with that?-- That's all right.

MR DEVLIN: You were asked by the Chairman about the terms of section 47 of the Health Practitioners' Professional Standards Act. Have you had regard, say, for the position of a nurse in respect of section 53? Are you familiar with the terms of section 53?-- I am familiar with the terms of 53.

It is headed, "Action by Board on receipt of complaint made or referred by another entity or complaint Commissioner not authorised to receive." If a registrant's Board receives a complaint from an entity other than a user of a service-----?-- It opens it up widely for all complainants. In terms of - this is not a comment about particular nurses, but I believe nursing as a profession is quite aware of complaint mechanisms that are available under the Nursing Act and would be able to generalise that to the other regulated health professionals.

Yes. Now, just lets go back and paint a small picture about the process by which health professionals who are accused of unsatisfactory practice are then dealt with. The Health Practitioners Tribunal is the highest body constituted by a District Court Judge and assessors; is that right?-- It is the highest tier of the disciplinary model.

That's right. There are lesser tiers which can be oversighted by your office?-- Not oversighted, but the Boards can refer charges to. There's the Professional Conduct Review Panel which can do all that the tribunal can do, except suspend or deregister or cancel registration.

So, where we have seriousness of alleged conduct which would call for suspension or deregistration, that goes before a District Court judge in the HPT?-- It does.

Now, does your office supervise the mounting of those cases?-- We do, and provide ongoing instructions to a range of

solicitors' firms and prosecuting-----

From the point of view of the office, can you describe the constancy with which those cases come before the HPT?-- We have sittings before the HPT for all its sitting days right throughout each year.

How many sitting days are allocated, can you estimate?-- I can't estimate at all. I know that it is scheduled and there's three to four week sittings at least every quarter.

Three or four week sittings at least every quarter?-- From my memory. I haven't looked-----

Does your office manage to fill those sittings with cases?-- Yes, we do.

Now, out of those cases, which, by their definition, will frequently involve suspension or deregistration, is there a level of publicity which your office also relies upon to keep the public apprised of their right to complain about, in particular, medical practitioners?-- Absolutely the majority of cases before the HPT in my time with the Medical Board and the other Boards has been published both by The Courier-Mail, the Sunday Mail, and if it is a matter that's flowed from a regional centre, it is usually picked up by the local newspaper in that area, such as the Sunshine Coast Daily - the Townsville Bulletin ran stories. I have provided to you some of the articles from our file over the last 12 months or thereabouts.

Thank you. I will tender that for the assistance of the Commission. I have three schedules that simply summarise the nature of the articles and I have a bundle of articles.

COMMISSIONER: Thank you very much, Mr Devlin. The schedule of newspaper articles and the articles referred to in that schedule will be marked as a single exhibit with exhibit number 32.

ADMITTED AND MARKED "EXHIBIT 32"

MR DEVLIN: Thank you. Now, I don't know whether you can answer this, but to what extent has your office then investigated and supervised the progress of complaints about medical practitioners engaged in provincial hospitals?-- They would probably reflect the same percentage of population as is in the rural and regional areas.

For example, do you investigate and prosecute in the HPT, for example, that sits in Townsville?-- We have had at least one case, from my memory, that sat in Townsville.

But the provincial cases are relatively infrequent compared to Brisbane, is that a fair comment?-- They are infrequent. We will seek to have the HPT sit in a regional location depending on the cost benefit of that. If it is cheaper for the parties to be - to have the HPT sit in Townsville, in terms of the witnesses to be called and minimising disruption to health services in those areas, that's the application we'd make to the HPT.

In any event, there is no bar, never has been a bar to people with a grievance about a medical practitioner operating in a hospital coming directly to your office to complain?-- No bar whatsoever.

Now, the Chairman raised for your comment the position with the HRC and its interrelationship with your office. Can you describe that briefly and indicate whether there is any change to that interrelationship that you see as necessary?-- The relationship is very good at a staff level. There is consultation as required under the Act, on a weekly basis, scheduled meeting each week. Agreement between myself and the Health Rights Commission that if there is a disagreement in terms of progressing a matter by our offices, then we will consult directly to work it through. So it is a healthy and at times robust relationship, but healthy. We're both committed to getting things done. There are some problems in the legislation that I think need addressing.

COMMISSIONER: You mean in the sense there is not a clear enough demarkation between-----?-- Look, I think it could create a perception amongst complainants that we're dealing with it in a bureaucratic way. For example, if we get the

complaint and we want it - from a health service user and the assessment is that it should be closed, it doesn't meet the threshold for investigation, then we have to refer it to the Health Rights Commission and we have to tell the complainant we have referred it to the Health Rights Commission, then the Health Rights Commission close it, I think that's nonsensical. If someone complains to a Board, then it should be the Board that tells them the outcomes of the assessment and consultation with the Health Rights Commission. That's a simple example. That's because section 51 is limited to what actions the Board can take after consultation. It doesn't include either further assessment of the complaint or for closure of that complaint with the agreement of the Health Rights Commission.

Can you give us some indication of the number of complaints you deal with and what proportion of those complaints are taken further?-- If you turn to the annual report that I handed up, Commissioner?

Yes?-- And go to - I think it is page 29 - you will see a table 5 which looks at-----

I must be looking at the wrong one. The 29 I have has notes on it but it is otherwise blank. This is the 2003/2004 report?-- Could I just see the cover of that, Commissioner? That's the Medical Board's report, not my report.

I beg your pardon, right?-- If we go to 2003 then, I think it is JPO4.

Anyway, just tell us the figures and we'll find the paperwork later?-- For the Medical Board, in the full year 2002/2003, received 221 complaints, and those complaints are broken down in more detail in the Medical Board's report about where they're from and what was done with them. But from my office's perspective, I look at how many investigations were initiated, and that was 46 out of those 221 complaints. Now, a number of those would still be in assessment, a number may have been referred to the Health Rights Commission for conciliation or closure, but I can say that 46 led to an investigation.

So it is less than one in four that lead to an investigation. And of those 46 that were investigated are you able to say how many - roughly what proportion resulted in some form of disciplinary action?-- I would, based on anecdotal data only. Of the investigations considered by the Board, 30 to 40 per cent would lead to some form of disciplinary action.

Yes?-- The test is quite low, Commissioner. It is a test of unsatisfactory professional conduct rather than a test of professional misconduct.

So that no-one misunderstands that, the test is low and therefore requires a very high standard of ethical performance by practitioners?-- Mmm.

Of the something over three quarters of the complaints that did not go to investigation - you say some, of course, may have gone to Health Rights or a different branch - is there a significant number of complaints that you would consider to be malicious or trivial, or otherwise, you know, a waste of time?-- Prior to my introducing an assessment process in 2002/2003, the Boards had been advised that they didn't have an assessment process and had to basically investigate everything.

Yes?-- So there were a lot of matters that I would have considered trivial or not meeting the threshold for investigation, or had already been adequately dealt with by another entity, such as the police force, that didn't need further investigation by the Boards. There are - in my view, no complaint is ever trivial. It is the information that you provide back that should deal with that. I think people make complaints because they believe something should be addressed and we try and address that through our assessment process. In terms of vexatious, I don't - I can only think of one or two complaints that I would have termed vexatious - not legally termed vexatious-----

I understand?-- -----but I would have termed vexatious.

Is that because they have already been considered and rejected by other competent authorities or-----?-- No, but I thought - I will describe the one that comes to mind. It was two doctors arguing over an exchange of a patient's records and we have a complaint after two weeks of arguing that the records were handed over from Dr A to Dr B, but he drew a picture of anatomy on the coversheet and got someone to put hiss marks on it and faxed that over with the patient records.

Yes?-- I don't think that's a matter that the Board should use their resources with. It is either tell the two practitioners to go and grow up and take no further action. It is not to put into investigation.

Yes?-- That matter was recommended for investigation under the old model.

Why I am asking you these questions - and I am happy to be candid about this - I mentioned yesterday I was on the Barristers Board for about 12 years until it was abolished, and of the complaints which we received, a lot of them were - perhaps vexatious is overstating it. But, for example, people who had been found guilty of a criminal offence by a jury and sent to gaol and their only way of dealing with that was to complain about the barrister's conduct, whether the barrister had done anything wrong or not, or things that had nothing to do with the barrister's professional practice; neighbours complaining that-----?-- We have had a few of those, too.

-----the barrister who lives across the other side of the fence has loud parties?-- Those type of complaints don't take up a significant amount of resource because we have a good assessment process in place.

Yes?-- What we do have difficulty with is the first one you described where we're getting an increasing number of complaints across at least two of the professions from medico-legal type reports provided particularly to the Family Court.

Yes, yes?-- Where the complaint is not about the report, it is about the - how the practitioner prepared that report. So it is difficult to say that - assess it, saying, "Well, because it may be a valid complaint, we may have to investigate those."

Yes, but it would make the process of investigation very difficult for you when that report has been submitted to the Court and been the subject of cross-examination and discussion and findings by a Judge as to whether it is right or wrong?-- And basically for the clear-cut matters, that's exactly the outcome of assessment. This matter has been before the Court, so any matter of that nature should be canvassed by the Court. If the Court has accepted it, then the Board is not going to take any further action.

Right.

D COMMISSIONER VIDER: Mr O'Dempsey, the 46 investigations - the 46 complaints that went on to become investigation, was the majority of those related to professional clinical competence?-- I couldn't say. We get a mix of complaints about communication at the lower level, to clinical competence, to boundary violation. It seems that boundary violation is well publicised but the clinical competence ones are as well publicised. So we do get the range, Commissioner.

And is there - do you have anything that would indicate that a number of those investigations involve overseas-trained doctors?-- They're not over-represented in our complaints at all. They're - in terms of their percentage of the whole population of practitioners. I think you will see that with tribunal matters, majority of those tribunal matters have been Australian graduates.

COMMISSIONER: The 221 complaints and 46 investigations referred to in the report are across the full range of medical practitioners; GPs, specialists in private practice, hospital doctors in private hospitals, and Queensland Health?-- We term the registrants it doesn't matter where they work, we will accept complaints and investigate them.

Amongst those different categories of registrants, are you able to give even a general indication as to where most of the complaints come from? Is it GPs, is it hospital doctors?-- No, I couldn't. We get referrals from Queensland Health Audit Branch, the D-G, some directly from districts, a lot from patients, particularly in the private sector.

Yes?-- So there is no general pattern that I can see. I would have to go back to the Medical Board report to see

whether there was, but I have got to say, and I mentioned it before, we're building a new information system. Part of that is developing a complaint system where we can actually capture that data so we can interrogate it and put statistics out.

One of the phenomena often observed in relation to complaint systems is that people who are paying for a service are likely to complain about it more than people who are receiving a publicly provided service. Have you noticed any such phenomenon in the health sector?-- No, I have not. But I've got to say that I would have noticed that with Queensland Nursing Council because I dealt differently with investigation reports as the CEO of that. Because I am CEO of 13 Boards, I don't always look at where that practitioner was employed at the time.

D COMMISSIONER VIDER: Could I just ask another question that is to do with registration? Yesterday we saw examples of a certificate of registration from the Medical Board and it just struck me, looking at that, that it had a certificate of registration and then it had underneath it "special purpose", I think, or whatever the appropriate classification was. I just wondered whether there would be any thought from the Board to perhaps be more definitive about defining what that might mean in the future?-- I will be proposing at the appropriate time that the legislation be amended, not for the certificate of registration but to include standard conditions for Area of Need registrants, consistent with the Board's plans which are being implemented for supervision and reporting. Currently the legislation provides that you can only put conditions on at the time of registration and then again at renewal of registration. I think we should be able to impose conditions at any time under the Registration Act in response to supervision assessment reports. But I also think that standard conditions to be applied on initial registration need to be standard, they go on the registration certificate, so they are quite clear and they're not subject to an information notice.

Mmm?-- Now, an information notice under the Act enlivens an appeal right. So an information notice has to be structured in such a way or a similar way to a statement of facts under the Judicial Review Act. So it is quite administratively costly in preparing those and issuing them and being exposed to an appeal against them when they are, in my view, standard conditions anyway for Area of Need registrants. So I will be proposing that through our solicitors in submissions at some stage to the inquiry.

COMMISSIONER: I was going to say, Mr O'Dempsey, it may well be - and I am just really thinking aloud at the moment - but from what we've heard in your evidence and the evidence of the previous witness, one course that we might take is in our final report to say Medical Board is looking after its own problems, has implemented new procedures and routines, and they're entirely satisfied with the processes you and the previous witness have described, but it does seem to me that we might be useful to you in a sense, that if there are things

that you are not in a position to implement but which you feel would make your functions more effective, then we would certainly appreciate any submissions the Board wishes to make through its solicitors as to points we should be addressing?-- I should say, Commissioner, the ones I have mentioned to you, I have mentioned - and to the inquiry are the ones that I believe have impact on the Terms of Reference.

Yes?-- My office has been preparing a submission to the Minister for a range of amendments to the Registration Acts and to the Professional Standards Act. As you probably agree, new legislation always has teething problems.

Yes?-- The Minister has agreed to accept such a submission but only wants to do one set of amendments. That's our advice-----

Yes?-- -----from the Minister. So the Minister - and we have to go through the argy-bargy of getting that up through the normal processes, and we've started those negotiations, but the ones in that policy paper that I believe would assist us to implement our more stringent regime I will put to the Commission because I think that that support from the Commission would be quite of benefit.

Thank you for that. Sorry, Mr Devlin.

MR DEVLIN: Just before we leave paragraph 21, you do mention there your knowledge of the Queensland Health complaint management policy. What contact did you have with that and when was that?-- I appointed - nominated someone from the Queensland Nursing Council to be on the Board that had oversight for development of that policy.

Is that back in your Nursing Council days?-- That was the Nursing Council days. There was a staff member nominated by my predecessor from the office to be on that Board. I reviewed a final copy of the policy at some stage after I started in March 2002 with the office and was aware at that time that there was going to be an extensive education program within Queensland Health at the district level for implementation of that policy, but I have no personal knowledge about the rollout of that education program. But-----

Go on?-- But we are mentioned specifically in that policy as Health Registration Board, as an external body that complaints can be made to.

Okay. So are we to understand then, in summary, that you have given us the aspects of how people might find out to complain to the Board, the website and so on, and that running alongside that within the public hospital system, for example, there would be, you would expect, the application of a policy which you had some knowledge of some years ago?-- Yes.

Out of that policy you understand there is a feed to the Medical Board in appropriate cases-----?-- Yes, I do.

-----is that right, by way of complaint?-- Yes.

Thank you. Now, if I can take you across now to paragraph 52? You mention the audit of special purpose registrants which Mr Demy-Geroe spoke about briefly yesterday also. That was conducted this year?-- It was.

To see if there were other discoverable irregularities?-- And that was its specific purpose, yes.

And what was discovered then?-- There was no discovery of anyone else submitting a COG - sorry, certificate of good standing or its equivalent that had been altered or didn't have all documentation referred to in the certificate being there. That was the primary audit. The secondary audit was an internet search where we dumped all names of special purpose registrants at that time through a program through Google and did an internet search based on disciplinary action. That search gives you back the best 10 - up to the best 10 returns against that name. We found nothing from that that directly related to the professional practice of an individual registrant as a health practitioner. Some did get disciplined by their polo club, and one did get disciplined by the employer for being five minutes late for work and it was a monetary discipline. But there was a range of authorities published in minutes on their website. So there was a section in the minutes on disciplinary action but this registrant's name appeared in the list of registrants who had been approved at that meeting. So it picked those up because they were in the same document.

Yes, I see. Looking at part K then, you particularly seek to address the history of examination, both on a State level, a national level and international level of the question of Area of Need certifications and assessment of overseas-trained doctors?-- Yes, I do.

Would you like to give us a brief summary of your experience in this issue? It is not a recent issue, would be the first point you'd make?-- It is absolutely not a recent issue. It has been around in some form or other since at least 1978. It has become more of an issue because of changes in the workforce structure, the international medical shortage, and removal of traditional countries from having direct access to registration in Australia. It's a problem in terms of internationally the whole aspects of medical migration internationally are problematic, in terms of exchange of disciplinary information, accessing certificates of good standing, and looking at the quality of medical schools in countries that aren't traditional-sourced countries, such as the Commonwealth. I attended a conference of the International Association of Medical Regulatory Authorities. They have got a number of projects on foot in relation to this particular issue. They have got a project looking at - and it is being piloted at the moment - looking at a medical passport system, so the medical practitioner carries his history from jurisdiction to jurisdiction, and we enter that data on that

passport. We see there is an electronic passport rather than a physical piece of paper. And we have got an Australian representative on that work group, being my equivalent in South Australia. We've got another work group working on exchange of disciplinary information, and it is being piloted at the moment, where we've actually set up an independent website where we can post our disciplinary information and drawdown from it rather than relying on certificates of good standing. And the third major area of work through IAMRA is in the accreditation of medical schools on an international basis. We have always relied on the processes by which WHO, an American organisation called FAMA-----

How do you spell that?-- It is the Federation of Medical Boards within America. It is like our Australian Medical Council.

IAMRA you referred, I-A-M-R-A?-- I-A-M-R-A, the international association, the World Health Organisation, and another body, being - I think former title is the International Federation of Medical Educators, jointly doing a project exploring the establishment of an international accreditation scheme for medical regulatory authorities.

You have had the benefit of reading Dr Molloy's draft statement?-- I have.

He makes a comment about the fact that there is no equivalence table of medical schools. Can you help address that, please, from your point of view?-- The World Health Organisation lists medical schools. Traditionally that list was created by physical review of them and some other criteria in terms of being approved by their government. They are not as active there. That's why we're doing this international project. But the American group that I referred to - and I could probably find its name by looking at a document here - is actually taking over from WHO, from the World Health Organisation, that listing, and their criteria is quite specific about when they will accept a medical school to go on that list. We will only accept people from schools on those lists held by the World Health Organisation to try and match the equivalence of a course conducted in Australia with a course conducted in any other country, it is quite a complex paper-based exercise based on a range of assumptions about the quality of the teaching, the quality of the teachers, the quality of the environment in which they are teaching, the quality of the clinical practice setting in which they have clinical experience, the quality of the equipment they have got. So the only way of making a match is to see whether they both reach the same standard in delivering a graduate who is safe and competent across a range of practice areas.

And how do you believe that will be delivered?-- Through IAMRA, through the IAMRA/World Health Organisation project. I don't think that we or anyone can do that. I know that the Australian Medical Council, which accredits Australia and New Zealand courses, have an extensive workload just in dealing with the additional medical schools that have been established in the last two to three years, being Bond, Griffith at the Gold Coast, Notre Dame in Western Australia, and I believe there is also one starting in Sydney - an additional school.

Okay?-- I should mention that AMC is looking at whether they can extend their accreditation to courses where the Australian or New Zealand university conducts that course in a foreign country, but that would be at this stage in South-East Asia, but there's no decision been made on that at the moment.

Very well. Now, at paragraph 60 of your Exhibit 18, you draw attention to the general history of the development of assessment processes for overseas trained doctors?-- I do, and I thank the Australian Medical Council for putting that together for me.

Thank you. You say that even back in 1996 this was an issue for the Health Ministers' Advisory Council?-- Yes, I've particularly attached that to my statement because it was on that document that I've modelled the registration regime that the Board is introducing in Queensland. That was presented to the Australian Health Ministers' Advisory Council at request in 1996, and it outlines the range of assessment and supervision issues that we have addressed or are addressing. We, as a group of regulatory authorities in terms of the Medical Boards across Australia, have recently refreshed that 1996 document, and I believe it's my attachment 20 which we endorsed as our position to take to the Commonwealth on Area of Need registrants.

So there are ongoing efforts by the various state jurisdictions to gain some commonality on this vexed issue, I gather?-- Yes. No state or territory has been satisfied with the legislative regime or the assessment processes and monitoring processes that are available to them within their resources. All this got some form of Area of Need registration, as you can see from attachment 18, and the only examination available to any office for those that are seeking our general registration rather than Area of Need Registration or conditional registration.

Okay. Anything more you want to say about all those aspects? You've attached all those various papers to assist the Commission?-- Only to say that we've modelled our regime, our stricter regime, directly in that document endorsed by all the CEOs of all the Medical Boards through the - and they meet regularly through the joint Medical Advisory Committee of the Australian Medical Council.

Okay. Finally, on paragraph 62, to give the Commission some idea of the breadth of the registration task faced by your

office, you've included figures here over the last few years for the number of registrations of overseas trained doctors and the number of rejections of such - or refusals of such registration?-- Yes, I have.

We heard a figure just off the top of his head yesterday of about 1200 from Mr Demy-Geroe. He may have been referring to Area of Need Certifications. Have you-----?-- I believe he may have been referring to initial applications for referral for Area of Need, or for applications from those that were in Area of Need but their Area of Need is changing. This table includes both fresh applications and renewal of previous Area of Needs where they're staying in the same Area of Need. So there are two workloads. There's the fresh application and then there's the annual renewal.

And to take just one snapshot, in the 2003/04 year you actually handled 3,400 applications?-- Yes.

For either renewal or fresh applications?-- That's correct.

And there were 27 rejections?-- That's correct.

Now, I mentioned briefly Dr Molloy's statement that you had the benefit of. Was there anything else that you picked up in Dr Molloy's statement that you would like to put your office's perspective on at all?-- There was nothing specific, no.

Mr Commissioner, that's the evidence.

COMMISSIONER: All right. Just a few very quick matters of clarification. If you go to paragraph 42 of your statement, about five lines down it mentions a conditional practice of registration boards in all of the jurisdictions of the Commonwealth exchanging adverse findings or conditions. In that context did you mean the Commonwealth of Australia or what used to be called the British Commonwealth?-- The British Commonwealth.

So you get information from Canada, New Zealand-----?-- Canada, New Zealand, South Africa.

Hong Kong?-- Not as-----

I suppose it's no longer part of the Commonwealth?-- No, not as we did, but - and we do the same. When we notify the outcome of a disciplinary action, we'll tell all of the Australian states and territories, New Zealand, UK, and I'm currently negotiating with the American Federation of State Boards for that to happen between Queensland and their body.

My next point is perhaps a matter for Mr Devlin rather than for you, Mr O'Dempsey. In paragraph 49 - well, in section I, but particularly paragraph 49, there's a reference to a doctor whose name hasn't come up in evidence otherwise. For the moment I'm not sure whether the sort of suppression order we made in relation to the doctor mentioned in paragraph 30 should also be made in relation to that doctor. He doesn't

seem to have any connection with our Terms of Reference for the moment.

MR DEVLIN: No. Perhaps I can refer to the Executive Officer. Would you ask for a non-publication order?-- We'd agree for a non-publication order, Mr Devlin.

COMMISSIONER: I will direct that the name of the doctor mentioned in subheading I and paragraph 49 of Mr O'Dempsey's statement not be published.

Going through to page 22 of your statement, paragraph 62 - we were just looking at this a moment ago - it looks like whilst there's been a fairly steady increase in the number of overseas trained doctors seeking registration, there's been quite a leap in the number of doctors whose registration was refused. It raises by 50 per cent from 2003 to 2004, and close to doubles 2004 through to the year to date. Is there any particular reason for that?-- I believe there are two reasons for that. One is the Board's increasing scrutiny of the applicants, particularly their concern about where they were applying to be placed under an Area of Need, and second is from January this year the Registration Advisory Committee hasn't had to deal with standard renewals of Area of Need because there's been a delegation. So that also has allowed them to increase scrutiny of the fresh applications, and I think that has led to that jump.

So in one way or another the increase is the result of a more rigorous scrutineering process?-- I believe so.

The other possibility - and please understand I'm not suggesting that this is the case, but the other possibility that might be suggested is that the urgent need for more doctors in Queensland has meant that those recruiting overseas doctors are being less careful in their selection?-- We don't seem to be seeing a change in the source countries over that period though. We've only seen that in the last two to three months, and we've seen - particularly one recruitment firm has started to go to Cuba, and we haven't seen someone - or an applicant from Cuba. So that's the case for that particular country, but I'm not seeing it at my level. There still seems to be a high level of applicants from India, South Africa - I know that the South African and lower southern half of Africa countries now won't give a Certificate of Good Standing to one of their registrants until they've done two to three years of service within the country.

Perhaps I shouldn't say anything, but I'm very concerned by the reference to Cuba. I mean, most of their technology is sort of 1950s or earlier?-- They've both been refused, those applications, Commissioner. I used that as an example of ones where I know that it was discussed by Board members saying, "And this firm's now gone to Cuba. That's new." But both applications were refused, from my memory.

Candidly too, there's a sort of socio-political issue that is probably outside our domain, but a lot of these countries, one

would think, need all the doctors they have. It shouldn't be a first world country like Australia taking away their doctors?-- The feedback - and I don't speak often to recruiting firms, but I know the feedback from one of the American based firms is they only go to - they're still having no problems recruiting the same standard that they've been recruiting for a number of years. I do think the figures are reflecting increased scrutiny by particularly the Registration Advisory Committee.

With the rejections, is that always on the basis of lack of training or lack of skill, or is it - are you picking up some who have been disciplined or struck off in other jurisdictions?-- No, it's primarily because the match of their knowledge, skill and experience isn't considered by the Board to be appropriate for the position they're seeking. We may - the Board may refuse someone an application for general practice for locum relief because they've never worked in Australia, but they write back to them and recommend that they may consider them for an intern-type position within a public sector, but only intern level. So that's in terms of an unsupervised practice environment, being a locum on call.

Yes. My last question by way of clarification is in relation to your paragraph 63 where you say that overseas trained doctors in Area of Need situations are never placed in the specialist register, but they are deemed specialists. Was Dr Patel a deemed specialist?-- No, he was not.

I see the figure you give is 94, so that's 94 out of however many there are over 1,500 working in Queensland?-- You could say that it's out of 3,000.

Who are-----?-- Who have sought registration in an Area of Need as a deemed specialist.

Yes?

D COMMISSIONER VIDER: Just one question, Mr O'Dempsey. Would the Board contemplate in the future, at the renewal of registration from overseas trained doctors, conducting some sort of audit to verify that the registration that has been granted corresponds with the employment status classification that the person is occupying?-- Part of the changes we've introduced are a requirement for the employer to both nominate and name the supervisor and detail all the supervision that's going to be provided, and we will be requiring, when we receive reports, that reports are again by that person and with a certification that they've actually provided the supervision as they've documented in the application, and it's an employer notification form. So we will be auditing that quite closely.

Thank you.

D COMMISSIONER EDWARDS: In the annual report of 2003/2004 of the Medical Board, it was stated there were 232 complaints to the Board for, I guess, eight or 9,000 practitioners. How

does that compare in numbers relative to the other states as an example?-- I don't know, Commissioner. I couldn't answer.

Those figures would be able?-- Yes.

Thank you.

COMMISSIONER: Just before you step down, of course in your written statement you've made the point - and it was made by Mr Demy-Geroe yesterday - that an error was made by your Board in relation to Dr Patel, and that's been acknowledged in a very frank and forthright fashion. I just wonder whether there is anything you wish to say for the benefit of the people, particularly in Bundaberg?-- Look, I can only reinforce what the Chair of the Board, Dr Mary Cohn, has said publicly. We apologise. It was a human error. We had identified that we had systems problems, but - and we're working on fixing them, but we are quite upset about the error, but we're putting the systems and processes in place to ensure as far as possible that such an error cannot recur.

Thank you very much for that. I'll ask you now to stand down so Dr Cohn can give evidence. You will have to come back at some time?-- I don't mind.

Is tomorrow convenient? Look, we'll speak with Mr Devlin and make sure that whenever you come back, it suits your convenience?-- Thank you, Commissioner.

Thank you.

WITNESS STOOD DOWN

COMMISSIONER: Mr Devlin, we might have a five minute break and then start with Dr Cohn's evidence.

MR DEVLIN: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 4.01 P.M.

THE COMMISSION RESUMED AT 4.08 P.M.

COMMISSIONER: Mr Andrews, there are probably enough people here that we can get started with Dr Cohn if you wish to.

MR ANDREWS: Yes. Indeed, we can.

COMMISSIONER: It's up to you.

MR ANDREWS: I call Erica Mary Cohn.

ERICA MARY COHN, SWORN AND EXAMINED:

COMMISSIONER: Please make yourself comfort, Dr Cohn, and thank you so much for making your time available?-- Thank you for affording me the courtesy of allowing me to come when it suited me too. Thank you.

MR ANDREWS: Would you tell the Commission your full name, please?-- My full name is Erica Mary Cohn.

Doctor, have you prepared a statement which was assigned by you on the 17th of May 2005?-- I have, Mr Andrews.

Would you look at this statement and annexures, please? Is it a copy of the statement you prepared?-- It appears to be the original.

Are the opinions expressed in that statement honestly held by you?-- They are.

And are the facts recited within it true to the best of your knowledge?-- They are.

I tender that statement.

COMMISSIONER: Thank you. The statement of Dr Cohn will be admitted into evidence and marked as Exhibit 33.

ADMITTED AND MARKED "EXHIBIT 33"

COMMISSIONER: Mr Devlin?

EXAMINATION-IN-CHIEF:

MR DEVLIN: When did you become Chairperson of the Medical Board?-- On the 2nd of December 2004.

And at the time that Dr Patel was first approved for practice or registered for practice in Queensland, were you an ordinary member of that Board?-- I was.

How long have you served on the Medical Board of Queensland?-- Since approximately April of 1998.

And how long have you been a medical practitioner?-- I graduated in 1968.

And are you a general practitioner?-- I am.

I want to take you to a particular aspect of your statement which deals with the work of the Registration Advisory Committee. So we need to go to about paragraph 16?-- Yes, I have it, thank you.

In fact at 17 you say that Dr Patel's initial application for Special Purpose Registration was considered by the RAC when Dr Mary Mahoney was the chairperson?-- That's correct.

Other members of it were Mr Clare, the consumer representative?-- Yes.

And Dr Toft, who was at that time the Chairperson of the Board?-- He was.

How many years was Dr Toft the Chairperson of the Medical Board approximately?-- Well, he was President under the old Act and Chairperson under the new Act for approximately, I think, about 11 years.

At least in recent years as the Chairperson did he sit on the RAC as an ordinary member?-- He did.

I want to ask you about the workload of RAC. We heard from Mr Demy-Geroe yesterday, I think, that in the months of December/January of any given year and about June/July the RAC would perhaps process up to 150 or 200 applications for registration?-- Yes, we could.

Do you currently sit on the RAC?-- I do.

Do you chair it?-- No, it's chaired by Dr Fitzgerald.

Thank you. So you have followed the practice of Dr Toft of being a member of the Committee?-- Yes, I have.

It sounds like at times in the year it is a very hard-working committee?-- It's always a very hard-working committee.

And the question then that arises from that is when we get these bubble periods which Demy-Geroe thought was partly influenced at least by the recruiting cycles of hospitals, for example - would you agree with that?-- It could be.

Does the RAC, and thence the Board, get a real opportunity to apply its mind to the details of these registrants - or applicants?-- Yes, we do, particularly over the last few months under the new Board, the delegation for reapplication for Area of Need residents, for example - the delegation has been appointed to members of staff. So only ones they're concerned about would come to us, and therefore it has decreased the workload to a certain extent whereby we do have more time to look at each individual application.

Now, despite the human error that's been identified in this application for registration by Dr Patel, are you satisfied

that the RAC of which you are a member gets appropriate service from the staff in terms of the initial assessment of the applications?-- Yes, the work is very good.

And tell us a bit about how the deemed specialty then works. If an applicant was to seek registration as an overseas trained doctor for a specialty, are there additional steps that would need to be observed?-- Yes. Well, they'd have to apply not only under section 135, but also under section 143A, and their qualifications and experience would then be assessed by the relevant college, and they would be either passed as equivalent - reasonably equivalent to Australian qualifications or refused.

So if Dr Patel, having claimed a background in specialty surgery, had sought specialty status in his application, he would have had to have jumped through a couple of extra hoops then?-- He would have.

Now, I want to ask you now about the process after the RAC has come up with its set of recommendations for the Board. To what extent then does the Board of which you are the Chairperson - to what extent does the Board have the opportunity then to apply its mind to what the RAC has done?-- The RAC makes a recommendation and a report to the Board at each Board meeting. There will be certain asterixed items which may be practitioners that the RAC has concerns about, and they will take those asterixed items to the Board for full Board discussion, and that might be - some weeks it may only be five or six practitioners. It could be 12, 13, 14. All the others which have been approved by the RAC just go through as a matter of course at Board level. The Board doesn't individually look at all of those registrations.

So, are we to understand that the RAC, up to a point, relies upon the assessment work of staff, firstly?-- Yes, they do.

But the RAC members have all of the materials which the assessors have looked at?-- Yes, they do.

The Board, though, will be supplied with the materials on the asterisked practitioners; would that be right?-- That's correct, or a summary. They may not have the whole registration file in front of them, but the Board members would be provided with a summary, and the relevant Chair, in this case Dr Fitzgerald, would give a work-up to the Board.

So, the Chair of the RAC leads the discussion at Board level customarily?-- He does, yes.

And so in your experience now, since 1998 on the Medical Board of Queensland, have you experienced robust discussion by Board members about applicants of the type of Dr Patel?-- Well, with Dr Patel, we didn't know there was any problem.

No, I meant in general, did the Board members participate fully in the discussion, particularly of the asterisked applicants?-- Most certainly. All Board members will be involved in that discussion.

And they have the materials in relation to those particular highlighted applicants?-- They have a summary.

Sorry, you said that?-- They have a summary. They can ask - I mean, the files are there and any Board member can ask to look at any individual file if he or she wishes to.

We only some moments ago saw the statistics for the last few years. The Chairman of this inquiry raised with Mr O'Dempsey the apparent rise in refusals of registration which we see on the screen there up 50 per cent in one year and then up - at least it is going to be - and no doubt 100 per cent over the previous year and the current year. Have you got anything to add to what's been said about that?-- No, I would tend to agree with Mr O'Dempsey that it reflects the ability of the members of the RAC to be able to look more closely and more carefully at the - matching the job description with the relevant experience and qualifications of the applicant.

So, the delegation of the renewals to staff has helped with the flow of work?-- Yes, most enormously.

Now, have you had the benefit of the draft statement of Dr Molloy who is to give evidence after you?-- I have.

Are there a couple of matters you would like to add to the issues canvassed there? Firstly, at page 3, there's a description by Dr Molloy about the standard doctor in Queensland. Is there something you want to add to his observations?-- Yes. Perhaps I would just like to say that some of the training programs are now taking second year

resident medical officers, or JHOs - Junior House Officers - into training programs as early as second year post-graduation, and that it probably doesn't take four to six years as a training Registrar to become a general practitioner. Probably one extra year after internship and then a Registrarship in private practice for a couple of years.

Now, at page 5, Dr Molloy has spoken about GPs working in a cooperative practice in a semi-supervised setting. Have you got some comments to make about that in the second paragraph of his draft on page 5?-- Yes, I think this is something which I have discussed with Dr Molloy just informally over the last few months, and explained that we are now - well, I, as a member of the RAC, will tend to look mostly at the section - the 135s which are going into general practice, and we are not allowing any doctor who doesn't have general practice experience in a country equivalent to Australia, such as Canada or the United Kingdom, to practise in either solo rural practice, solo general practice anywhere, or in locum agencies where they are likely to be going out and seeing patients at night on their own.

Okay, just slow down your speech a little if you would. So, do the members of the RAC split up the classifications of applicants as well so that you are looking consistently at a particular class of applicant?-- In my experience, that's the way we manage the workload.

And you look after particularly those seeking general practice admission to areas of need?-- I do, because that's my area of expertise.

Thank you. And Dr Molloy makes a comment on page 11 in the first paragraph about the prices that Queensland Health are prepared to pay for staff specialists being poor by national standards and terrible by international standards. Have you got any comments to make about those observations by the president of the AMA?-- Well, I don't know about the salaries involved and I take at face value what Dr Molloy has said, but I think it is simplistic to then say that Dr Patel was part of this scenario. Dr Patel was more, in my opinion, a refugee from the United States and-----

What that observation, you say, does not take into account was that he actually acted fraudulently in his application to the Board?-- He did. I mean, Dr Patel would have been taking a very large drop in income coming from the United States as a surgeon to work in a Queensland public hospital.

Does the RAC and the Board, in your experience, look critically at applicants claiming a lot of experience wanting to come to Australia to, perhaps, reduced circumstances by way of income?-- We would be aware of that and take it into consideration and be a little cautious, perhaps.

COMMISSIONER: I guess what Mr Devlin is saying is that one can understand why a doctor would choose to leave Albania or

Cuba or Uzbekistan to come and work in Australia, but you would have your suspicions about someone who gave up an apparently lucrative practice in the United States?-- Yes, Commissioner, that's correct.

MR DEVLIN: Another aspect of the culling of the applicants as one moves up from staff assessing level to RAC to Board, is a Board member or an RAC member able to unilaterally asterisk an applicant for discussion?-- No, at the end of the RAC meeting, we all go through the whole of the applicants and whomever has looked at that particular file will say, "That one is okay. This one asterisked. There's a problem here.", and then that's collated by the staff and then that report goes to the - so, everybody at RAC level would have looked at the problems first before they - and that may be solved at that level, but if it is not, then it will go to the full Board.

Okay. Can any Board member - is any Board member free to raise a query?-- Absolutely, yes.

These RAC meetings, in your experience, how long do they take when you are into a heavy workload?-- Anything between three and four hours.

And of the Board's business in any given meeting, how significant is the taking of the RAC recommendations - taking and considering of?-- Well, unless it is a very heavy night for complaints, it is probably apportioned between health assessment, monitoring complaints and RAC and they would all be probably given equal weight.

I see. So, you have got three major streams?-- Yes.

Complaints of unsatisfactory professional conduct?-- Mmm.

Health and-----?-- Health assessment and monitoring.

Health assessment and monitoring?-- And registrations.

And registrations?-- Yes.

Thank you. That's all I wish to take Dr Cohn to.

COMMISSIONER: Thank you, Mr Devlin. Dr Cohn, there are six registered members of the Board; that's right, isn't it?-- No, there are eight, Commissioner. There are currently only seven, but there is provision for eight.

Are they in any way selected by reference to a sort of range of the profession so that you have some GPs, some specialists, some public, some private?-- No. The appointment is made by the Minister and currently we have three psychiatrists, for example, on the Board.

Would it be your personal view that it would be desirable in any restructuring of the Board to ensure that there is a range of professional interest groups represented in the sense of

some public, some private, some GP, some specialists and perhaps a bit more diversity amongst the specialists?-- Perhaps not so much public and private, but I would like to see a greater diversity amongst the representatives of the profession on the Board, mmm.

And I see that two of the members at least, as listed in your paragraph 3, have the title Professor or Associate Professor. Are they principally academics or are they practising members of the profession?-- One is Professor Laurie Geffen, who was on the previous Board, and he is a psychiatrist and Head of - was Dean of the four year course when it was first introduced. He does do private practice in psychiatry. And the other is Associate Professor Beverley Rush, who has a PhD in skin disease, and she is one of our Townsville members. She works in a skin clinic part-time, but she is involved in academia as well.

I also notice that one of the members listed in your paragraph 3 seems to have obtained his primary degree at Madras. Has it been the tradition to have overseas trained doctors represented on the Board, or is that again just a coincidence?-- No, I think we call him Dr Kaly because his name is hard to pronounce. Kaly was appointed during a term of the last Board to replace a member, and I can't remember why the member retired, but I think representation was made by my predecessor for a doctor representing the non-white Australian trained doctors.

Am I right in thinking that all of these positions are honorary?-- We do receive a very small stipend.

There's a meeting fee or something like that?-- A meeting fee, yes.

I guess it goes without saying that that in no way compensates you for the encroachment on your professional time in these duties?-- Definitely not. You don't do it for the money.

You do it for the sake of the profession?-- You do, yes.

Mr Devlin, I notice in paragraph 46 in the subheading there is again a reference to a doctor about whom there's been a non-publication order, and I just indicate that the same non-publication order applies on that occasion as well.

MR DEVLIN: Thank you, Commissioner.

COMMISSIONER: Dr Cohn, I'm going to invite the representatives of the various parties to ask you any questions. I will encourage people to bear in mind that it is probably more time efficient if questions relating to the nuts and bolts of the operation of the Board are left to the professional staff who assist the Board, rather than Dr Cohn. On that footing, though, I put the matter open to any questions. Mr Boddice, are you happy to start again?

MR BODDICE: Yes, but I don't have any questions.

COMMISSIONER: Does anyone else have any questions?

D COMMISSIONER VIDER: I have a question for Dr Cohn. Is it common practice to second members of the profession to the standing committees?-- Yes.

For example on the registrations committee, do you second members to that committee?-- Not on the Registrations Advisory Committee, but on the Complaints Advisory Committee we do have a seconded member. It helps with the workload.

Yes. I was just thinking of the - if you could second, you could second according to areas of speciality or the particular-----?-- Yes, that's a useful suggestion, but I think it would be more useful to have that representation at Board level where the ultimate decision has to be made.

You said to the Commissioner that the Minister appoints the people. You don't have a process whereby you call for applications for membership of the Board in professional journals?-- The Minister does to various organisations including the Australian Medical Association.

Thank you.

COMMISSIONER: One of the considerations that often arises in this situation is whether having more members of the Board would actually make your job easier or harder. My experience on various committees is the more members you get actually the longer it takes to get anything done rather than having more people to spread the work amongst. Do you have a view about that?-- I do, and I disagree with what you have said. We desperately need another Board member at the moment because the workload is enormous. We institute a lot of disciplinary committees for example and I'm forever - because I'm involved with the Commission at the moment, and that's a big workload, I'm having to ask my Board members to sit on a lot of these committees, which is eating into their time enormously.

Do you consider that there would be merit in increasing the total number of Board members, particularly the registered members?-- Probably we could do with one or two more members, but just to have a complete Board - one extra member - preferably a proceduralist - at the moment would be very useful.

And may I take it from the way you have given your evidence that you and the other members of your Board are satisfied with the level of administrative support you receive from Mr O'Dempsey and his office and the people who work-----?-- Most certainly, Commissioner. Most certainly.

Sir Llew?

D COMMISSIONER EDWARDS: You say you don't recall Dr Patel being discussed in the Board meeting in your statement, but there were at that meeting, I see, 75 names of overseas

trained practitioners applying for special purpose registration at that meeting?-- Mmm.

Is that about the usual number?-- No, that was in January/February, Commissioner, when the - there is a hump in the people applying, and there is a very heavy workload.

Would it be fair to say that with that large number or a large number of applicants being considered that you would be extremely dependent on the reports made relative to their past competency and any reports of adverse activities in previous jurisdictions?-- Yes, you would be.

COMMISSIONER: I had asked whether there was anyone at the Bar table who has any questions for Dr Cohn. There doesn't seem to be. So, I'll also ask, as I did yesterday, if anyone in the public gallery, including the present media representatives, feel that there is something that should be asked of Dr Cohn that hasn't been, I would invite you to come forward. No? Dr Cohn, it looks like you are excused from further attendance?-- Thank you, Commissioner.

Thank you, again, so much for your time?-- Thank you very much.

WITNESS EXCUSED

COMMISSIONER: Now, Mr Tait, are you ready to proceed with Dr Molloy?

MR TAIT: I am, thank you, Commissioner.

COMMISSIONER: I will ask Mr Andrews formally to call Dr Molloy and let you take him through any specific matters that you feel would be important to the inquiry.

MR TAIT: Thank you, Commissioner.

COMMISSIONER: I should say, Mr Andrews, I don't actually have a copy of Mr Molloy's statement with me. If there's a spare one, that would help. It is all right. The secretary has one.

MR ANDREWS: Dr Molloy's statement does, Commissioner, refer to the submission of the Medical Board as well.

COMMISSIONER: Yes, I have all of that, thank you. Dr Molloy, would you be kind enough to come through to the witness-box?

DAVID MOLLOY, SWORN AND EXAMINED:

MR ANDREWS: What's your full name, please, doctor?-- It is David Molloy.

And you have prepared a statement that was typed out last night, or yesterday. Do you have a copy of it with you?-- Yes, I do, sir.

Is it a statement of 14 pages prepared yesterday?-- That's correct.

Are the opinions expressed in it honestly held by you?-- That is correct.

And are any facts recited in it true to the best of your knowledge?-- That's correct.

Dr Molloy, within your statement, you observe in the preamble that it is meant to accompany the initial submission to the Bundaberg Hospital Inquiry submitted by AMAQ. Do you have a copy of that submission with you?-- I do.

Now, I do notice within that submission that it does, from time to time, recite words to the effect that this is the opinion or the belief of the AMAQ. Are the opinions expressed in that submission opinions that you also hold?-- Yes, they are.

And where that submission recites facts, are they facts that you consider to be true to the best of your knowledge?-- Yes, that's correct.

Commissioner, I tender the statement-----

COMMISSIONER: I think, for convenience, I will mark as a single exhibit the three documents, being the statement of Dr Molloy, Dr Molloy's CV and also the submission from the AMA Queensland, described as the Initial Submission, dated May 2005, and those three documents, as it were, inter-relate. Those documents collectively will become Exhibit 34.

ADMITTED AND MARKED "EXHIBIT 34"

COMMISSIONER: Mr Tait, just before you begin your evidence, may I mention one matter? You will recall yesterday morning I raised the fact that there had been some discussion in the media about the birthing unit at Herston and some documents had been received by the Inquiry. As presently advised, I'm unable to see that there's anything emerging from that which is relevant to our Terms of Reference, except in the very

general sense that one of the Terms of Reference asks us to consider how more doctors can be attracted to Queensland, and I suppose, as part of that, we need to consider whether and to what extent other health care professionals can be substituted for medical practitioners in certain areas of practice such as maternity practice. The upshot of all of that - I'm not sure whether Dr Molloy will be disappointed or relieved to hear this, but I don't think it is appropriate that we have any discussion about the maternity unit at Herston, except to the extent that it is relevant to that point of obtaining appropriate staffing levels for hospitals throughout Queensland.

MR TAIT: Thank you, Commissioner. That will present no difficulty.

COMMISSIONER: Thank you.

EXAMINATION-IN-CHIEF:

MR TAIT: Dr Molloy, I would like to take you, first, through the role of the AMA and how it is structured - only briefly - but to indicate how the AMA forms its collective opinion on matters, matters to which Mr Andrews has referred. Then I would like to deal briefly with your involvement with the AMA, what the AMA President does and how the AMA President in Queensland gathers opinions to be able to understand the AMA position, and then I would like to deal with some highlights of your statement. I don't want to go through it line by line, the statement speaks for itself, and, of course, it adopts the submissions of the AMA; is that correct?-- That's correct.

Also there are, I think, 15 or 14 other available witnesses for the AMA dealing with a number of special areas, areas of expertise and interest; is that correct?-- That's correct.

And a table has been prepared cross-referencing those witnesses to the areas - parts of the AMA submission?-- That's also correct.

Can you tell us how the AMA works on a national and state basis, just briefly?-- Yes. The AMA is a national organisation representing registered medical practitioners in this country. Recruitment occurs at state level. People join a state branch of the AMA. The state branches of the AMA have a federal coalition called the Federal AMA, which then the membership is shared between each state branch and the Federal AMA. The Board of the Federal AMA is made up of representatives from different specialty groups and also the state branches.

COMMISSIONER: Dr Molloy, the shorthand writers are exceptionally good, but if you could go a little bit slower,

it will probably be easier for them?-- Sure.

MR TAIT: Doctor, in Queensland, we have a President and a Chief Executive Officer who remains from year to year, but the President changes each year?-- That's right, the presidency is each year. We don't have a Vice President, we have a President Elect, and then we have an Executive that consists of a secretary, treasurer and three or four other elected members.

And there's a State Council?-- That's right, the State Council, I think, has 27 members on it. They represent a number of special interest groups such as specialties, but mostly derived from electorates within Queensland.

And how often does the State Council meet?-- The State Council meets quarterly.

And the executive?-- Meets approximately every two months.

And are there, in addition to that, quite a number of subcommittees?-- There are a number of very large subcommittees, ranging from aged care, indigenous health, public hospital subcommittees, to name but a few.

And how many employees are there in the AMA in Queensland?-- I understand that we have a secretariat of about 38 employees based at Herston.

And currently based only in Brisbane, but in the near future perhaps to expand north?-- That's correct.

And in your capacity as the President in the previous year, you were President Elect?-- That's correct.

And you have chaired a number of committees?-- Yes. In AMA Queensland, actually, I've only chaired two committees, one was the medical indemnity Task Force and the other one, automatically, the President Elect chairs the membership committee. Those are the two subcommittees that I chaired.

And in your capacity as President, how do you gather opinions - the opinions you expressed in your statement - in saying the AMA has this view on something?-- Well, we do have policy, a deliberate structure to make policy, in that the policy is decided, first of all we have a very efficient bureaucracy that researches policy for us and produces policy papers. Those policy papers are then distributed to all interested parties, be they the particular craft groups or colleges associated with the AMA and the AMA itself, or to interested parties within the AMA, then to the council members of the AMA. On a day-to-day basis, the AMA is run particularly by the executive and particular policy positions are particularly decided by the executive but matters of very important policy will be withheld to council.

Now, you are yourself a specialist obstetrician and gynaecologist?-- That's correct.

In full-time practice in Brisbane?-- That's correct.

Your CV is attached to your statement?-- That's correct.

I would like you to turn to page 2 of your statement. Towards the bottom you say that AMA Queensland has for some years been concerned about uncertainty in the quality of IMGs - IMG being the new term for OTDs - who may come to work in Queensland. Can you tell us about what work the AMA has been doing and why there has been any concern?-- Yes, I guess starting initially with the concerns, there was significant feedback in two sectors. The first was the public hospital sector where the recruitment practices raised a number of significant concerns. Firstly, there was significant problems with language. There are a large number of doctors, or seemingly large number of doctors in around 2000 plus - sorry, that's not the number of doctors; I mean by the year - who seem to have significant language difficulties and we were getting constant reports of major communication problems, particularly in regional hospitals. The second issue was there were issues of competence, but the third issue was also that the - particularly the issues of competence where doctors were slotted into positions above their level of competence. And there seemed to be a very significant problem with doctors that should really have been placed at perhaps Junior House Officer level, being a PHO, or Registrar level, and people who should have been just Registrars being put into specialist positions where they could do unsupervised specialist work.

Now-----

COMMISSIONER: Dr Molloy, you identify those three problems with overseas-trained doctors or international medical graduates, but from the evidence we've heard so far, it seems that there may be a fourth category of problems, and that is simply that the overseas-trained doctors are compelled to work for one employer, Queensland Health. Their options are really to continue to work for Queensland Health or to go back to where they came from, and that creates a level of difficulty for overseas-trained doctors to make complaints, to query the

way in which the hospital is run, to criticise the performance of their fellow practitioners or other staff at the hospitals, to complain about the conditions in which they are working, and so on. Has the AMA received complaints, either from doctors who have been trained overseas or from the doctors they're working with, that they are in that situation, as someone described it, almost like bonded slaves?-- Yes, Commissioner. I guess I didn't mention that because I was putting that in a separate category of the problems to be addressed in relation to overseas doctors. When I answered Mr Tait's question I was really referring to the problems that we saw that were affecting quality in the health system.

Yes?-- That is quite correct, although directly to us from these sorts of overseas-trained doctors, we don't have many of those doctors as members, and we have tried very hard to recruit in that area with our recruitment section and they're - you know, the feedback I got from the recruitment section when I actually specifically asked about this is that they're actually quite scared to be seen to be even talking to a high profile group like the AMA. And we have had great difficulty getting direct communication but we do get a lot of indirect communication from that group and also through the doctors that they work with, and I think that your summary is absolutely spot on, it is absolutely correct.

MR TAIT: The - you refer on page 2 of your statement to the Lennox Report?-- That's correct.

Is that an attachment to the AMA submission?-- That is correct.

What was the Lennox Report?-- In 2001 and 2002 the AMA lobbied hard on the issue of international medical graduates and, as a result, Queensland Health commissioned a report by one of its employees, Dr Lennox. This report was completed in approximately July 2003. The report - this was a little bit before my time - was leaked to the press, to Mr Hedley Thomas, in fact, who is well-known to this Commission, and it did actually create quite a significant stir, for want of a better word, at the time. The Lennox Report then promptly died. It was only ever leaked in its draft form. To my knowledge it was never completed and I am really not too sure whatever became of Dr Lennox. The supposition was that the report wasn't completed because basically it is an excellent report. It accurately defines all of the problems that were emerging with overseas-trained doctors or IMGs. It provides very real and sensible solutions. But there was a significant cost impact in Queensland Health and also a significant recruiting impact in Queensland Health if it was ever implemented.

Doctor, we have heard some evidence about the AMA's attitude to the Lennox Report. Are you able to say what the AMA's attitude was?-- Well, we were supportive of it. We had been major contributors to it. In fact, it echoed much of the policy that we had. A lot of the problems that related to overseas-trained doctors is that when they arrive in this country they are not well treated. They arrive, often in a

provincial area from another country, they really have a very, very poor level of initial assessment, they have a poor level of mentoring and supervision. Medical training is basically apprenticeship training, it has been for hundreds of years, and these doctors don't get that when they come into the system. Whilst we might be critical about the fact that they are promoted to a level beyond what they should be doing, that's very hard for them as well, it is very stressful and I suspect a lot of them struggle to cope in that sort of situation. As well as that, there are cultural problems, in terms of many of these doctors are not used to Australian society and they don't understand the Australian medical system. They don't know what Workcover is and they don't know what Medicare is. You know, they don't know how to fill out a certificate for social security. They have never been taught that and they are not taught that very well. So, you know, a lot of the things that the Lennox Report addressed addressed those problems of - not really being terribly critical of these doctors, but finding a way of bringing them up into the Australian medical community in a useful sense so that they'd be able to make a long-term contribution to medical care.

COMMISSIONER: Is it consistent with your experience in dealing with Queensland Health that reports like the Lennox Report disappear into a black hole if they don't say the things they are hoped to say?-- Well, I have limited experience in my time as President with reports of that significance. That was, you know, a very major project by Queensland Health. In general terms, our view of Queensland Health is if there is something that will impact adversely on cost or be difficult to implement politically, it tends not to be acted on.

MR TAIT: You speak in paragraph 4 on page 3 of your statement of the normal career path for the medical workforce and then you deal with that further down the page, a one year internship when the doctor has limited registration can only work in a hospital under supervision. Is that-----?-- Yes, that's correct.

Then one, two or three years as a resident medical officer-----?-- That's also correct.

-----working in a hospital but with less supervision. And then perhaps going on to train as a Registrar. And whereas an RMO just in the general hospital system can be moved from one section to another, from psychiatry, to obstetrics, to surgery, when one becomes a Registrar you stay in that one specialty for years?-- That's correct.

And registrars work under consultants or staff specialists?-- That's correct.

Report to them and are trained by them?-- That's correct. The exception being general practice registrars who are 50 per cent of the training workforce. They will usually train out in private practice under the supervision of other general practitioners.

Yes. Rather than in hospitals?-- That's right.

COMMISSIONER: I assume that the time periods you mentioned in paragraph 4 are typical and it would - for example, the period spent as an RMO would depend on what specialisation you are interested in going to, as to how long it would take for a vacancy to come up?-- That's correct, Commissioner.

So if one was silly enough to want to follow your career path in gynaecology and obstetrics, it might be a lot easier to pick up a training position in that field than, for example, in a smaller specialisation like dermatology?-- That's correct. The wait in my specialty is a couple of hours.

MR TAIT: Is that to see a doctor?-- I was here on time, Mr Tait.

This is all privileged, isn't it, your Honour?

COMMISSIONER: Absolutely.

MR TAIT: Now we're going on to specialists in the hospital. On page 4 you talk about commonly many specialists used to work for a couple of years in the public hospital system as full-time junior staff specialists and then they went on, left the hospital, became a VMO. We have heard a fair bit of evidence about VMOs but tell us briefly how the VMO system works in Queensland or is intended to work?-- Yes, could I just make one point before that? This is an extremely important career path and it is one of the reasons that the workforce in Queensland hospitals has broken down and one of the reasons - one of the prime ways that the workforce could be built back up. Doctors, when they graduate from university, only really know the public hospital system and it is - particularly specialists. So they're juniors and then they are registrars in the public hospital system, and most of them feel very comfortable in them. Many, many of the senior specialists in this town spent some years as junior staff specialists or assistant directors before they went into full-time private practice, but they developed a very strong bond with their public hospital, and then they often were VMOs for 20 or 30 years. Now, visiting medical officers are specialists who come back and work in the public hospital system often for two, perhaps three sessions a week. A session is three hours. In that time, particularly in the procedural specialties, they will usually do an outpatients and an operating list. They're an extraordinarily important source of medical expertise in the public hospital system, particularly because they bring a breadth of skills. Often they are the best specialists in the city or in the State who come and work in the public hospital systems, they teach, they direct. They raise the intellectual level of the hospital very significantly.

So there are 10 sessions a week, are there? Two, one morning, one afternoon a weekday?-- That's correct.

And a VMO might work two or three?-- That's correct.

So would you need three or four VMOs to be the equivalent of one full-time staff specialist in terms of workload?-- That's also correct. The VMOs also contribute to the intellectual life of the hospital outside of their sessions, in terms of attending, you know, clinical review meetings and CME, Continuing Medical Education activities. They also usually do their share of on-call, after-hours, both evenings and weekends, to provide an after-hour roster within their particular specialty.

Have you worked as a VMO?-- Yes, I worked at the Royal Women's Hospital from 1987 I think to 1992.

Do you not now work as a VMO?-- No, I am - I think I am still on the relieving list at Royal Brisbane but haven't been asked in some years.

Have you been able to discern through the AMA any particular attitude to VMOs by Queensland Health - and I don't mean in Bundaberg, I mean generally?-- Yes. We do strongly believe that the VMOs are being phased out by Queensland Health and we think this is a significant contributor to the medical workforce shortage in Queensland. The generic broader evidence for that is that our figures suggest that five years ago there was something like 298 full-time equivalent VMOs working in the system. There are now, as of the latest figures released by Queensland Health, it is just under 250. So over the last four to five years we've lost about 50 full-time equivalent VMOs to the system, which is, you know, an extraordinarily - that's a tragic loss of intellectual property in the Queensland public hospital system. The second - so in a generic sense we feel there is very strong evidence of this. But also, I mean, the attitudes to VMOs has changed in Queensland Health. The VMOs are considered a troublesome lot. They're sort of fairly independent specialists, they are not easily pushed around by management, you know, they're used to working. They spend most of their life working in the private sector and the attitude between - or the relationship between a hospital administrator in the private sector and the doctor is a much more cooperative one where the doctor has more influence. And as well as that they're actually quite productive because they're used to working pretty much at the same speed when they go into the public hospital as they might at the Wesley or the Mater or the Holy Spirit. And they want to work at that speed. That means they are very productive, and production in Queensland Health means cost.

Why wouldn't it mean a saving, getting patients through quicker?-- If you treat fewer patients you spend less money. So productivity, unfortunately, where budget compliance is one of your main core business focuses, the cost of providing services is significant. So it is commonly used in Queensland Health to cancel services and not provide services as a means of budget control and this is very commonly used in all of the public hospitals. These are highlighted periodically in the press. You know, a good example was the Princess Alexandra

psychiatric unit over the Christmas/New Year period, which is a notorious time for people to have psychiatric illness, you know, breakdowns of their psychiatric illness, and because the unit was over budget, 12 psychiatric beds were closed at the PA until a fuss was made in the press. The operating theatres are closed for three weeks over the Christmas period. It used to be one week. The reason that's given out by management is the doctors are away. That's simply not true. Over Easter, other areas, you know, what used to be a couple of days' break now is often up to two weeks. So if you can cancel services, then you don't spend as much money when you are not treating people. It is cheaper to have empty theatres that aren't being used than it is to have working theatres.

Needing nurses and beds and-----?-- That's exactly right.

I see. And are VMOs-----

COMMISSIONER: Sorry, Mr Tait, I want to follow this up and I know Sir Llew does as well.

MR TAIT: Sorry.

COMMISSIONER: This is an area of great interest to us. Let's start with the example of Dr Patel, since, in a sense, he is the person who brought us here. We keep getting told that it is very hard to attract doctors to the Queensland public system and Dr Patel was, as I understand it from the documents I have seen, on a package of about 200,000 a year. We've also seen a doctor like Dr Miach who is obviously an extremely well qualified and competent medical specialist who has chosen to come to Queensland not for the money but for a sea change, for almost, one might say, a retirement position. If Queensland Health were to go into even the Australian market and say, "Look, we need a full-time surgeon at Bundaberg" - rather than offering one person $200,000, if they were offering four specialists $50,000 a year to practise two sessions a week at Bundaberg as specialist surgeons and make the rest of their income in the private market, surely there would be a better chance of attracting that calibre of specialist to a place like Bundaberg?-- Commissioner, you are almost correct. In a town like Bundaberg, I am not sure, the population is about 78,000 people. I think it would probably support two to three people in private practice, you know, with a VMO position and then probably one staff surgeon or probably two. And providing the VMOs helped out in the hospital, that would leave a one-in-three or one-in-four roster which would be liveable.

But it is really the supervision you need, isn't it? It is needing to have the VMOs in the hospital so that doctors like Dr Patel are having their work scrutinised by someone of a higher calibre?-- Again, that's partly true, but if Dr Patel was the Director of Surgery, a VMO would be answering to the Director of Surgery rather than the other way around. Could I branch out of my evidence, Commissioner? I have done some research as to how Dr Patel ended up in Bundaberg by speaking to the previous Director of Surgery and it is very pertinent

to what you have just said.

Yes, certainly?-- I didn't have - wasn't able to include it in my statement because I didn't finish the research till this morning. The story of how Dr Patel ended up in Bundaberg, in my view, is typical of what we believe to be some of the employment practices in Queensland Health. And I think, frankly, Commissioner, is a disgrace. Prior to 2001, Bundaberg Hospital had an Australian-trained surgeon who had given, in my view, and from all the research that I have been able to do, exceptionally good service to Bundaberg Hospital. He worked in Bundaberg Hospital for seven years as the Director of Surgery. For most of that time he was on a one-in-two. That means he was on every second night and every second weekend call for a district of 78,000 people. Country surgeons take everything. There is no neurosurgery unit. If someone comes in with head trauma, the general surgeon takes it, and they take all the road trauma, the farm and industrial trauma as well as the sick people in the community. They are very busy people. He frequently had no cover. The hospital didn't bring in locums when he went away. He found it very difficult to get away because of the sense of responsibility. There was no effort made to bring in other doctors from other hospitals on rotation to give him some relief. He had a great deal of difficulty with his housing, and it is my understanding - and I haven't spoken to him to confirm this - that he would have liked to have settled in Bundaberg, exactly as you suggest, and do private practice and come back to the hospital as a VMO but was told he couldn't do this and he is now working for the public sector at Logan Hospital as a very reputable surgeon. He was replaced by Dr Sam Baker who held the Director of Surgery position from 2001 to 2003. Dr Baker had aspirations to settle in Bundaberg as a VMO - sorry, as a private surgeon. He took the position there and worked again at Bundaberg Hospital. He was mostly working a one-in-two but was often working a one-in-one and he had frequent arguments with hospital management to advertise for another surgeon and they consistently failed to supply another surgeon to, you know, beef up the call and split the workload, and he was frequently the only surgeon again for that population of 78,000 people. He actually resigned his position three days before Country Cabinet in protest and actually then received quite a lot of pressure from the powers of Queensland Health to come back and stay on at Bundaberg Hospital. He then approached Bundaberg Hospital, having come back for a permanent VMO position or a quarter-time position so he could go into private practice in Bundaberg. Commissioner, this was a University of Queensland graduate, an Australian surgeon who wanted to be a country surgeon. He wanted to settle in the country and is now working in Townsville because he was driven out of Bundaberg, and he was told there was no place for him. That's how then Dr Patel was employed. Two Australian-trained surgeons were driven out of that city by the management of that hospital who didn't value their work, who didn't employ them properly, who didn't arrange relief or cover, and who simply had no concept of how important it was to keep surgeons in the country.

You mentioned Dr Baker's predecessor but you didn't give us the name. Do you feel at liberty to tell us that name?-- I was hesitant, just simply because Dr Baker has provided me with a very significant briefing in notes in relation to that doctor but I haven't personally spoken to him. He is not a member of the AMA, whereas Dr Baker is and authorised me to speak on his behalf. So I was hesitant to mention his name, Commissioner.

What I will ask you to do is to provide that name to counsel assisting?-- I will of course be happy to do that.

We will approach him directly and try and get a statement from him?-- Commissioner, the other thing that happened in relation to the research that I did with Dr Baker is that there was very, very clear evidence from Dr Baker's discussions with management that they actually very much understood at district manager level and at EDMS level the issues relating to the employment of senior medical officers, the needs for supervision, and they had a very good understanding of, deeming of specialists and Dr Baker has spoken at some length with me about that. He even, I understand, has taped records of conversations with the management. I found it extraordinary that Dr Baker took the precaution of taping meetings that he had with management within months of him being employed. That's quite an unusual step for a senior medical officer to have to do with a district manager.

D COMMISSIONER EDWARDS: Can I ask, Dr Molly, I take it then that you're suggesting there were less VMO positions made available and there were then more full-time but they weren't filled either?-- That's right. I understand also there was a confluence of events in Bundaberg around that time and that two surgeons who had given the town very good service were also getting to retirement age and, you know, as you approach those older practising years, you tend to avoid, like, to cut back on your after-hours work, and I think that's causing problems on the roster as well.

COMMISSIONER: We were told by Dr Miach that there are other specialists in Bundaberg but that their services either aren't used or aren't regularly used as VMOs. He mentioned, for example, Dr Brian Thiele, who I think he is a vascular surgeon. I think he mentioned Dr Pitre Anderson, who is a urologist, so that's in a different field, but it just strikes me as extraordinary that you have Australian-trained, highly qualified specialists there on the spot in Bundaberg and the hospital is not availing itself of their services?-- Yes. There will be a complexity of reasons for that. There is absolutely no doubt in my mind that Queensland Health has moved away from the VMO model to employing full-time staff specialists who are basically their employees and can be basically employed under the code of Queensland Health. There is no doubt that this is causing problems in provincial Queensland. You know, we're aware, for example, Mackay, where there used - I actually used to go and visit Mackay and operate in Mackay some years ago and I was impressed. At that

time it was an incredibly good medical town. There was a really strong interplay between the private sector and the public sector and even, you know, at the time I was there the anaesthetic practice, for example, which was three anaesthetists, they used to do one week apart in the public hospital. One would go and sit in the public hospital as a VMO all week and the other two would do the private work in the town and then they would all rotate around. There was such a healthy interplay and now my understanding in Mackay, that's all been destroyed with a divide between staff specialists and a private sector with very little interaction between the two.

D COMMISSIONER VIDER: Dr Molloy, you mention the difficulty of the rostering and the on-call and after-hours work. In the areas outside the metropolitan area are there sufficient doctors around to provide some sort of relief?-- No, there aren't. Although, you know, the situation could be better than it is. All of the provincial cities that I am aware of, possibly with the exception of Townsville and Cairns which have bigger regional hospitals, have significant problems with after-hours rostering, the problem being that you really need a one-in-three roster. One-in-two is a killer. And also that means you have got no capacity if someone is away or ill. So you really need at the very least a one-in-three roster and that's sometimes very difficult to organise.

Would you see the AMA having a role in that generally, as in through your membership if you were notified that there will be doctors on leave in country area A, B, C and D at this time in the year, that you could assist with some of that relief?-- Well, we actually do have a formal organisation called AMAQ services which does try to provide locum services, although that - in a more commercial sense rather than an altruistic sense. But we also have various publications that people advertise in and we also provide a forum for word of mouth. A little bit of this is done, you know, with word of mouth with people saying, "Hey, can you come up?", you know.

COMMISSIONER: Dr Molloy, dealing with this perception you have that Queensland Health is moving away from the use of VMOs, we've also received suggestions - and I can't put it any higher than that - that the scheduling system itself has been rejigged in a way that's unattractive to VMOs. So, for example, if a specialist surgeon from the Terrace goes to a public hospital to perform surgery, it used to be possible to start at 9 o'clock in the morning, as that surgeon would do at The Wesley, and work through until the list is finished, whether that's 4 o'clock or 6 o'clock or 10 o'clock, but now with public hospitals, the sessional periods have become so rigid that it becomes impractical for a surgeon to get through the list and it gets to the point where the next patient on the list is ready to be brought into the operating theatre and the surgeon is simply told, "Well, you won't get through this patient by midday so you can't even start."?-- That does happen, but Commissioner, this is just one small subsection of a system that has got a lot of quality problems. That's a quality issue, and it's one quality issue of multiple quality issues. That list might never have started because there aren't beds to put the patients in. Every morning at Royal Brisbane Hospital they have a Bed Committee Meeting at about 9 o'clock to decide how many patients they'll be actually able to operate on, and some will be sent home because there won't be beds for them. With the complexity of surgery being done, many of these patients now need an ICU bed or an HD - high dependency - bed which is one step down from an ICU bed to recover in. Royal Brisbane Hospital ICU turns away one admission a day. Very frequently that's an operative case. Very often at the hospitals there are access block where patients just simply can't be moved from the Emergency Department to a bed. So all of these issues relate to the quality of the system, and the VMOs don't really just not want to work in the system because their lists gets shortened or cancelled. That's part of it. It's because the total quality of the system is in decline, and it is very emotionally difficult for these doctors to be associated - be working in a poor quality system, and the divide between the private system and public system is becoming even greater, and so you come from The Wesley or Wickham Terrace to a hospital like Royal Brisbane, and the difference in quality gets to a point for many doctors where I believe it's distressing, and doctors leave the system partly of their own volition because they see the compromises in care that are occurring and, you know, sending someone home when they need an operation is simply compromised care, or, you know, sometimes they're encouraged to leave by - and administrations have a number of ways. Mackay Hospital, I understand, managed to lose its surgical VMOs simply by refusing to put an extra nurse on on Saturdays. So that meant when there was a string of cases to be done by the visiting surgeon as emergencies, one nurse had to unscrub, when she unscrubbed then had to completely recover the patient in recovery, then go and set up a theatre for the next case, and it meant that the surgeons on their Saturdays and Sundays that they were covering the public hospital had to sit around for hours between a case, and they put in repeated representations, I understand, to the hospital management about this, and the hospital management knew that they would

leave if that wasn't changed, and they did nothing to put that extra nurse on to keep those surgeons working in the public system.

Doctor, you refer to the fact that specialists feel a loss of heart almost because the circumstances aren't satisfactory. Again one of the suggestions we've had is that specialists feel disheartened in another sense in that they go for their sessions at major public hospitals and they know that there are lists of people - I won't say waiting lists because they're the people who haven't been able to get on the waiting list - there are lists of people wanting to have the initial consultation so that they can get on a waiting list, but hospital management isn't allowing them even to see the specialist, even though the specialist has time or is prepared to stay back after hours to see them?-- Well, waiting lists are a problem, and the waiting lists for the waiting lists - I mean, there are two hidden waiting lists in Queensland. One is the waiting list to be seen at outpatients before you can go on to an operative waiting list, and for many of the hospitals now patients are just receiving a letter saying that, "Your request for an outpatient appointment has been noted and you will be notified in due course", and for some of the specialties that could be up to an eight year eight.

D COMMISSIONER EDWARDS: Eight years?

COMMISSIONER: Eight years?-- For some of the subspecialties such as ear, nose and throat it can be up to eight years. Four years is common. For example, orthopaedic outpatients at PA, orthopaedics in Nambour, that's somewhere between four and five years to get an appointment.

And you've actually seen these letters to go to the patients?-- Commissioners, the letters are a matter of public record. They've been written into Hansard and Parliament and they've been extensively published in the press. I'm sorry, I lost my place. I was developing a theme.

No, let Mr Tait continue anyway.

MR TAIT: Just dealing with that, is that four years to get on the waiting list or, when you're on the waiting list, four years to be seen?-- That's four years to get your first appointment as an outpatient to be assessed by a specialist. After that, if it's determined that you need an operation and you consent to that, you will then be put on the waiting list. That's what's measured. That's what I was going to say. The other waiting list for the waiting list is that a large number of important procedures have what I call entry procedures. For example, if you're going to have bowel surgery, you usually need an endoscopy - a tube down your throat or up your bottom - or if you're going to have heart surgery you need a catheter study to look at the vessel disease in your heart. So the entry points for those - the waiting lists for those procedures, because they're not called operations, isn't measured. So they often have quite long waiting lists, but you don't measure those. You only - once that procedure has

been done and the patient's level of disease has been determined and they're actually put on the operative waiting list, that's when the measurement starts. So what happens is that you create access block to control your major operating over here, you create access block here with the entry procedures, but you don't measure that.

COMMISSIONER: Doctor, I have to admit I'm probably getting out of my depth here, but I would have thought that nobody in the world has bowel surgery unless they need it. How can it possibly be the case in Queensland that we've got people waiting years for bowel surgery, which presumably they need?-- Well, I guess using a clinical example - you have to remember that bowel surgery is somewhat removed from my specialty - a patient - there are multiple causes of, say, bleeding from your back passage. Colonic carcinoma is one of our most important cancers, but there are multiple reasons you may bleed, including a cancer, but it could be something as simple as haemorrhoids. So a general practitioner will try to send a patient to a public hospital to have a colonoscopy to find out if they need that bowel surgery or they need treatment for cancer. But the waiting lists for colonoscopies in many areas, particularly provincial areas, can be huge, and so, you know, there are a certain number of patients whose cancers aren't treated or become advanced. There are risk assessments when the referrals come in to try to assess - there are risk assessments to try and say, "Well, that patient's more likely to have cancer and this one's less likely and we'll do this one first", but it's very difficult to pick that off a GP's letter.

D COMMISSIONER EDWARDS: This is common throughout the whole of the state in the health system?-- That's my understanding, that particular example that I've used. I have spoken to general practitioners in - extensively in South-East Queensland and I know that to be the case. For example, the last time I spoke at a meeting at the Gold Coast I spoke to GPs about this specific example and their view was that they actually now try to encourage the patients to go to the private sector to have that procedure done because there are relatively cheap procedural clinics for having colonoscopies in the private sector and they don't even actually bother to send their patients to the public sector, and that's increasingly happening. The truth is that if you talk to the general practitioners around town, frequently they don't send their patients to the public hospital because they know they're not going to get an appointment

COMMISSIONER: I may be mistaken about this, and no doubt Mr Farr will ultimately correct me if I am wrong, but I'm of the impression that Queensland Health spends a lot of money telling the public that they should be checked for the common cancers - breast cancers, bowel cancers, that sort of thing. It seems bizarre to spend money telling people you should be checked, but when a GP refers you to be checked you're put on a waiting list?-- Commissioner, we do have a significant resourcing problem in Queensland. I apologise for not attaching it to my statement, and it probably reflects the

fact I was a little less organised for this than I intended to be, but when the AMA presented an audit of Queensland Health spending in February, we did put out a two page brief which I have brought 15 copies of. It basically runs through the problems - the resourcing problems that we have in the Queensland public health sector, and the fact is that the Productivity Commission says that we spend less per head of population in Queensland than in any other state, and that lapse in spending per head is between two and $300. That amounts to $700 million of current spending per year. That's year after year. That's last year and the year before and the year before that. We have the highest readmission rate to hospital. We have the lowest spending on aged care. We have the lowest spending on indigenous health. We way and above have the lowest spending on mental health. We have the lowest number of aged care places being approved of any state in the country, and basically this is a two page brief, which you're welcome to take, and the data has not been collected by the AMAQ, just simply collated from the Australian Institute of Health and Welfare and the National Productivity Commission.

I think I led you down a sidetrack. You were telling us about your recent discoveries regarding how Dr Patel came to be at Bundaberg. Have you finish the discussion on that?-- I think so, sir.

Yes. Mr Tait?

MR TAIT: Thank you, Commissioner. Just to take it one-----

COMMISSIONER: I'm sorry, Mr Tait. The document that Dr Molloy mentioned, I'd like to receive that, and I think we'll probably make it an exhibit, but would someone be kind enough to bring up three copies for the members of the bench in any event? The AMA document headed "The State of Queensland's Health" dated 28 February 2005 will become Exhibit 35.

ADMITTED AND MARKED "EXHIBIT 35"

MR TAIT: Thank you, Commissioner. Doctor, just to take up one point the Commissioner raised about the advertising for people to have cancers investigated, the people who go to the public hospital wanting to have some sort of an investigation, they've already been assessed by their GP and the GP has decided there are sufficient signs and symptoms to warrant an investigation?-- That's correct. Apart from breast screening - and I must compliment Queensland Health on its breast screening project. I think that the breast screening project Queensland Health has is a very good one. There's very little screening done in the public health sector. Some ill - or potentially ill people go to the public health sector. Screening is mostly done in the private sector.

So the step is you see your GP with signs and symptoms, the GP refers you to a hospital, and then the hospital - you'll go along with your referral letter and the hospital writes back saying, "Your application has been noted. You will be told when you can see a specialist."?-- That's correct.

The specialist then sees the potential patient who - at this stage they're not on a waiting list - sees the potential patient and says, "Yes, I agree with the GP. You need a colonoscopy", they're still not on a waiting list. They might wait months or longer to have the colonoscopy. When they have the colonoscopy and the gastroenterologist or whatever says, "Yes, there is a problem", then they're put on the waiting list?-- That's correct.

And then that waiting list can be years?-- Yes. But in fairness also to Queensland Health, a GP could say, "I've got a patient who's got bleeding. I've done a digital examination. I'm sure that this patient has a cancer and I believe this patient should be seen immediately", and there are mechanisms in the Queensland Health system for genuinely seeing sick diagnosed patients quickly, and of course that - being fair to the system - reaches its zenith in the A & E Department. The Queensland public hospital system, some of their A & E Departments is the treatment of choice if you have, for example, a major vehicle accident or something like that. You can get instant care at a very high level.

And see very highly skilled specialists in an Accident and Emergency?-- That's exactly right. So, you know, part of the problem that we're struggling with in a more philosophical sense is trying to define the roles of the public hospital. In a political sense, we've been told that the public hospitals are everything to everyone, but in a realistic sense they're becoming increasingly acute centres as far as the management of acute trauma. This is particularly so, for example, at Royal Brisbane where the Orthopaedics Department has very, very serious problems because of the large amount of trauma in its case mix, and the management of the very ill, and we have a dichotomy between the service being offered and the political presentation of what the public health system has to offer.

Thank you. I wanted to go, please, to the bottom of page 4 of your statement, "The pathway of IMGs into the Queensland workforce is more problematic", and you refer to the AMA submission, and then on the next page you say there are a number of problems in relation to the assessment and introduction of international medical graduates into the Queensland medical workforce. First is there's no equivalence table of medical schools. I understand Mr O'Dempsey may have given some evidence about this earlier today. Just tell us briefly your understanding of the problem. We don't want to go over - waste time on grounds Mr O'Dempsey covered?-- Well, the simple problem is that not all medical schools are created equally, and one has to balance that against a level of intellectual snobbishness, if you like, and also, you know, a level of political correctness and, you know, this has been

partly a difficult subject. It's discussed because if you imply that perhaps some medical schools from third world countries don't have an equivalent degree to University of Queensland, you know, the racially correct nature of your statement or whatever is questioned, but the truth is-----

COMMISSIONER: Well, Dr Molloy, I don't think anyone here is concerned about political correctness when it comes to the standard of health in Queensland, and the fact, as we all know, is that people from many parts of the world, particularly our neighbours in Asia, send their children to be educated in Queensland universities in other faculties - in business, in law, in commerce, in computer technologies and sciences and so on. It just seems extraordinary to me what we heard a couple of hours ago from Mr O'Dempsey, that Queensland Health is recruiting doctors from Cuba. It's mind boggling from two viewpoints. One is Cuba probably needs all the doctors they've got. Two is why shouldn't a healthy country like Australia be able to educate our own doctors rather than importing them from Cuba?-- Well, I think those are very prescient points, Commissioner. It's interesting you mention Cuba. I mean, we are aware that there's been a batch of applications from a recruitment agency that specialises in Cuba at the Medical Board. I actually looked up the Cuban medical schools through the International Education Directory from the ECFMG site of the - in the United States. There are actually 16 medical schools in Cuba, but the actual site in the United States that keeps the directory of all medical schools and is going to provide the screening actually only has addresses for two of them. It has them in cities. They actually have no contact addresses, no telephone numbers, no websites. It is a major level of concern, and I don't think it's a case of intellectual superiority worrying as to whether a Cuban medical degree is equivalent to a University of Queensland degree.

MR TAIT: How many medical schools are there in Australia?-- I'm sorry, I'll have to think about that for a moment. They're proliferating at a rate of knots.

Compared with the 16 in Cuba? Many more?-- There'd be probably 14 or 15.

About the same number as Cuba?-- Yes. The population of Cuba is 11 million people.

D COMMISSIONER EDWARDS: A bit higher standard though, I hope, than Cuba?-- The other thing is that there's a three to five year entry/exit visa delay on a doctor leaving Cuba. So in other words, they try to keep their medical workforce there, and some of the African countries are doing that, not unreasonably. There was a major conference in Cairo a couple of years where it was pointed out, as you said, how immoral it was for the first world or the second world to be stealing third world doctors simply because they had stronger currencies and could afford to pay more, and so quite a few countries have actually put exit requirements on their doctors in return for their training. But you know, you also worry

about who is allowed to leave.

COMMISSIONER: Yes.

MR TAIT: All right. You were dealing with the problem of the equivalence table, and you say on page 5 that there's no check done, as you understand it, as to what the degree comprises and how people have done in their degree?-- That's correct. There are two partial solutions to this, the IELD - the International Education something Directory - the ECFMG - that's the Educational Commission for Foreign Medical Graduates - in the United States is, I understand, starting to put this work together, and I also understand that there's a federal government taskforce which will at least define good quality medical schools that everyone is comfortable with, and these people can be fasttracked into the Australian system.

You were talking about VMOs, the VMOs are predominantly specialists?-- Yes, although there are small - yes, there are small areas where a VMO may be a GP working in a particular GP capacity in a hospital.

In Accident & Emergency or as-----?-- That's correct.

-----something like that in a small town. You were talking about the difficulty with the VMOs and the specialist accreditation. To be a specialist such as the specialists you spoke about in Bundaberg, those specialists have accreditation from their respective colleges or fellowships of the college or admission to the college?-- That's correct.

And the college then accredits them and they are registered as a specialist in Queensland?-- That's correct.

So all VMOs in private practice - with the exception of a small number of general practitioners of whom you spoke - will be registered as specialists in Queensland?-- That's correct.

But the specialists VMOs, when they are replaced by a staff specialist, that staff specialist need not himself be a registered specialist?-- That's correct. They may or may not be.

Now, we have a system-----?-- Can I go back one step?

Certainly?-- If they're actually - their pay classification is a staff specialist, they will be a registered specialist or deemed-----

COMMISSIONER: Or a deemed specialist?-- Or a deemed specialist. If they're doing specialist work they will be in the classification of an SMO, a senior medical officer.

D COMMISSIONER VIDER: But a non-overseas trained doctor as a staff specialist would probably belong to one of the colleges?-- Yes, I couldn't imagine that not being the case. I've never heard of that not being the case.

D COMMISSIONER EDWARDS: You say in your statement that although they are not awarded a fellowship by the college, they are deemed. So they could not - may not necessarily have college equivalent degrees?-- Just slightly at cross-purposes, Commissioner. For an Australian graduate - I couldn't imagine an Australian graduate working both doing specialist work and designated as a staff specialist who didn't have an Australian qualification. If you go back to overseas trained doctors, there are three possibilities for those doctors to work as a specialist in Australia. The possibility one is that they have an equivalent degree and a CV that allows them to be given a fellowship by the college. They are therefore exactly the same as any Australian trained specialist and they have a fellowship of their college.

COMMISSIONER: You'd expect, for example, an oversees trained doctor coming from the UK to have little difficulty getting admitted to the relevant college?-- Well, it depends. For example, a Fellow of the Royal College of Surgeons, that's actually quite a low level exam, the FRCS, in that you do it soon after you start your training and it's an academic exam that gives no guarantee of practical competence, whereas an FRACS - Fellow of the Royal Australasian College of Surgeons - is only awarded when you complete six years of training, and it includes a component of guaranteeing practical competence with your hands.

I really meant just in general terms if someone has been a consultant specialist in a UK hospital, then that person is likely to qualify automatically for the Australian college?-- That's correct, yes.

The second alternative you were going to mention is the deemed specialist?-- Is the deemed specialist, and then the third alternative is that they do specialist work in a public hospital as an SMO, but they have not been deemed - their specialty qualifications have not been run by a college, they're just used to do specialty work.

That's the one that interests me for the moment, because we have here the evidence of Dr Patel being put in a position of Director of Surgery even though he wasn't either a specialist or a deemed specialist. Is it conceivable that an Australian trained doctor employed as an SMO would be made Director of Surgery without specialist qualifications?-- I honestly couldn't imagine that happening.

It almost seems as if there's some sort of reverse discrimination here, that unqualified overseas trained doctors are being given opportunities that an Australian trained doctor couldn't have?-- I really can't understand the employment thinking behind this, and - I simply can't understand the employment thinking behind it.

MR TAIT: The particular position where you will have an overseas trained doctor working as an SMO is only if it's been declared in an Area of Need?-- That is correct, but that's also correct for a deemed specialist as well.

Yes. The area - as we've heard from - or seen in the Queensland Health submission, the entire Queensland Health system has been declared an Area of Need?-- That's correct.

When did that happen?-- I'm not sure, Mr Tait. I understand it was in the last 12 months, but I'm not sure of the answer to that.

So the Director of Neurosurgery at Royal Brisbane Hospital need not be a neurosurgeon in theory?-- In theory, yes. I couldn't imagine it happening in practice.

COMMISSIONER: But then the people of Bundaberg probably couldn't imagine having the chief surgeon at Bundaberg Hospital being someone who is not a surgeon?-- Well, that's correct, and it comes back to the difference from doing work as a surgeon and being a qualified surgeon.

Yes?-- Or may I say, an Australian qualified surgeon.

Well, that's one aspect to it. As I understand the law - and I stand to be corrected on this - any registered doctor in Queensland can perform any sort of surgery he or she chooses. Sir Llew could theoretically perform a heart transplant tomorrow, but would be far too sensible to try because that's not his area of expertise.

D COMMISSIONER EDWARDS: Very theoretical, Commissioner.

COMMISSIONER: The difficulty, as I see it, is not merely that people are performing duties in that position, but they're being either directly or implicitly held out to the public as being qualified specialists when they're not?-- Yes, this is a constant problem, that part of the spin that occurs is that - and I don't know if this happened in Bundaberg, but I certainly know that it's, for example, happened in Rockhampton, and it did happen in Hervey Bay, I'm reliably informed - is that a new SMO is employed by the hospital and there will be a press release saying, "We've got a new orthopaedic specialist in town", as it happened in Hervey Bay, or I recently had some good-natured argy-bargy with a local member for Rockhampton who had supplied figures to the press about the number of specialists working in Rockhampton, and in fact many of these were SMOs or - not many, a number of these were SMOs, not specialists.

As presently advised, I don't think it is even good enough to be very careful in the language you use. You know, it wouldn't, to my mind, be sufficient for the Bundaberg Hospital to be careful to say that this man is our Director of Surgery without saying he is a specialist surgeon. I would have thought, and I would be interested to know, how many of these hundreds of patients we have heard about from Bundaberg were actually told, "The man that is operating on you is not a specialist, is not a surgeon."?-- I would imagine very few, but, Commissioner, that's speculation. I wasn't there.

Yes, Mr Tait?

MR TAIT: So, have you known for some time that a Director of Surgery in Queensland may not be a surgeon?-- We have understood the system for some time that people doing specialist work are not the specialist they are held out to be. I-----

Sorry, the Medical Board prosecutes general practitioners for calling themselves cosmetic surgeons - I saw the Court next door where it was prosecuted and fined - but a man who has got no surgery qualifications sufficient to register himself as a specialist is allowed to be called a Director of Surgery?-- Yes, and that's wrong.

COMMISSIONER: I assume this isn't limited to surgery. There are people running psychiatric units who aren't psychiatrists and people running ear, nose and throat practices in Queensland Health hospitals who aren't ear, nose and throat specialists, and so on?-- Yes, and there seems to be a very significant number of people working, particularly in regional areas, as SMOs who are held out to be specialists - qualified specialists, but they are not.

D COMMISSIONER EDWARDS: And would be deemed to be specialists?-- No.

Not necessarily deemed?-- Commissioner, would it help if I ran you through the deeming process?

COMMISSIONER: Yes?-- Mr Tait seemed to think that there was some difficulty with that. May I refer - I again apologise for my lack of organisation, but there is actually a deeming book that you may like to take possession of. I can get other copies. But this is the official deeming book put out by the Australian Medical Council, the committee and presidents of medical colleges, the state and territory Medical Boards and the Commonwealth Department of Health and Ageing, and you are welcome to it. You don't have to read it all. The first three pages have the deeming process set out in living colour and you are welcome to it if it is a useful exhibit.

You can spare it?-- You are welcome to it.

Thank you very much. I will deem that to be Exhibit 36.

ADMITTED AND MARKED "EXHIBIT 36"

WITNESS: The deeming process, I believe, is fundamentally a good one in that it allows people who are working - and to take the Commissioner's example, a surgeon in England who is working at the level of a specialist - to have their work assessed for full registration or full fellowship with their college, and, as such, it will be used as a good process. The process is a doctor who comes in as a deemed specialist, through perhaps a recruiting agency or off their own bat, will have their job assessed as an area of need position and will then run their qualifications past three people: first of all, the Australian Medical Council, and then they will present their CV and their qualifications to the relevant college. The relevant college will then assess what competence that specialist has in their view, and if they are - and depending on their level of satisfaction with those qualifications, they will then say to the Medical Board, "We accept that this doctor can work as a surgeon or anaesthetist or a physician", or whatever, "in a specialist capacity with these limitations under this level of supervision.", and the rider is that the intention is then that this doctor gets themselves up to speed and is given or is awarded a full fellowship of the college; in other words, they become a full specialist, a properly qualified specialist, but they are able to work at the level they have been used to whilst they are either studying or they are being mentored and, perhaps, assessed. So, what the college might say is, "Look, we are 99 per cent happy with this doctor, but we would like to see them operate for six or 12 months under supervision before we award them a full fellowship."

D COMMISSIONER VIDER: And where doctors come in under that system, does it work?-- Yes, it is a good system.

The assessment has gone on at the college?-- Because the people have been assessed by the AMC, the colleges, they are put into a supervised position. Because it is nearly always a supervised position, there are reports back to the Medical Board and reports back to the college and the intention is always eventually for this person to get the full fellowship either by doing more study and sitting an Australian examination, or their work is at a very high level and perhaps once it has been assessed in a practical sense over perhaps a six or 12 month period - or there may be a certain skills shortage they have that an Australian specialist might have, and they will be specifically given a six month term perhaps in a hospital to bring them up to that standard. So, it is a very good system of creating new specialists in a very open and transparent way. But the problem is, and the problem with Dr Patel was that he was never deemed, and the deeming process is a strong one and should be supported, but the other process where you simply bring someone in to do specialist work in an undeemed capacity is open to abuse.

D COMMISSIONER EDWARDS: You say somewhere in your statement, if I recall, that Queensland Health avoids - likes to avoid deeming processes?-- There are a number of advantages in Queensland Health in terms of avoiding the deeming process; one is the lack of complexity. You know, shuffling paperwork between the college and getting the college - and the colleges are hard task masters. There are a lot of doctors they won't tick off, so you are more certain to get your applicants through if you don't go through a deeming process because you don't have the hard-nosed colleges knocking them back. The second thing that happens is that when they come into that capacity, until very recently, they had workforce mobility within that area of need. I mean, we saw that with Dr Patel. He came in as an SMO and was Director before we knew it. The third thing is that if you look at the pay scales, the pay scales of an SMO are very flat. There is only three pay scales, and there are something like I think about seven for staff specialists, and the pay scales for SMOs are about $10,000 less than for staff specialists, so there is a very, very significant saving if you avoid the deeming process because you are still getting the specialists work out of that person at a much lower price.

D COMMISSIONER VIDER: Where a doctor comes in under the deeming process, if that doctor was to go and work in, say, a provincial centre in Queensland, is there enough specialists there from the various colleges to provide adequate supervision?-- There may or there may not be. It would depend on the relationship, it would depend who the Director is. I mean, the implication is that it will nearly always be under supervision.

And the college continues to monitor that?-- That's correct, because if you didn't need to be deemed as a specialist, you could, after all, be a specialist, and there will be people who come in with fantastic CVs to be professors or something and they will be awarded a full fellowship of their college because they are very, very good doctors.

COMMISSIONER: Just going back to the three reasons you identified why Queensland Health might not like the deeming process, it strikes me that Deputy Commissioner Vider has really identified the fourth reason and that is the supervision requirement. If Dr Patel had been brought into Queensland as a deemed specialist, not only would he have had to be paid more, but he would have had to be supervised?-- That's correct, and, of course, there was no Director of Surgery at Bundaberg at the time that Dr Patel was employed or started work. The other reason, following on from Commissioner Vider's, is that Queensland Health has a poor reputation for ongoing medical education. One of the really big problems I have with these SMOs is that, as a specialist, I have a very rigid continuing CME program - continuing medical education program - and I have to get a number of points every three years in different categories to recertify as a specialist - by the meetings I attend, papers I write and all of those things - and that goes for nearly every

specialist in this country. All of the colleges have these. Now, we have a specialist workforce that doesn't have any formal CME process out there, and Queensland Health is a very difficult employer in terms of giving people study leave, examination leave or professional development leave, and when you don't have the deemed specialists who, almost by definition, are in the process of upskilling to that full degree, they are going to need time off for that study, attend meeting or pre-exam courses, or whatever, and so that's another incentive not to employ them.

But it then produces that extraordinary situation where the people who most need the continuing medical education are the ones who are not at least required or guaranteed to get it, namely the SMOs who are performing specialist functions?-- That's right. Although, to be fair, Commissioner, it is not impossible, it is just difficult. I'm sure there are many SMOs around Queensland who do get to go to courses and conferences; it is just harder.

But the real concern is that the Director of Surgery at Royal Brisbane, who is undoubtedly one of the top specialists in the country, possibly the southern hemisphere, is obliged by his college to do continuing medical education, whereas Dr Patel, because he's not a specialist or deemed specialist, it is entirely up to him whether or not he does any further continuing education?-- That's correct.

MR TAIT: And a general practitioner in the suburbs also has to do continuing medical education to keep register?-- That's right. Nearly every college that I'm aware of has formal recertification programs for their specialists, and I was including GPs as specialists in family practice.

I see. Commissioner, I have the payrates which Dr Molloy spoke of for VMOs and staff specialists. I tender that. I hand up three copies.

COMMISSIONER: Thank you, Mr Tait. Dr Molloy, I know you have only been here for an hour and a half, but we have been going since 2.15, so I think we might take a dinner break if that suits everyone. Until 7 o'clock. Is that convenient?

MR TAIT: Thank you.

COMMISSIONER: The pay rate scale that's just been tendered, "The Medical Salaries, Sessional Rates, Fees and Conditions - Public Sector" will be received into evidence and marked as Exhibit 37 and we will now adjourn until 7 p.m..

ADMITTED AND MARKED "EXHIBIT 37"

THE COMMISSION ADJOURNED AT 5.58 P.M. TILL 7 P.M.

THE COMMISSION RESUMED AT 7.03 P.M.

DAVID MOLLOY, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Tait?

MR BODDICE: Thank you, Commissioner. Doctor, if I can take you to page 7 of your statement, the paragraph proceeds at the bottom of the page, "Queensland needs to import doctors because of the local workforce shortage contributed by a series of poor decisions by the Federal Government in the late 1980s. The Federal Government restricted the number of medical school places and restricted the number of provider numbers." Then you deal with a number of other particular problems that affect Queensland with that shortage of doctors: the first, "Queensland Health is chronically short of doctors because there is an international shortage of doctors."?-- That's correct.

Can we deal then - go on, please, "We are competing on an international market base for doctors offering salaries in Australian dollars rather than stronger currencies."?-- That's also correct.

And you dealt then with the pay rates?-- That's correct.

Next, "Queensland Health is the worst paying government in Australia."?-- That's correct.

Then the low purchasing power in the international medical market. Why is that?-- Well, with the international shortage, for example, the EEC is introducing a safe hours policy where they have mandated that no doctor will work more than 45 hours in a week and you will have to keep a log book and stop working - a little bit like a truck driver - once you work 45 hours, and that's caused a big shortage of doctors as countries start to need to plan for the workforce needed to take up that shortfall, and that's one of the reasons Tony Blair put 2 million extra pounds into the health system in the last couple of years, and part of that is for medical salaries to purchase doctors on the international market in English pounds.

COMMISSIONER: I understand, though, that Mr Blair didn't give his 2 million pounds to buy too many more doctors?-- That's true, and also interestingly, Commissioner, the productivity of the international health system only went up about 3 per cent and most of that money was actually consumed in new layers of bureaucracy.

When you mentioned it a few moments ago that Queensland is the lowest paying state in - state or territory, I think you said, in terms of salaries-----?-- That's correct.

-----is that across all grades and categories?-- It is true for all staff specialists at all levels. The submitted pay rates don't look that bad, but, in fact, the pay rates in Queensland are based on a 45 hour week and every other state, they are on a 40 hour week, and also in Queensland you don't get a lunch hour. So, it is actually a nominal 50 hour week, but the actual values of the dollars are lower than every other state, but then they are even worse because it is a nominal 40 to 50 hour week.

Comparing wages is often difficult because one has to take into account salary packages, a car and accommodation or - are the comparisons you are talking about - does that take into account the full value of a package rather than-----?-- No, it doesn't, Commissioner. That's the base salary. But when you take into account the base - what they call the "grossed up package", that's a double-edged sword. Queensland is still much worse off. If I might introduce a piece of anecdotal evidence, I've actually tried to get this out and find it for you but we ran out of - we just ran out of time, but there was recently an advertisement for an anaesthetist to work for Queensland Health - you are aware of the shortage we have, particularly at the Royal - and one in Bendigo in Victoria and they were side by side and the difference for the same positions was nearly $200,000 in the grossed up packages. It was about $400,000 versus $200,000, and the - but also the grossing-up causes some problems, in that the doctors are offered grossed-up packages in the advertisements and when they apply to the advertisements, they find that the base salary is down around the 110 to 120 mark, and there are things included such as the value of the car or the mobile phone, or also included in it is their nominal indemnity cover, grossed up at private practice rates for - but really they are all covered by Queensland Public Health, but there's a sort of component put in there as if they were in private practice, and several doctors have told me that, you know, that first contact in finding out what the real salary was as opposed to what they read in the advertisements, it is not a good first contact with Queensland Health either.

I don't want to cause anyone any embarrassment, but can you offer us some sort of comparison with the private sector with, as I mentioned earlier, Dr Patel's package, I think, was about $200,000, although that was a salary component, I think, of 110 and all sorts of other add-ons?-- That's right.

How would that compare with a surgeon in private practice?-- Well, it would probably be - it would not be half that. It would probably be more like a third.

Mmm?-- You know, a very competent surgeon - I'm not saying Dr Patel is competent - but a very competent surgeon in private practice, you know, could earn a salary of 450 to $500,000.

Yes. Yes, Mr Tait?

MR TAIT: On page 8, you deal with a number of problems. You

say many staff doctors regard their management as relatively poor - that's in Queensland Health. "Reports of bullying are common." And you talk about clinical autonomy being reduced?-- Yes.

Tell us a little about that?-- Well, you know, this is a recurring theme. I'm just trying to organise my thoughts for a moment. I guess if I could deal with the management issue first. Queensland Health has 64,000 employees. It has a large number of layers of management and doctors are very frustrated by those layers of management because the decision-making is becoming increasing devolved, and within those layers of management there are sublayers of management, because they all have assistants who are also part of the management structure and may make particular decisions, and so there is a lack of accountability in the management which, in my view, is poor in a clinical system and, at times, possibly down-right dangerous because there's a devolution of decision making and doctors are very frustrated because there's been a degree of medical disimpoundment in the system, and the line managers, they have to report to someone who has to report to someone else, and, for example, when they put in a business case, it disappears into what might seem a well-structured management, but that business case may never return or, if it returns with a "no" attached to it, they don't know who's made the decision. So, for example, they may put in a business case to do something in their units to improve patient care, they will give it to the Director of Medical Services, the Director of Medical Services will hand it on to the Assistant District Manager to give to the District Manager. The District Manager then wants to get some advice from the Executive Director of Corporate Services who manages the money. The Executive Director of Corporate Services says "no", but a second opinion might want to come from the-----

COURT REPORTER: Sorry, Dr Molloy, you get a second opinion from who?

WITNESS: Look, I'm lost even myself. From the Assistant's own manager. I apologise. From the assistant's own manager. I get agitated when I talk about this. From the Assistant's own manager, who then may make another decision, and then finally it will go back down through the ranks back to the doctor with, "No, we can't do this.", and, you know, you are talking about a plan to improve the care in your unit and you don't know who to go and negotiate with or who has made the decision, and it is - it is almost an unworkable system.

COMMISSIONER: Well, just following on from that, if I may, I see from your CV that it was about 25 years or 26 years ago that you were a resident at the Royal Brisbane Hospital?-- That's correct.

Have you noticed any change in the management structures within Queensland Health over that period of time?-- Well, yes. Yes, I mean, the most graphic illustration is that - you know, when I was a basic trainee at the Royal Brisbane Hospital as a very junior Registrar, the whole hospital, which

was actually doing more work than it is now, was run from one section - one tiny - one floor of one wing of the old Women's Hospital. Now, you know, that building has now been pulled down and replaced by that very modern building, but in my time there as a consultant and by the late '90s when I had very little to do with the public sector there, that simple management where you could always get a decision - you could wander in at any time and see the Director of Corporate Services or the Medical Superintendent - that management had been replaced by three storeys of the nursing home - the old nursing home where the new building is now standing - and now at Royal Brisbane Hospital the - when I was a resident there, the white building on the corner opposite the circular carpark, that, I think, has got floors to M, that used to be mostly wards and a casualty department; that's now all offices. So, you know, the bureaucracy has absolutely burgeoned in Queensland Health and-----

Am I right in thinking the number of beds at the hospital has actually dropped over that period?-- That's correct, Commissioner. When the new hospitals were built at PA and at Royal Brisbane, Brisbane lost nearly 650 beds.

Have they been made up somewhere? Is there-----?-- No, Commissioner, they haven't. And, indeed, it is not where - you see closed beds, unfunded beds at the Royal Brisbane Hospital despite the fact there may be access block. I understand there are 15 closed beds in the intensive care unit that turns away one patient each day. Now, you know, these are beds that exist but they are unfunded and they're - you know, they are not staffed. And on weekends when there can be quite serious access block, some of the wards are actually closed. So, you know, again it is a drive for budget control where, you know, it is this - the thing the AMA has been talking, and the media for the last three months, about budget compliance being a core focus of the business of Queensland Health is a very real phenomenon.

Dealing with the layers of administration that you are talking about and the need to deal with them, one anecdotal statistic we were given is the director of a unit within the Royal Brisbane has to go through some several tiers, five or six tiers of administration to get a decision from Director-General level. Are you able to comment on that?-- Well, yes. I mean, for example, as I understand it at the Royal Brisbane is that you may be, say, the Director of Orthopaedics or the Director of Surgery. Now they have just recently put a new tier above that and, in fact, that's caused a lot of problems because - I don't want to have the nursing union down on my head again, God forbid, but, you know, you were talking about the Chief of Surgery at Royal Brisbane being the best surgeon perhaps in the southern hemisphere. It is not a surgeon, it is a nurse. And so the executive Director of Surgical Services, a nurse, and then the answering then is to the group at the top which may be the Executive Director of Corporate Services and the Executive Director of Medical Services and the Director of Nursing, and then beyond that there is the assistants to the District Manager, and the District Manager, and then the District Manager answers to the assistant in the zonal management, zonal management system, and then you arrive at Charlotte Street and there are several layers at Charlotte Street.

Apart from the number of layers of administration that you have to work through - I am wondering if there is also a significance in the character of the layers of administration. If you go back to the days not so long ago when each hospital was presided over by a medical superintendent or even the situation which I think existed at the PA in the 1980s when you had a clinical nurse as the person in effective control of the entire hospital, does it make a difference to the doctor working in the hospital whether you are answering to a person who is a clinician rather than a person, whether or not they have medical qualifications who has no clinical practice?-- Well, it does make a difference to doctors, and I don't think it is a case of being elitist, it is just - I was saying to the Premier last night that doctors see themselves as leaders in the medical system - not the only leaders, but it is an important part of the leadership of the medical system. And to a certain extent or to a large extent in Queensland Health that's become disempowered in this devoluted management

structure, and the core business of a public hospital system should be about looking after sick patients, and the people who look after sick patients are doctors and nurses. You know, the ideal management structure is that where you have a supporting system to help that core business happen, and there are a lot of businesses and there are a lot of companies where the people who are providing the product and making the product - in this case health care - are supported in their role by the people who do the financial modelling. At the moment we have the financial controllers making the decisions over here. What should be happening is that there should be a line of decision making relating to patient care, and the corporate services that control the budgets should be actually supporting those people in their decision making. Now, that model actually does exist under fee for service in some of the hospitals. For example, I have spoken to doctors who are very happy in their work in Queensland Health and have set their units up in that way, where their competence has been recognised and they run their units and the function of their business managers is to give them support in that decision making.

I don't think anyone here would dispute for a moment that there is - there has been an increased need for administration within the hospital system over, say, the last quarter of a century because of Medicare and funding arrangements and the paperwork, and so on, but if one were restructuring the system, how would you like to see it operated at a hospital level?-- Well, I think what I would do is empower the directors of the departments to make decisions within their own department and then basically have a management triumvirate or duumvirate running the hospital, which would be the Director of Nursing, Executive Director of Medical Services and Corporate Services do the job they used to do in the past, which is basically provide the financial modelling so that those two people can make their budget decisions and that the directors report directly in a clinical line to those people. I would certainly get rid of the zones. I cannot see any function in the zones. In this inquiry, you know, here we have one of the biggest problems in Queensland's health history. Where were the zonal managers when all this was happening? I think the zones are a completely unnecessary layer of bureaucracy. The point is getting rid of them isn't going to do much. There is not that many, there is only three zones. So you are not lopping much dead wood off the tree. But - and, you know, there are really too many districts. There are 39 districts including the Mater Hospital, and some of the districts are tiny. You know, they're really just a hospital and a Maternal Child Welfare Services, something like that. They are really very small districts. So whether you need districts or regions, I am not sure. But, if so, they should have a coordinating role and, you know, it is very wrong that the people in the frontline running the hospitals are answering to a more remote person who is the district manager. And what that very blowsy structure creates is a structure that can't make a decision. So the whole impetus is to say "no" or "maybe" but hardly ever "yes". Yes has to be said at Charlotte Street. And then so what the whole impetus

becomes is to ways of delaying decisions, or workshopping decisions rather than making decisions. You know, "We'll set up a committee. You can be the head of the committee. Report back to me in six months. Even a year would be better, whatever." And that's very bad for clinical care. But also it is harmful because it consumes needed resources, and when you are putting your resources into talking about clinical care rather than giving clinical care, that's a harmful situation in the medical system.

Since I have distracted you down this track, could I ask another thing? Did you have experience of the operation of Queensland Health back in the days when there were Regional Hospital Boards and, as I understand it, almost all decision making in relation to a hospital was made at Regional Board level rather than Brisbane?-- Yes, I did, although, you know, I was only in the country for a - I worked in Townsville for a relatively short time. I am truly of two minds about hospital Boards for the city hospitals, which, you know, are large, complex, technologically-advanced institutions in big cities, and I am not sure that that's a defined management structure that will work for them now.

Yes?-- However, you know, I really do think that there is a case for those in regional centres because, you know, I think part of the problem in hospitals like Bundaberg is that the hospitals get out of touch with their communities. There was a lot of strength in having the hospital responsive to the community needs, and you had community leaders on hospital boards. Now, I think sometimes the system did go astray in that, you know, hospital boards used to get politically stacked and I think there honestly was evidence of that, I have been told, back in previous days. But-----

I think, if Sir Llew will forgive me for saying so, it is pretty common knowledge that in a lot of country areas in the 70s and 80s, the local hospital board was almost the mirror image of the local National Party organisation. But, you know, if one puts that sort of political influence to one side, my thought is that, again going back to Dr Patel who brought us here, if the hospital was being responsive to a local board and a local board was in charge, I imagine that with that local input they would have heard about the problems and reacted to them a lot more quickly than Charlotte Street could do?-- There is something to be said for that. The political answer to that is there are actually regional health councils in Queensland but they are a complete waste of time. They do nothing. And we mustn't let that distract the argument, I only mention it for that reason.

You are being a bit unfair. We have heard about the regional council in these proceedings and I know that the Chairman of the regional council in Bundaberg wrote a letter of commendation to Dr Patel four days after he left Australia. So you can't say they do nothing. But I haven't-----?-- May I requalify that to nothing very useful. So, Commissioner, I think a stronger local input in the regions - I mean, Townsville, Cairns, Mt Isa are a long way from Brisbane, and I

guess that was what the district management was supposed to do, is to provide that strong regional management. I don't believe the system is. Certainly, there are a lot of institutions - I mean, Australia's biggest companies and most successful companies are run by boards of competent citizens, and Queensland Health, I understand, is the largest institution in this country. You know, having a board of management at Queensland Health level may upset the traditional ministerial responsibility and public service structure but there may be something to be said for it. I think out at regional level, having hospitals more in touch with the community and, you know, sort of having community leaders drive their hospitals, and many of these people are business people who are very competent at driving their own businesses, I think the hospitals could truly benefit from that sort of management.

Sir Llew, did you want to-----

D COMMISSIONER EDWARDS: Are you really saying that there should be more power in the administration of the medical systems at regional hospital levels vested in the local community rather than, say, the medical director of that area or the nursing director, and so forth?-- No, Sir Llew, I think what I am saying is (1) there needs to be a collapse in the management structure so that, you know, a hospital say the size of Bundaberg, I can see a case for a Director of Surgery answering to a governing committee or directly to the Director of Medical Services. And then the next stop being, you know, a regional board, like in a company, and that's it. That's the management structure, and you get a decision or you don't get a decision. And financial modelling for improvement in your service is done by the corporate services section of the hospital for the EDMS and the DON. And if it is a big decision, it goes up to the Board and that's it. You have got a three-tiered management structure between people providing the health care and people making the final fiscal decision. At the moment it is 78 or 79.

In this case it appears, from some of the information being provided to us, that it was really the nurses at the workplace level who made the large noise about the competency of Dr Patel. How come, in your view, that such a situation can arise with - I have enormous respect for the nursing profession who do this kind of thing - why didn't the doctors around the place with this - who probably had greater influence in a system that we have, why didn't they make such a noise as the nurses who were caring for the patients?-- Commissioner, you know, I am not trying to cop out here, I wasn't in Bundaberg, and a lot of what I know about Bundaberg I have got secondhand or I have got you know from the newspapers. I have provided the Commission with evidence to say that the first person who piqued Dr Patel was a doctor. May I go into that, Commissioner?

COMMISSIONER: Certainly?-- I mean, I provided a letter to the Commission from Dr Peter Cook at the Mater Hospital. Dr Cooke is the Director of Intensive Care. Two months after

Dr Patel started work, Dr Cook wrote a letter to the Director of Medical Services of the Mater which was designed to be passed on to Southern Zone Management and then to Central Zone Management, raising concerns about Dr Patel's surgery and a patient who was transferred to Mater ICU two months after he started work. You know, the doctors were the first persons to raise the alarm two years - two months after Dr Patel started operating and nearly two years before anybody else did.

I think probably the difficulty that Sir Llew is identifying, though, is that you mentioned the case of Dr Cook at the Mater, and we have also had the evidence of Dr Miach in Bundaberg. Both of them tried to work within the system. It took someone, if I am permitted to say so, of the bravery of nurse Hoffman in Bundaberg to realise that working within the system wasn't solving the problem and she had to go outside the system. Is it perhaps that doctors are too conservative to fight the system?-- Yeah, it is an interesting question. I know personally Dr Cook. I know he won't mind my saying this - he is really - he is not a happy person that he went within the system and nothing was done, and I know that he has raised concerns about similar operations that were done at Hervey Bay, and this time he took a firmer stance that didn't necessarily include being totally within the system, and so I think - I think that there is a variety of, you know, effect by doctors when they are trying to judge quality issues within the system. I don't work in the public hospital system, but I know there are meetings and clinical audit meetings and things like that in most good hospitals. I don't believe that there were at Bundaberg, from what I have read. Also - I mean, there are doctors that consistently go outside the system and act in a similar way. I mean, I guess I refer to Dr Cook who initially worked within the system with Dr Patel. The Hervey Bay episode was brought up by the orthopaedic doctors in Brisbane picking up a string of complications, initially going inside the system but when no action was taken they went outside the system with the AMA's help and that's how the investigation into Hervey Bay occurred. The Maher report into cardiac deaths and the management of heart services was initiated by a staff specialist at Prince Charles Hospital, Dr Con Aroney, who has suffered immeasurable stress and bullying and harm, which I would suggest is probably greater than nurse Hoffman suffered, and has in fact lost his job at Prince Charles and has now had to go into full-time private practice. You know, whilst that is a secure career for him, he loved working as the Director of Coronary Care at Prince Charles and was responsible for many of the innovations that came into that hospital and keeping it at the leading edge of cardiac care. You know, so we do actually have a time-honoured tradition of doctors exposing problems within the system and, you know, we do have very, very strong evidence within our groups and our societies and our colleges of clinical audit and trying to make sure that the health system works well. Now, I would suggest, though, that everything I have been told is that it is very, very hard to buck the system in Queensland Health and, you know, I would be very happy to lead into evidence some of the cultural things that make it hard, I am sure, for nurses like Toni Hoffman and

also for doctors that I represent, to bring to the administration's attention deficiencies within Queensland Health.

In fact, I was going to ask you about that but I will just find out whether-----

D COMMISSIONER VIDER: No, I was going to ask the question that Sir Llew's asked.

COMMISSIONER: Yes, because you have referred in your report or in your statement to the poor reputation of Queensland Health, and there is the reference of reports of bullying being common. That's one thing that this inquiry has had a lot of trouble putting our finger on, because we keep hearing anecdotal references to bullying but no hard evidence. What can you tell us from your members' perspective about this phenomenon?-- Well, firstly, just in a general or generic sense, Commissioner, when - when the Premier announced your Commission and also Mr Forster's inquiry into the management structure of Queensland Health, I convene a group that the AMA works with called the Heads of Colleges in Queensland, and these are the heads of all the colleges, the local chairs, and some of them are national Presidents of colleges, like, for example, Russell Stitz is at the moment, and there is about 35 of the most senior doctors in the State that control the training positions in the State and the medical practice standards. Now, the colleges are all about standards. They are not medico-political organisations like the AMA but we work together, and we do their politics and they look after the standards and that's the basic split. Now, I called the heads of all these colleges together and I introduced them to Peter Forster and explained that the AMA was committed to working with Mr Forster to try and build a better health system, when this - you know, as a result of your work and the work of Mr Forster. And I was stunned, because one after another each of these senior doctors, most of whom either work in a staff capacity or VMO capacity in Queensland Health, got up and said that they felt that they would be scared to speak to him because of reprisals and what protection did he offer, and we have correspondence between Mr Forster and the AMA, our CEO, Kerri Gallagher, where we address this issue, asking what levels of protection will exist for doctors who try to help Mr Forster build a better health system. Now, I was stunned to see the heads of meds in Queensland scared of Queensland Health because, you know, I am not scared of Queensland Health and I have to negotiate with them many times but I have got the security of just working in private practice and, you know, my AMA work, well, we're trained up to do that. But, you know, this is something - there are sort of core incidents in your life that you carry with you, and this, to me - I just couldn't believe what was happening in this meeting. So I guess in a generic sense that's the first thing I can tell you. The second thing is that I can give you serious examples of bullying. Now, one of the most classic serious examples of bullying that I have seen is political bullying, in that the Minister and Mr Buckland - Dr Buckland taking the College of Pathologists to the ACCC. Now, that might be defended in all

sorts of clever ways as a political act but what this was was fundamentally an act of bullying. What had happened was the Queensland Health wanted to employ three pathologists in an Area of Need at the Royal Brisbane Hospital. The Royal Brisbane Hospital pathology department has been a shambles for a couple of years. Indeed, I saw today - there was a submission to the inquiry from the pathologists who work for Queensland Health Pathology Services. Now, these three pathologists came from south-east Asia, and in the view of the pathology college they were not up to standard. The pathology college put on a special exam in Sydney for two of these doctors and I am told that they failed miserably. Queensland Health wanted to still employ these doctors and, you know, the pathology college said no. It was after that that the Minister decided to take the Royal Australian College of Pathologists to the ACCC and that's what they were threatened with. Then at subsequent college meetings this example was trotted out to the other colleges of, you know, "Knock back our specialists and look how we've taken the College of Pathologists to the ACCC." Now, down in Wollongong there was a Dr Patel case two years ago. Didn't get much publicity - just shows how funny things can be - but an overseas-trained pathologist employed in Wollongong - case is well documented. He misread a large number of pathology slides. There were a number of patients who had unnecessary surgery for cancers that did not exist, they had bowel removed and things like that. This is all documented. The Royal Australian College of Pathologists had to put together a taskforce to re-do two years' work of this doctor. That's documented. It really happened. And Queensland Health, in the submission to your inquiry - I hope I am not doing anything wrong, preempting - the pathologists point out that there is, you know, now a doctor with no pathology qualifications working as a senior staff pathologist at Royal Brisbane Hospital. So this move to the ACCC, which I represented the college to the Premier was simply an act of bullying. It was really an act of political bullying. If you then move down a level, one of the better documented episodes of bullying that I have seen, you know, again at a fairly macro level, is Dr Ross Cartmill. He is a VMO at PA. He is Chairman of the VMO subcommittee of the AMA and he is also chair of the senior staff association at PA Hospital. The VMO negotiations are happening this year for the award rates for VMOs and Ross is fronting them. There was a lock-up at the north coast to try and do it all in a couple of days and one of the controversial things had been that Queensland Health, during the waiting list blitz, had flown up Victorian anaesthetists to do work in the hospitals as locum anaesthetists, but they wouldn't give that work to Queensland anaesthetists, and it was very significantly inflated pay rates. That had got up the nose pretty significantly of the doctors who work particularly at the PA. Ross, in the negotiations, simply said - he quoted the pay rate of these Victorian anaesthetists, and, also without mentioning any names or anything, had said that he had been told at PA that wasn't true, but he had seen a payslip and it was. That's all that happened in this negotiation. We had this documented because we had to get legal advice on his behalf. But a couple of days later, he got a call from the District Manager

at PA who threatened to sue him for defamation because he had brought up that she'd apparently misquoted the pay rates, and furthermore went on to say - and we have this documented in letters to our solicitors - that if he said anything bad about the hospital she would take that as a personal reflection on her management at the hospital and would sue him. Now, he is Chairman of the Staff Association, for goodness sake, you know.

What's the name of that manager at PA?-- Is it - can I ask my - is it Podbury?

Podbury?-- Yeah. The-----

Can I ask if you make arrangements for the relevant papers to be provided to counsel assisting - not immediately, just whenever is convenient?-- Sure. The AMA industrial officer - you know, we have this documented because the AMA industrial officer arranged legal advice for Dr Cartmill. We have - you know, there are other examples of doctors that have had very, very robust negotiations. I am not - I think that you might have received submissions from Dr Boeticher, who was the Director of Psychiatry at the Gold Coast Hospital, and his predecessor I think has also contacted the Commission about allegations of industrial bullying. Within the hospital system itself, we attend to, in our industrial division, quite a significant number of doctors who feel that they have had bullying episodes in relation to management and have had quite a large number of these documented. May I use my notes for a second?

Of course?-- I refer first of all to the Princess Alexandra Senior Medical Staff Association actually raised issues in relation to the Terms of Reference for the Forster Review. Their second sentence is, "The issue of an intimidatory culture within Queensland Health is a consistent theme being raised by many stakeholders in early discussions about the review." That came from the senior staff at PA. Dr Con Aroney is another high profile doctor who has been very public with the episodes of bullying that happened when he went public about the shortfalls in cardiac care at Prince Charles.

Sorry, Ms Kelly?

MS KELLY: Sorry, Mr Commissioner, I am reluctant to interrupt but I should advise the Commission that I act for Dr Con Aroney. He is one of the named persons who is on my list which will be forwarded to the Commission tomorrow.

COMMISSIONER: Which doctor is that?

MS KELLY: Dr Con Aroney. Dr Molloy has mentioned him in evidence.

COMMISSIONER: Yes.

MS KELLY: And his statement will be forwarded in the morning.

COMMISSIONER: All right. You have no objection to-----

MS KELLY: No, not at all.

WITNESS: I think what I am saying I think Con would be happy with-----

MS KELLY: Exactly.

WITNESS: The - I have paperwork from - we have represented, for example, the doctor at QEII Hospital who had a - had a patient cancelled for a liver biopsy and wrote and he was - the patient needed a lot of prep and had been brought into hospital specially, and it was cancelled because the one nurse who could help him apparently was unwell. He wrote in the chart that the nurse was unwell and the patient was cancelled, and wrote to the GF saying why the patient had been cancelled for such an important procedure. He was then hauled up before the hospital manager and was told that he might be put on a charge for writing in the notes that the nurse was unwell and violating her personal privacy.

Sorry, I've brought all of these cases. Dr John Blackford has given me permission to use this. He was a VMO in vascular surgery for 20 years at the Royal Brisbane. He has worked a one-in-four roster there all of his life. He asked for some leave and was threatened with dismissal if he kept pushing his application to go on conference leave because of the shortage of vascular surgeons at the Royal, having worked there for 20 years. I understand he's since resigned, leaving the hospital relatively short of vascular surgeons. Dr Giblin and Dr North who did the report into Hervey Bay have, you know, had a level of pressure applied to them in terms of that report.

COMMISSIONER: I'm glad you mention that because it's been pointed out to me that although that report has been admitted into evidence, it hasn't been given an exhibit number, so since it's been raised, we'll call that Exhibit 38.

ADMITTED AND MARKED "EXHIBIT 38"

COMMISSIONER: Do you have any more details about the pressure applied to Dr Giblin and Dr North?-- Well - sorry, Commissioner, I'll just go back in my notes. Well, there was a copy of a letter from Dr Buckland to Dr North. "I note there's no hard evidence to support your recommendations...want an urgent meeting...I would like to personally sight the documentation that was used to prepare your report", and my understanding is that there was quite a lot of pressure applied to the Orthopaedic Association, particularly in terms of whether there would be indemnity for the review. So, you know, those are probably matters you yourself may do better exploring, Commissioner, but I draw them to your attention, if I may.

Yes?-- So, you know, our industrial department has managed a very significant number of bullying complaints which in themselves - I've got a list of them there - seem relatively petty, but there's basically this culture that's reported to me by nearly all the doctors who work there, of, you know, this attitude within Queensland Health.

Mr Tait, that was a fairly lengthy interruption. Do you want to take over from there?

MR TAIT: Thank you very much, Commissioner. On page 11 of your statement - I'm trying to avoid repeating topics that have already been dealt with, and we've jumped around a little?-- Yes, sure.

Paragraph 10, "AMA Queensland believes that the problems at Bundaberg Hospital would not have happened in a more robust health system which had better resources and better management", and then we deal with, in a series of lettered paragraphs, the problems, for example, globally under-resourced. Is there anything more you need to say about

that?-- No, I think the resourcing of Queensland Health has been adequately dealt with in the one-and-a-half page document - the brief that I presented AMA. I would, in fairness, draw the Commissioners' attention in that document that that was presented as a political lobbying document at the time that we were auditing the activities of the government and Queensland Health. There are areas in Queensland Health that do well by national averages, particularly in cancer management, but if you've had time to read that one and a half pages, you'll see that really the spending in almost every area is the lowest in the country, and that the health outcomes, particularly for heart attack and stroke, are the worst in the country as well, and - although our cancer management is in line with national standards.

COMMISSIONER: I suppose I should say our difficulty is that it's not part of our Terms of Reference to go back to the Queensland government and say, "Write a bigger cheque", so my concern for the moment is to explore ways that the available health care dollar can be taken further, and just by way of thinking aloud, one of the things that has crossed my mind and been discussed between myself and the Deputies is whether there should be a system, for example, that in a budget allocation for health a specific amount is to be devoted towards actual health services so that we don't have this fudging where one talks about hundreds of millions of dollars being spent on health, but we find out that a lot of it's being spent on support services, administrative services and so on that don't provide any health care?-- Yes, and certainly people who are interested in larger system management of health talk about measuring health outcomes as your end points for funding, and also using regional funding based on population based funding rather than at the moment the average weighted separation funding causes particular biases in clinical services. The other thing that probably would improve service in the system is hospitals having to purchase services from one to the other. At the moment there's no incentive in the system for hospitals to supply services to other hospitals. So, for example, if you have a heart attack in Nambour, you may have to wait up to 10 days to get transferred to Prince Charles to have a catheter study. If you have it in Prince Charles, there's an economic imperative for them to clear you out as quickly as possible, so you might get it quite quickly, but they do it out of the "goodness of their heart" and because they're supposed to for the hospital in Nambour. If Nambour was able to purchase services from Prince Charles and have a budget for doing that, there would be incentives for Prince Charles, as only one of the four hospitals in the state that can do catheter services, to provide the service to outlying districts.

And I guess the other side of the coin - one side of the coin is to offer budgetary incentives to provide good service, but what seems to have emerged in the evidence so far anyway, is that there was actually an incentive for Dr Patel to perform services that resulted in the death of the patient when he chose to perform oesophagectomies on patients who had been rejected for that sort of treatment at the Royal Brisbane,

that actually made money for the Bundaberg Hospital even though the patient died?-- Yes, and I think that would be a peculiarity to the system in that size of hospital in that I'm not sure that that would have made a lot of difference to Royal Brisbane's budget because that's the sort of work they're doing anyway, but it shifted the average weighted separations in Bundaberg very favourably.

MR TAIT: Doctor, that probably takes us to paragraph B at the bottom of page 12. Insufficient use of resources by Queensland Health, overall management of Queensland Health is poor, management layers are excessive, large groups of bureaucrats whose purposes seem ill-defined, project officers abound. Do you want to say anything else about-----?-- I think the Commission has been very generous in the time they've given me with that, and we did talk about the multiple layers.

COMMISSIONER: What is a project officer?-- Yeah, that's a good question. A project officer is somebody who is somewhere between an AO4 and about an AO7 or eight who works in a team. Commissioner, you may do better to get a second opinion on this, but I understand they work in a team or a group on a particular project that might be, say, a Quality Assurance project or whatever, and they - or to give a specific report or a specific outcome, or what they're being increasingly used to do around the hospital is what they do is they add another administrative layer. For example, in the budget there was money promised for a renal access surgery. This is just really important surgery so that people with dialysis problems can have veins and stents put in their abdomens to have renal dialysis. Now, $1.5 million was promised over three years, and this is really important because, for example, if you don't have - if you have temporary access catheters for dialysis, that increases your mortality by 80 per cent in the first year of your dialysis, and something like 70 to 80 per cent of all the deaths at PA's Renal Dialysis Unit are related to temporary access for dialysis. So half a million bucks a year was put aside for new operating lists. A year after that money was put aside the only thing that happened is they appointed a project officer to work out how to put people on an operating list, who needed to have it? Well, I mean, we've been putting people on operating lists for centuries. I understand - and I'm not being critical in view of the recent controversy, but I understand one of the steps to sorting out the problems at the birthing centre at the Royal is that they've appointed a project officer to help implement the changes. So project officers seem to be administrative facilitators depending on the level that they're at. I truly suspect that they're an unnecessary layer in that that's the sort of work that we used to do and the nurses in the unit used to do, and that if there were Quality Assurance issues or patients needed sorting out to go on lists, we just used to do it and get on with it.

You go on and say in that paragraph that there seem to be a number of generic projects which seem to serve no useful purpose. Can you identify-----?-- Yes, and I'm sorry in

terms of - I think the English I used there was poor in that we're getting constant reports around the hospitals that there seem to be all these project teams doing projects that the doctors just can't understand, and they don't seem to have any specific health outcomes, and it seems to consume the activity of the hospital, be they administrative projects or budget projects or, you know, projects like I discussed in terms of that renal dialysis list. That sort of seems to be the mode of administration and the mode of how something happens in a public hospital, and instead of someone doing something, it seems to go to a team and then the team becomes a project, when really it's just a simple case of making a line decision and carrying out a task.

If you'll forgive me for dragging us back to perhaps the central issues for this inquiry, from what we've heard so far, it seems that the head administrators at Bundaberg were Mr Leck, the Regional Manager, Dr Keating, the Medical Superintendent, in effect, and the Nursing Superintendent, none of whom - well, Mr Leck, of course, isn't a doctor, but none of whom seem to do anything clinical at all. I'm just hoping someone will tell me before this inquiry is over what those people do do, why three people at that level are needed to run the Bundaberg Hospital plus all their support staff and secretaries and the rest of it?-- I mean, obviously some level of administration is required. I mean, I do believe you need a DON. I do believe you need someone in charge of medical services in a hospital. I truly don't see a function for district managers, and I think we could do away with district managers, and, you know, there seem to be so many other jobs in the system that I actually don't understand, Commissioner. I mean, I'm not actually having a go at Queensland Health in terms of this, but when you read their submission to your inquiry, their list of witnesses - I mean, you know, I just can't actually understand from the titles what those people do. Not all of them, but many of them. There seem to be these sort of jobs that I just can't understand how they contribute anything to the core business of getting a sick patient better.

MR TAIT: In paragraph C you talk about the layers of management and you say that accountability for decision making allows management to defer a decision. Is that what you were talking about going up to someone, then they can go and consult with somebody else and somebody says no, but you don't know who?-- That's right, yes.

Paragraph D, "Management often seen or described as difficult and bullying", we've dealt with that. Paragraph E, "Productivity issues must be addressed. Fee for service model for medical and paramedical groups", is that what you're talking about, the transfer for the angiogram to Prince Charles, that sort of thing?-- At that level, and also, you know, possibly as a salary based modified fee for service. The basis of a lot of the Canadian system - which is a completely socialised health system and public hospital system - is that there's still fee for service for the providers within those hospitals, and that provides an incentivised

system, and that can work at both medical and paramedical levels. I don't mean at nursing level, but for paramedical services as well.

COMMISSIONER: To go back to an example you gave us this afternoon, you talked about the fact that there are waiting lists for colonoscopies and GPs are referring patients to private clinics that provide that sort of service at a relatively moderate price. Is there some reason, if that's so, why Queensland Health can't outsource to that sort of clinic to provide those services?-- Yes, outsourcing - outsourcing has been heavily considered by Queensland Health, and indeed was an election commitment and was actually used during the waiting list blitz, Commissioner. It's a controversial policy that, interestingly, doesn't have widespread medical support, and we convened a number of issues, and we're currently - sorry, we convened a number of meetings with our - with the medical colleges on it, and also we have a negotiating group with Queensland Health to see how we can bring this in. Now, put simply, it's a very attractive idea in terms of churning through easy procedural numbers, so for things like colonoscopies, perhaps cataracts and stuff like that, it is a good solution. At a more complex level it actually has a lot of difficulty - doctors have a lot of difficulty with it, particularly those who work in the public system, and some of those arguments are cogent. The first is that we have got not a very good public hospital system there at the moment. When you start putting - taking outsourcing as the simplistic solution - the mantra in Queensland Health for the last year with the new administration is that the two solutions to the public hospital system are outsourcing and task substitution. Now, outsourcing is purchasing the services exactly as you've discussed, and what - but it can go further. For example, instead of opening up one of those intensive care beds of the 15 that are closed at Royal Brisbane, what you do is you go and purchase intensive care bed days from the Holy Spirit or St Andrew's or something and you don't have to open that bed, and can you say, "Well, instead of us going to the cost of opening an intensive care bed at $750,000 a year, we'll just buy the days as we need them from St Andrew's or Holy Spirit." But what that does is irretrievably start to weaken the public sector because you find less and less reasons to resource the public sector properly. Now, the public sector - we actually believe in the public sector because it's very important. It provides care for 60 per cent of the people in this state. It looks after some of the sickest people in the system because the sickest people come from the lowest socioeconomic groups that don't always move in the private sector. It provides teaching and training, and it provides a depth of resources to take care of urgent medical problems in the state, for example such as disasters. Now, when you start to weaken such a system and you start to outsource bits of it and it starts to implode on itself, a lot of doctors believe that that will lead to an irretrievable weakening of the public hospital system, and the ideals that the public system are built on, particularly for the training of doctors and nurses, will be gone forever, and so a lot of doctors are very, very hesitant about endorsing

that.

Particularly if what is sourced out is the high turnover/low margin sort of work. You end up with a sort of cherry picking where the most profitable-----?-- That's very true. There is also a less noble argument in that doctors go to the public hospital system for those very ideals, and so they go to work in the public hospital system and they want a good system to work in, and one of the reasons they're leaving is there's not a good system there. Now, you know, if you're not going to resource a good system but you're going to pay an entrepreneur down the road who has a very quick turnover clinic public dollars and they will personally benefit from doing easy work quickly while these - some of our best doctors are there in the public hospital system trying to hold it together, you get a very, very angry group of doctors who really feel that that's not very fair, and as well as that, then you have the issues relating to training and you take that work that's very, very important for teaching our younger doctors out of the system and you put it with the entrepreneurs and then they don't learn how do it, and so you have a weakening of the system where you start to eat your young. Those are the arguments against outsourcing. In a superficial sense they're very attractive, but they have very, very serious implications for the public hospital system, and to be fair, those have been accepted by the government. You know, the government was very keen - or outsourcing - at the moment has backed off a little bit to look at those sort of outsourcing implications.

You mentioned two current buzz words. One was "outsourcing". What was the other one?-- Task substitution. That's what you might have seen a little bit in the paper over the last couple of days. This is going to be very important. Not just from doctors, but from nurses' point of view. So what there is is okay, at the moment we've got trouble with the workforce. We haven't got enough doctors and it's difficult employing nurses. So what we'll do is we'll move down the needs - or we'll move down the qualifications of people who can do particular tasks in the public hospital system. So we'll get some nurses doing doctors' tasks, but also there are plans to introduce a generic one year health workers course, and they will become substitutes for registered nurses. Those courses are currently being set up in some of the universities and colleges. So whilst I'm very protective of doctors' turf, and I've been very public and not very supportive of nurse practitioners, the truth is I'll go a mile to defend the nurses as well, because I don't want to see a lot of work that is currently being done by RNs and standards that are being maintained by excellent registered nurses moved down to people who have only got a one year generic health workers degree either. The really bad thing about task substitution and why I've gone so hard out to start to fight it is it let's the people resourcing the system off the hook, because the reason that we've got workforce shortages - a lot of the reason we've got workforce shortages, I believe, is that there's not a very good system there. Look, doctors and nurses want to work in a good system. Not just doctors, but nurses. Nurses don't want to go and do an eight hour shift and be stressed out because

there aren't enough nurses on the ward, there aren't enough beds, they're looking after somebody who's perhaps been in an ED on a trolley and they come home stressed out and sickened by a system where they know the right things aren't being done for patients, the same way as doctors do, and they get angry, and so what do they do? They leave, and there are lots of nurses sitting out there who are no longer nurses in other careers, or they're not going to work at all. They're not doing a couple of shifts the week the way they used to, and the doctors have left the system as well because it isn't a good system. So what the end point is creating a bad system that you haven't resourced well, you haven't managed well, and you've let go into decay, is that you start to lose your staff. So then you turn around and say, "Well, golly, we've got no staff. It's not our fault. What we'll do is we'll give even less competent staff than the ones we're left with, so we'll start to task substitute to make up for the management and resources deficiencies of the last decade." That's the reason that I've gone out so hard against task substitution, because it lets the poor management and poor resourcing off the hook in this system.

No-one's thinking of task substituting, let's say, zonal managers or district managers?-- You've got to define the task first, haven't you?

MR TAIT: Doctor, I want to finish you on one other buzz word or buzz phrase that might give an example of why people were leaving Queensland Health disenchanted, "reversal of flow"?-- Yes. Commissioner, I asked Mr Tait just to lead me into that because of a comment that you'd made about doctors having to finish their lists early, and the productivity in the system, and the reason - part of the reason that that happened was that at places like Royal Brisbane five or six years ago, prior to about '98/'99, we had some of our best doctors in the system doing all day lists at the Royal and they'd start at about seven, 7.30, they'd work right through, they wouldn't have lunch, morning tea and lunch would just be a sandwich while the next patient was being brought in or out, their Registrar would be with them, they were incredibly productive lists, and the waiting lists at Royal were very short for general surgery and for most other procedures, and if you really want to rattle the bureaucrats in Queensland Health, ask them to describe reversal of flow to you, because this was a disastrous policy that was brought in in '98/'99 and what it was designed to do was basically say, "Well, the people - many of the users of the public hospital system live out in the peripheral areas of Brisbane. So what we'll do is we'll resource-up hospitals like Redcliffe and Caboolture and Logan and we'll do all the simple stuff there - the hernias and varicose veins and stuff - and in the central hospitals we will only do really big, complex works at places like RBH and PA, and they'll be really super tertiary referral centres". But what happened was - so what they did was they cancelled a whole heap of operating time, took away a whole heap of lists, took away the MO sessions, cancelled clinics at these big hospitals, and never resourced the smaller hospitals and didn't put the staff and didn't put the lists and didn't put

the resources. So they simply, at the end of the day, made a big saving in the system which they never replaced. No-one's ever really been called to account on that, and it was really one of the most disastrous policies in terms of reducing productivity in the public sector that's occurred in the last decade, and I felt that in terms of understanding this deficiency of the public sector that should be drawn to your attention.

COMMISSIONER: Sir Llew?

D COMMISSIONER EDWARDS: Can I just go back to the point I raised earlier? You say in your submission to us that change in management to allow doctors to be in charge of clinical care of patients and accountable for their meds and so forth - can I get you to expand where that is being interfered within the system, where doctors are not in charge of patients?-- Daily at Royal Brisbane Hospital cases are cancelled by a management team that says, "We haven't got the resources. Doctor, you've decided that patient needs surgery for cancer, but I'm sorry, we can't do it."

For any reason particularly?-- "We don't have a bed" or, you know, "something's more urgent" or "we don't have the staff and the list has to be finished at this time". So that's an important clinical decision. Equipment decisions. There's a letter in there relating to bullying where a gastroenterologist at QEII Hospital was being told what particular instruments he had to use to do colonoscopies that fitted into the hospital budget and fitted in with the manager's decision who was not a doctor. We have clinical - line managers who are deciding who will have treatment, who won't. We have beds being closed by district managers. We have intensive care beds being closed or opened. That's at a macro level, and a micro level - there are little decisions that are made every day. I mean, one case - one example that was brought to me was there was an acoustic neuroma, a tumour of the ear - and I didn't mean that for your benefit, Sir Llew, I meant it for-----

COMMISSIONER: I appreciate it.

WITNESS: -----Mr Morris' benefit, but that takes a team of about - I understand about seven or eight nurses and neurosurgeons and ENT people, and it's about a six or seven hour case. Then the patient has to go back to intensive care. Now, what would have made the whole thing - you've got to put aside a whole theatre for nearly a day at the Royal to do these, and the intensive care people agreed to do an early round at 5.30 in the morning to clear a bed for this case and make sure there was going to be a bed so that the case could start at 7.30. One of the managers interfered and said, "No, we're not going to bring an intensivist in at 5.30 to do a round", so the team had to sit around - seven of them had to sit around in a tearoom until 9.30 before the case could be started while the intensivist did their rounds at the usual time and cleared a bed. That's the sort of thing that's happening every day in the system where you have budget

compliant managers deciding what will happen with patients.

D COMMISSIONER VIDER: No further questions, thank you.

COMMISSIONER: Just before I turn the dogs loose, in the document you provided to us, "The State of Queensland's Health", which I think is Exhibit 35, the third dot point says that Queensland has one of the highest unplanned readmission rates to hospital at 4 per cent per 100 admissions. What would be the cause of that?-- That really worried me when I saw that statistic because I wondered just how bad our surgery was, but in fact that's not the cause. It's because we have the lowest spend per head in Australia on rehabilitation services. So we have the poorest rehabilitation services for patients in the country. We have the lowest number of rehabilitation specialists employed in the public sector and the lowest number of registrars training in rehabilitation medicine. So what happens is that when someone gets sick in Queensland, they're actually - a really sick person's not badly treated in the public hospital system often, but they've got nowhere to go. Discharges are the shortest they've been, so what happens is they have to go home. They don't have a facility where, for example - with a fractured hip or something they don't have a guaranteed facility where they go to be rehabilitated after their illness, whereas the other states have probably nearly twice the facilities that we do in Queensland. So when these people go home and relapse, they come back into an acute bed and they're counted in the statistics as a readmission, whereas in another state they might get sick, but they're sitting in a rehabilitation ward. They don't need to be re-admitted, but often because they're being better cared for by rehabilitation experts, they won't have that relapse anyway.

Thank you for that. Where do we go to next?

MR DEVLIN: I would be happy. I have got a few questions.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Dr Molloy, I'm Ralph Devlin and represent the Medical Board. The questions I have don't imply a criticism, but I'm inquiring of the circumstances surrounding the period when concerns did grow around Dr Patel and his clinical expertise or lack thereof. This Commission so far, to fill you in, has received evidence from a number of sources about what complaints were made. If I can take you through them just in a rudimentary way. We have heard from Dr Miach, who responded partly in a way to simply put the complaint up the system within the hospital system, and then acted to look after his own patients. So, that's one response. We have, through Dr Miach, seen a letter from Dr Jenkins, a specialist down here, who wrote a letter back - I forget who received it - but it was copied to Dr Patel, expressing serious concerns about the state in which an amputee was found by him in Brisbane.

COMMISSIONER: I think it was copy to Dr Keating as well.

MR DEVLIN: Indeed. We have, of course, nurse Toni Hoffman's response, but that's not my immediate area of concern, and you yourself have identified the concerns of Dr Peter Cook who you said went up through the system. Before I come to my question, what did you mean when you said that with Hervey Bay, Dr Cook took a stance which was not totally within the system? Did you mean within the Q Health system?-- Yes.

And what was the step that you were thinking of when you said that?-- Well, I understand that he was more public with his concerns, and I think he wrote letters further and wider in relation to it than just going straight up through his line manager into zone.

All right. You would understand the Medical Board's interest that it might be that people instinctively try and complain up the system, but, of course, the users of health services can go to the Health Rights Commission directly, so that's the ordinary citizens, presumably, but others who are in the system, like doctors, could go to the Medical Board of Queensland. One could imagine some cultural reasons why that wouldn't happen. For example, one could imagine that local doctors would be reluctant to take that complaint outside the system without trying the system first?-- Yes.

Would that be a realistic view of it?-- Probably realistic

and probably also reasonable.

Yes. What about, though, somebody of the standing of Dr Jenkins? I suppose he's gone back through the system, hasn't he, with a letter addressed partly to Dr Keating, but at what point, as a matter of culture for doctors, do they take that step of going to the Medical Board to issue a formal complaint in circumstances where they must surely understand that the Medical Board is one area which would investigate and prosecute where the evidence is found?-- Yeah. I think doctors, in general, are hesitant - I think in general terms, doctors are hesitant to go to the Medical Board with that sort of clinical complaint, but I think they are more comfortable going to the Medical Board in the area, for example, of an impaired doctor. So, for example, if they knew a colleague - and, you know, I have personally experienced this and seen it at closer hand - was taking - was drug addicted, I think they would almost always take that problem to the Medical Board because I think the Medical Board has a very good track record of handling that.

Or perhaps sexual misconduct or things of that kind?-- Exactly, that's right.

So what's the issue with clinical competence? Is it that the doctor becomes a witness then against a fellow doctor, perhaps, potentially?-- Well, it is just that there are other pathways to handle it. See, I mean, the Commissioner talked earlier about Sir Llew being allowed to do neurosurgery. There is actually something that stops us all doing that. It is called the credentialling within our hospitals and, particularly - I mean, in the private sector, that credentialling process is surprisingly robust, particularly with the changes in insurance over the last five or seven years - you know, the hospitals have to be very robust in terms of their risk management. So, there is actually a system where, you know, yes, I might be able to, in technical sense, do neurosurgery, but, you know, if I walked into St Andrews and tried to go anywhere near a neurosurgery case, that hospital would be down on me like a ton of bricks. Similarly, we have examples in our private hospital system and also they exist in the public hospital system where we handle clinical competence within our profession by boards of review that look at the cases, and there are a significant number of those, and the Medical Board, in fact, would be aware of some of those at the moment. We think that that's a very proper process, and so sometimes the first act is to actually bar a doctor from a hospital, limit a doctor within a hospital as to what they can do, and to have our investigations involving our colleges and our standards bodies.

Thank you. One other aspect then is this: we heard from the local member, Mr Messenger - and there was an early statement from you that suggested that you might have, in fact, had supportive statements from some of your members about Dr Patel's clinical abilities?-- We didn't have that at all. You know, I've been asked this numerous times. We actually were - we had actually had information that the Chief Health

Officer we thought with some Medical Board backing was actively investigating Dr Patel. The AMA was critical on one point with Mr Messenger, and that is that he, in our view, peremptorily named a doctor in Parliament whilst an investigation was in progress. You know, we felt that there is an important professional principle that if a professional is being investigated, if he has done something terrible and he gets named in Parliament after the investigation is completed, so be it; he should certainly be investigate. But we didn't want to encourage parliamentarians making a habit of naming any professional and, in fact, I personally was supportive, for example, of Mr Boe when he was named in parliament. You know, I actually went out and supported a member of the legal profession because I thought, in principle, that that was wrong. So, we made an in-principle decision to attack the naming, but we never actually defended Dr Patel. In fact, politically, I'm very, very careful in that situation. I, numerous times, have been rung by the press when, for example, bad news comes on - for example, when a drug like Vioxx gets knocked off - and I'm so careful to get the facts first and not just - people expect you, because you're a doctor, if there's bad news about a drug or bad news about a doctor, they automatically stereotype you to going to a point where you are automatically going to defend that position and, in fact, I'm so careful not to do that because I'm so careful of the consequences not to do that.

COMMISSIONER: Am I mistaken or was there a statement attributed to you somewhere to the effect that it was lazy nurses in the ICU?-- I'm glad you brought that up. I absolutely categorically deny ever saying that. Mr Messenger had got some - Mr Messenger had clearly done some homework around Bundaberg which I thought was to his credit and he tossed that line at me and - you know, when he was briefing me, and I didn't know Dr Patel, I didn't know anything about Bundaberg Hospital, and I simply absorbed that as a comment that he made. Mr Messenger, I'm afraid - you know, I believe that he was angry in that the AMA had criticised him for the naming and he attributed, one, that I had praised Dr Patel. I have done so much media on Dr Patel. I've never praised him once. And the second thing is that, you know, I made an adverse comment about the work ethic of nurses and that was extremely unfair and, in fact, it distressed me very much.

MR DEVLIN: One other aspect to it: does your association have much contact with many members amongst those who - the young interns, if you like, who go on educational forays to these centres such as Bundaberg?-- Yes, we do. We have a very, very strong doctors in training - or it is now called the Council of Residents and Registrars Group. They are an incredibly active, vibrant group in the AMA.

I have a specific question about that?-- Okay.

Dr Patel was there long enough at Bundaberg and one of his work specifications/job descriptions was to provide education, so one can assume that over the couple of years that he was there, that education was provided by him to some of these -

what are they, undergraduates or just fresh graduates?-- Probably both. You know, I think there would be a number of interns at Bundaberg Hospital, although I'm not totally sure of that, but I'd be amazed if there weren't, and also medical students were there as well.

Does your information extend to whether any of these students had positive things to say about the education they received from Dr Patel?-- No, I haven't asked them that. That's an area of research in terms of researching the Patel case that I haven't done.

Because one of the things that we are yet to know from the evidence that will come before this Commission is whether a very, very wide range of procedures were under the accepted standard or whether a much smaller group of procedures, perhaps more complex procedures, fall into that category. You would appreciate that?-- Yes, I think you brought up a very important point. I'm looking very forward to hearing the medical evidence because, you know, before we got up to this level, of course, there was that Committee of Inquiry announced by the government and I understand that Dr Peter Woodruff, a very respected surgeon, is reviewing the cases and I'm looking forward to that evidence, because, honestly, I find Dr Patel an enigma. He did an awful lot of surgery and there's clearly a lot of survivors, but there's also some terrible outcomes, and I'm having trouble getting my mind around just how bad he was, and I'm really looking forward to hearing what Dr Woodruff does when he reviews those cases.

And it would seem that your organisation also has the capacity to draw from those who went up as students as to whether the quality of the tuition they received from Dr Patel might have even in more basic procedures been acceptable perhaps?-- We could certainly help find out through the university. Many of the medical students would be members and certainly a fair proportion of the training doctors would be, but it would not be invariable that they were.

Thank you.

COMMISSIONER: Thank you, Mr Devlin. Who is next?

MR FARR: Commissioner, I'm happy to go next.

COMMISSIONER: Yes, Mr Farr.

MR FARR: Are we breaking at 9 o'clock?

COMMISSIONER: The plan was to break at 9. Is the plan to take us through to then?

MR FARR: I'm sure, and beyond. If anyone else wishes to start, then I'm happy to wait.

COMMISSIONER: We will go through the rest. Mr Mullins?

MR MULLINS: I have some short questions, Commissioner, but

they cover some areas that have already been covered and I think Mr Allen might also cover, so it might be best if you let the other questioners go first. We will have little-----

COMMISSIONER: All right. Ms Kelly?

MS KELLY: No, thank you, Commissioner.

COMMISSIONER: Mr Allen, you would prefer to defer for the moment?

MR ALLEN: I'm happy to ask some questions now.

COMMISSIONER: All right.

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Molloy, when dealing with examples of bullying of doctors by Queensland Health, you gave striking evidence, something which resonated with you, concerning your discussions with the heads of colleges in relation to the Forster Review?-- Yes. Mr Allen, could I ask just who-----

Yes, excuse me, I appear for the Queensland Nurses Union?-- Thank you.

Now, they were very real concerns expressed by those doctors?-- Yes. As I said, it is just something that - it is actually quite deeply - it quite deeply affected me. I was really quite surprised to see my colleagues - I apologise, Commissioner, I was really quite surprised to see my colleagues, you know, expressing those views.

All right. And did they express specific concerns as to what protection would be afforded them if they were to be frank in their discussions in relation to the Forster Inquiry?-- Yes, that's correct. Our CEO, Mr Gallagher, spent several days following this up with Queensland Health and with Mr Forster and it became the subject of, you know, not difficult correspondence, but correspondence between us and Mr Forster, because we were very keen to get as many doctors involved in this. We see this as a positive rebuilding of the system, and we saw this as an impediment.

Now, did those concerns include any type of legal protections that would be available to those doctors if they were to be frank in their discussions?-- Yes, they did.

All right. Now, have you or anyone acting for you sought to gain clarification of that matter with the Director-General of Queensland Health?-- I'm sorry, I can't answer that. I can get that information from our CEO, because he handled that.

I'm not sure who he spoke to in what particular way about that issue. I was briefed on the issue and the fact that we were moving towards a resolution. It is just that I don't know who he spoke to on the way.

Because the Director-General of Queensland Health has taken certain steps to allay such concerns in relation to communications with this Commission of Inquiry by Queensland Health employees, and certainly the same sort of concerns you have raised have been raised by nursing employees in relation to their dealings with Mr Forster. You are not able to say whether that has been clarified to an extent which would allay those fears on the part of your members?-- Well, I think to a large extent they have. I mean, let me say at the outset, I didn't actually totally agree with all of my colleagues, but then I hadn't been exposed to the system for quite a long time. You know, first of all, I was reassured by Mr Forster's - Mr Forster honestly strikes me as a man of considerable intelligence and integrity, and I actually felt in talking to him that we could have confidence in his process. The second thing was that this was a generic inquiry into systems with the idea of hopefully building a better system, it wasn't about lots of little incidents and lots of little personalities, and I felt that really it wasn't a very threatening thing to comment on a system and help build a better system. However, my view was in the minority amongst all of those doctors, and I think, to be fair, really a lot of the reassurance without legal protection has come from Mr Forster who said, "Look, he said those things. It is a generic inquiry. What we are going to be looking for is symptoms of generic problems rather than, 'He said this or she said that', and names going in. What we want is the evidence of a systematic nature."

From what you have said, it would certainly facilitate that process if persons involved in it felt that they would be legally protected in making disclosures to the Forster Inquiry?-- There is absolutely no doubt that that was the view of senior medical staff.

Now, you have touched upon this in response to questions from Sir Llew and also, to some extent, from Mr Devlin. The Association in its submission at paragraph 4.4 states that, "Whilst it is plausible and, in fact, probable that individual members of the Association were aware of disruption or complaints at the Bundaberg Base Hospital, AMA Queensland was not alerted as to the emerging situation in any manner." Is that the case?-- Yes, that's true. You know, I really didn't - I had not heard of Dr Patel - sorry, I had not heard of Dr Patel until he was named in Parliament.

All right. Are you aware as to whether any of the doctors employed in any type of surgical capacity at the hospital were, indeed, AMA members?-- I don't think any of the doctors employed in a surgical capacity were. I know at least one of the anaesthetists was.

Who was that?-- A Dr Jon Joyner was - sorry, is.

All right. There has been some evidence that, in fact, earlier in the piece, that Dr Joyner went along with Toni Hoffman to speak to Dr Keating about concerns regarding Dr Patel's clinical competence. You weren't made aware of that by Dr Joyner at that time?-- No.

Okay. And you weren't made aware of any concerns prior to Dr Patel's naming in Parliament through any other member?-- No.

You were asked by Mr Devlin whether, in fact, it was true that the AMA or yourself stated that local doctors had supported Dr Patel, and you say that you didn't make any such comment?-- In the time between the naming and now, I have had evidence - or I have heard from Bundaberg that there was variable support for Dr Patel amongst local doctors, and the other thing was that I think some members of our secretariat rang general practitioner members we had in Bundaberg to get a feel for what was happening in Bundaberg. We couldn't really get a feel. There didn't seem to be a large - often the GPs are very sensitive at picking up these sorts of things because they see a trickle of complications. We couldn't really get a feel for that.

Are you aware as to - from your own investigations into the matter - whether, apart from Dr Joyner, there would have been any other members of the AMA who would have been in a position to assess Dr Patel's clinical competence through working with him?-- I don't think - I mean, assessing a surgeon's competence, I guess, would be - you know, the anaesthetists do do that because they are in the theatre at the same time, and other surgeons do, but I didn't know any of the other surgeons in Bundaberg to talk to.

You didn't know the doctor who acted in the capacity of intensivist?-- No, I didn't.

And can you say whether or not he is a member of the Association?-- I'm not sure.

COMMISSIONER: Can you remind me who that is you are referring to?

MR ALLEN: Dr Carter, I believe - Martin Carter.

COMMISSIONER: Yes.

MR ALLEN: Now, just so as to make it clear - perfectly clear - following on from a question Mr Devlin asked, the transcript of Mr Messenger's evidence at page 254 at about line 15 attributes to you a comment that the concerns regarding Dr Patel, quote, "was a case of lazy nurses at Bundaberg and that Patel was merely trying to whip them into shape", unquote. You categorically deny making any such comment?-----

COMMISSIONER: When you say "quote", "unquote", that's a quotation from the evidence given at this Inquiry by

Mr Messenger.

MR ALLEN: From the transcript of this Inquiry of Mr Messenger's evidence.

WITNESS: Yes. I absolutely categorically deny that. I am pleased to have the opportunity to categorically deny it. I knew nothing of the work ethic of Bundaberg Hospital. I knew nothing of the situation at Bundaberg Hospital. I was not in a position to even start to make that sort of comment. I have not researched the situation. I knew nothing about what was happening at Bundaberg at that time, or I had only the most minimal information that there was a problem there, and I don't see how I could possibly have made that up in my first discussion or any subsequent discussion with Mr Messenger.

MR ALLEN: At paragraph 10.4.9 of the AMAQ submission to this Inquiry, this statement appears: "Queensland Health know that VMOs have a traditional and principal base commitment to public hospitals and have continued to milk that through successive negotiations." So, are you referring there to the fact that doctors who choose to work in the public system as visiting medical officers have a professional and emotional commitment to doing such work?-- Yes, I strongly believe that to be the case.

And you believe that that has been taken advantage of by Queensland Health in industrial relations negotiations?-- Yes, that's the strong view of the association.

The submission goes on: "A review of the comprehensive submissions made by the VMO committee and comparisons with 'negotiated' outcomes will reveal the vast differences in that reasonably claimed and that paid by Queensland Health."?-- Sorry, could you repeat that?

Yes, "A review of the comprehensive submissions made by the VMO committee and comparisons with 'negotiated' outcomes" - "negotiated" in inverted commas - "will reveal the vast differences in that reasonably claimed and that paid by Queensland Health."?-- Yes, I wish we had that in English.

I'm after an interpretation.

COMMISSIONER: The suggestion is that there's a vast disparity between what is, in fact, paid and what has reasonably been claimed by or on behalf of the VMOs?-- Yes. Yes, okay. I can understand that. What happens is that there are a whole series of things in the awards which Queensland Health regularly don't pay or that the doctors - they have just got to chase it through the system, you know, for hours to get it paid. Things like they are supposed to get an indemnity subsidy, and the form is so complex, and then half the pay officers don't understand it, so a lot of them just give up in disgust. It is things like that or after-hours calls and things like that that, you know, they become so much hassle, they just know the hassle they are creating, the doctors will drop it. I think that's what the interpretation is.

MR ALLEN: All right. So, it is, in fact, the experience of the Association that in relation to Queensland Health employees, they have to spend a lot of time and energy in actually gaining or seeking to gain the entitlements under industrial instruments?-- That's exactly right.

Yes. And I think that the first sentence that I quoted to you seemed to be of broader application in that Queensland Health in negotiating any types of industrial instruments applying to VMOs in your opinion takes advantage of their commitment to the public system to drive a hard bargain?-- Well, that's correct. I mean, really, the VMOs do have a very, very strong commitment to the public system many of them have worked in for 15 or 20 years. Many of them passionately believe in teaching and creating the next generation of doctors to come up, and you can only realistically do that in the public sector for specialists. There's a small amount of private sector training, and we actually - you know, many of the doctors believe very strongly that there needs to be some equity in the health system as well, and so that they actually really do have very good motives for going and working in a public hospital.

Yes. And it certainly wouldn't surprise you if a similar approach to industrial relations on the part of Queensland Health also extended to its nursing workforce?-- Oh, you know, I mean, I was - you know, realised what a difficult negotiation there was in the last EB agreement for nurses with Queensland Health.

Did it appear to you to evidence the same type of approach as you have described in that paragraph of the association's submission?-- Oh, yes. I can't understand a system which is so fundamentally adversarial in that you have got a lot of good people working in a system and I just - I just - I fundamentally can't understand why there is such an approach in a system where you are relying on the goodwill of people to effectively care for your citizens. It's just so counterproductive.

And it has led to the situation you have described where persons who otherwise would make that contribution to the public health system simply give up in disgust or resignation?-- Yes, I believe that's occurred in the medical workforce, but I also believed it has occurred in your nursing workforce, in that the - you know, I understand - I haven't got these figures at my fingertips, but I understand the drop-out rate of people who complete nursing but practise less than two years of nursing once they graduate from college, I understand the loss rate is something like 50 per cent. It is really quite an enormous population - did you want to say something, Commissioner Vider?

D COMMISSIONER VIDER: No, I can't comment.

WITNESS: It was an astonishing figure I heard for the first time the other day and it is an indictment on the system from

which they graduate.

MR ALLEN: That exacerbates the Australian-wide nursing shortage?-- Exactly right. They will work in a good system where they are valued nurses - like doctors - and I think that it goes across all employment systems. Robust private enterprise companies that do well do look after their staff and value them well and make them productive and trust them and they don't overmanage them, and nurses and doctors have both the same problems substantially in the Queensland Public Health Sector.

Just by way of clarifying the discussion that you have engaged in with members of the Commission, you described a three-tiered health system to Sir Llew where there was essentially the Board and answerable to them the three - or the triumvirate of the Director of Nursing, the Director of Medical Services and the Director of Corporate Services and obviously the Directors of Surgery and other fields reporting to the Director of Medical Services. If I could just ask you a few questions so we fully understand what you recommend there.

Now, you have made it quite clear in other evidence, in particular to a question from the Commissioner, that you do believe that it is necessary to have a Director of Medical Services?-- Yes.

And obviously you believe it is necessary to have a Director of Nursing and a Director of Corporate Services?-- Yes.

COMMISSIONER: Is it necessary, in your view, for the Director of Medical Services to be devoted full-time to bureaucratic duties rather than split between clinical and administrative functions?-- Well, yes, I think so, Commissioner. Firstly, I think we have to accept that running a health system these days is more complex than it was. And, you know, whether we view that complexity as desirable or necessary, it is a fact of life that it is. So I do think that that will mostly be the case. The other problem is that most medical administrators now are members of the college, too. They have the best organised medical college. They have - you get a Fellowship of the Royal Australian College of Medical Administrators. So there is no clinical component in their training. They have been out of the clinical line for five years doing their specialist training in medical administration. Now, what's supposed to provide them with insight is that they are a doctor, they have done a medical degree and that is supposed to provide them with the insight to managing a hospital. And, you know, I guess in a way it is not much different from, say, a Director of Nursing wouldn't be scrubbing in theatre, or changing a bed, and helping a patient, you know, in bed or dispensing medication.

I suppose the problem I have with that sort of triumvirate model is then you have the hospital run by three individuals, none of whom have any involvement with what goes on in the functional parts of the hospital?-- But, Commissioner, it is a case of leaving your office.

Yes?-- And, you know, a good medical super will be out there on the wards. Now, it doesn't mean that they're operating but a good medical super will be down there on the wards and will do a round and the good medical supers I have worked with walk around the wards every day.

Well-----?-- And talk to the staff and talk - you know, talk to the charge nurses, not just talk to the doctors.

Yes?-- And they're in touch. They go and talk to the patients.

I suppose my question was to some extent jaundiced by the evidence we have heard here, suggesting that neither the medical nor the nursing superintendent at Bundaberg had any involvement outside the administrative office and, indeed, this impression that the administrative offices were humectantly sealed from the rest of the hospital?-- I think that that is a real problem in parts of Queensland Health. But, you know, a good manager will get out there with the troops but it doesn't mean they're necessarily having to do

that particular work.

Just to explore a possible alternative to your model, my initial reaction to the evidence we've heard - and it was no more than initial reaction - is that, if you like, the figurehead of a hospital should be a practising clinician, even though day-to-day management and administration functions are done by a Director of Nursing, Director of Medical Services and Director of Corporate Services, but that the person at the top of the tree should be a clinician?-- That would be quite reasonable because, in fact, the structure comes back to perhaps some sort of board structure. And it was not rare in any hospital, and still very common in the private hospital system, to have the chairman of the board a practising clinician from the hospital. But, you know, it is like, I guess, the chairman of, directors of a company, they are actually - you know, the hands-on work is done by the CEO, but the chairman of the board is only there in a more part-time capacity on that board.

Let me try and exemplify the area of concern I have. We heard evidence last week from Dr Keating that he had received from Dr Miach an audit of the placement of catheters by Dr Patel. The audit disclosed a 100 per cent complication rate. Dr Keating's evidence - and I can't quote you the exact passage, but the effect of his evidence was this: that the 100 per cent complication rate was meaningless to him because he didn't have any statistics to compare it with. I don't know whether he is looking for statistics showing a 120 per cent complication rate, or what sort of comparison he was looking for, but that's the sort of situation where I would have thought having a clinician at the top of the tree is quite essential, that you need to be able to report ultimately to someone who actually knows what's going on in the hospital?-- That may be so, Commissioner. I just think that thinking is flawed. I don't know whether it matters if you are a clinician or not, to be honest. I just think that's a silly thing to say. And, you know, I mean, what you do is you go to the evidence. It is not hard to get. It is a simple, you know, medical search in the journals, what we call a Pub-Med, published medical search, and it would take you 10 minutes to get a review article and work out what acceptable complication rates were. You see, that's a deficiency of management because what should have happened was - what you do is you go to the literature and there is plenty of reviews to know what acceptable complication rates should be for that procedure. And, you know, it may - and then you know the-----

Candidly, Dr Molloy, you don't have to go to literature to know 100 per cent complication rate is unacceptable?-- No, no but - I am not suggesting that. What I am simply saying is, okay, there is obviously something wrong, okay.

Yes?-- But the way I would manage that - and I might be sticking my neck out here - is I would go to the literature and say, "Okay, best evidence is it should be 10 per cent."

Yes?-- Okay, call the doctor in. "You are 100. Look, we

have got these X cases. There is a concern been brought about you. You have got these X cases. You have got 100 per cent complication rate. Best evidence is. Now, have you done this before? Where did you do it?" You know, find out what the skill base of the doctor is. Okay, "Now, you know, we're happy with your surgery in these areas, but this is clearly an area you are sub-standard. What say we give you four weeks off and we get you down to PA and we get you working in a renal unit and teach you how to do this." You know, that's what effective management is about in medical systems. So, you know, you start with a problem, you work out what the best evidence base is to apply it to that problem, and then you get a solution.

Thank you.

MR ALLEN: So, doctor, are you saying that you believe that there should be someone in a position of Director of Medical Services but that that person should carry out the duties of their role conscientiously and responsibly?-- Yes. I mean, look, you know, one of the mantras, I guess, that we're talking about is effective management, you know, and accountable management. It is too easy, when you have got lots of layers, to be not accountable.

Someone who would be responsive to concerns raised by medical staff or nursing staff of the nature that you have been asked about?-- That's correct.

Not someone who would closet themselves behind closed doors and discourage communications of such a sort?-- Well, I don't believe that's an effective management tool.

Likewise, a Director of Nursing fulfills a very important part of the management of any hospital, public or private?-- Yes.

And as long as you have a Director of Nursing who carries out that position and doesn't closet themselves behind closed doors, then they're an important part of the system?-- Yes, and, you know, again the best directors of nursing that I have known have been - and the best, you know, next level down nurses in charge of sections have been hands-on. They're out there. You know, they have their share of meetings, they have their share of time in the hospital in their offices but they are out there, you know, doing their rounds and communicating with the line managers.

The top of that three-tiered system that you were discussing, being the Board, you seem to draw a distinction between the metropolitan situation and the rural or regional situation?-- Yes, and - you know, being very honest, I am not sure about either. You know, the board system did have its weaknesses, you know, particularly where people of sufficient competence weren't on those boards, but it seems to me that a hospital that's in touch with its community needs can be a very important provider of care in that community, and if you have got people involved in the running of the hospital who are out there at the barbecues or the dinners or the fetes and they

are getting feedback that people can't get into the hospital or they are not being well treated, that comes back very quickly to the administration. But I think in a big metropolis like Brisbane, I am not sure that putting a board as opposed to an accountable management system at Royal Brisbane will make a lot of difference because the reasons for having a board is an interaction - one of the big advantages I could see for a board is interaction between the community and their regional health providers and I am just not sure that will happen in a metropolis like Brisbane.

Would one of the possible downsides of a board of that nature be the question of whom they are accountable to?-- Yes, that would be. At the end of the day, though, accountability has got to stop somewhere, doesn't it? You know, I guess it is better to know where accountability stops than have it in a more devolved system.

Would the board in the scenario you have discussed - I understand you are not tied to it particularly - in your view be responsible simply for the management of the hospital or of what's now the responsibility of a health district?-- Probably a hospital, I suspect. And I think that you need - you know, you do need some model for integrating the services in the district, but, you know, I mean that could be done at a much lower level than it is now.

Well, wouldn't it need to be done at that level or, indeed, higher when one looks at the nature of health delivery in this day and age?-- Well, I am not sure. I think - I think that more effective management systems can be put in between hospitals and community health that currently exist. I am not convinced under the current Distract Management model they are being effectively delivered anyway.

You gave the example of something you would give Queensland Health credit for, and that was the type of steps taken in relation to breast cancer screening?-- Uh-huh.

Obviously there are aspects wider in the health system than simply reactive treatment of patients who present sick at a hospital. There is that whole concept of preventative medicine of which breast cancer screening is part. Who would be responsible for that type of delivery of services under your model?-- Well, it would depend on the particular service and whether that was better managed at a community level or at a State level. So, I mean, there may be community health programs that are better managed at a State level. There may be community programs that are better managed at a relatively small district level.

COMMISSIONER: And, in fact, that's what happens at the moment, isn't it?-- Mmm.

There are some Queensland Health Statewide or community-based programs that operate throughout the entire State?-- I actually don't think some of those community programs are actually badly run, you know. I mean, Maternal and Child

Welfare, you know, seems to do a pretty adequate job and doesn't seem to be overtly over-resourced or over bureaucratised and provides a relatively simple and valuable community service. So, I mean, I actually - I don't think - you don't hear a lot of criticism of the public health functions of Queensland Health and things like infectious disease programs and things are actually really quite effective public health programs.

It is plain on any view there are some aspects of public health administration that do have to have a Statewide basis. Indigenous health is another area where you can't divide that up by regions?-- No, that's true.

MR ALLEN: At dot point 3, 13.3 or the first dot point of that paragraph in your submission, you use a term remedicalise the decision-making. Could you just clarify what you mean by the association in that part of the submission?-- It is simply what I have said through the earlier part of my evidence, that I think an increasing number of decisions that affect the outcome of patients are being made by people who are not clinicians. Now, you know, I predominantly mean doctors but I also include nurses in that, and that decisions that affect the health of a person who is admitted to the hospital system are being made increasingly by people who are not in the clinical line management of the patient - clinical line management of the patient, you know, particularly referring, though, to the medical staff who are responsible for those patients' care.

Do you envisage to some extent some type of multidisciplinary team approach but primarily consisting of those persons and actually involved in the delivery of clinical care?-- Yes.

Such as doctors and nurses?-- We already have a fairly - at the coalface there is already a fairly therapeutic team approach in terms of how doctors and nurses work together, which is mostly in a ward or theatre situation, very good and very effective and very productive. I basically see an expansion of that decision making and control.

Okay. Obviously to some extent there would be a role for administrators even at that level?-- Oh, look, you need - I am not saying get rid of all the administrators, but what it is a case of is defining their functions. You know, you need some administrators. I understand that there are quite a number of organisations, though, where the administrators exist in a support role to do the modelling and provide the support services to allow people to get on with their core business. That's what I am proposing.

COMMISSIONER: So in the hospital context, for example, there are the hotel services, the clean linen, the catering, that sort of thing, which has to be administered. Someone has to deal with that. It is not going to be the doctors and nurses?-- No.

And the gardeners and the cleaners and the pay clerks and all

those sorts of things have to be operated?-- That's right. But also - I mean, going one step further, you know, if a director of a department has got this budget, I don't think the administrator should be saying, "You will spend it this way." I believe that the administrator will be saying, "You have told me you want to do this. I have modelled it for you. Here is your second set of alternatives and if you try alternative three you are going to be breaking two sections of the Act and you will probably end up in gaol, so scrap that one. But you make the decisions. We have done the modelling for you, and during the year we'll do your accounting for you and tell you whether you are on target and whether you are going under target or over target", et cetera. So what we do is provide a support service, a lot like happens in private enterprise, like your or my accountant does, they provide us with the support service but we make our financial decisions based on competence.

And your accountant doesn't tell you how to practise gynaecology and obstetrics?-- They don't even tell me that much about accountancy.

No, no.

MR ALLEN: And in that context, to an extent the third member of that triumvirate, the director of corporate services?-- I see them moving to a support role. My view in the hospital services at the moment, they are in a controlling role because they hold the purse strings.

You were asked by the Commissioner to draw a comparison, say between the sort of package that apparently Dr Patel was receiving and a surgeon in private practice. In relation to the position of VMOs and the type of weight that Queensland Health can have in competing for the services of appropriately qualified doctors in that capacity, how does the type of remuneration paid to VMOs compare to what they could otherwise be earning in private practice?-- Oh, it is very poor but I think to their credit that's not quite worried them. A lot of the time the pay rates, the hourly pay rates to VMOs have been tied to a medical index of what it costs them to run their practices whilst they are at the public hospital. And the best evidence from our - you know, the medical fees index and the other medical - medical fee information that we have is that it costs you about $150 an hour to run your rooms. You know, that's secretary, rent, electricity, medical indemnity. All of the things that provide you with the infrastructure to practise. Basically, what we aim for with VMO remuneration is you can go to the public hospital and not lose.

So the aim is to basically meet the sort of costs that will be involved by the practice being empty?-- Well, that's right. You know, when you go across for three hours to the public hospital, your secretary is still sitting there, you know, you are still paying for floor space in your building and all of those sorts of things. What we aim to do with our remuneration negotiations is pretty much break even for those hours, VMOs at the public hospital.

Is the figure of $150 an hour simply something plucked out of the air as an example, or is that-----?-- No, that's-----

-----an actual figure?-- No, it has actually been financially modelled. And, you know, I mean, obviously it varies a little bit depending on the real estate where you have your rooms and things like that but somewhere between 130 and 160, $170 an hour is about right for Queensland.

Have you been successful in - or have VMOs been successful in negotiating fees of that amount?-- The current hourly rate - I think industrial negotiations and pay rates are a relatively weak point of mine - but are around, I think, about 110 to 130 and the current round of bargaining is looking at an increase to around that 130 to $150 mark.

COMMISSIONER: So presently anyone working as a VMO - at least if he or she has rooms on the Terrace or in an equivalent standard costed facility is actually losing money for every hour they spend?-- That's right. It's about $20 an hour, Commissioner.

Mr Allen, I do notice the time. Have you got much to go?

MR ALLEN: I haven't, but I'm quite happy to finish tomorrow morning, Commissioner.

COMMISSIONER: Well, of course, Dr Molloy, we'll have to fit in with your convenience. I understood you're able to come back on Thursday afternoon?-- That's right, Commissioner. I would be - I'd like to thank you very much for the late session today. It was very considerate of you, and I would ask could I do 4.30. I do have two operating lists that were booked, one all of tomorrow and one on Thursday afternoon that I should be finished by about 3.30 or 4 o'clock. If I start again at 4.30 on Thursday, would that inconvenience you?

Not at all. I just want to work out - Mr Allen, how much longer would you expect to be?

MR ALLEN: Five minutes, perhaps.

COMMISSIONER: Mr Farr, you thought you might be some time.

MR FARR: Yes, but if we start at 4.30 on Thursday there would be no difficulty with Dr Molloy finishing his evidence. I would expect I'll be perhaps an hour, a bit longer, depending on the way things go. That's a rough estimate.

COMMISSIONER: Mr Mullins? Ms Kelly?

MR MULLINS: I'll be 15 minutes.

MS KELLY: No.

COMMISSIONER: You won't have any questions?

MS KELLY: If I do, it will only be one or two.

COMMISSIONER: Mr Perrett?

MR PERRETT: I'll have no questions for this witness.

COMMISSIONER: Mr Ashton?

MR ASHTON: Very unlikely.

COMMISSIONER: Okay. What we'll do, Dr Molloy, is ask you to come back on Thursday at 4.30 and we'll go as long as is necessary, but it sounds like we won't be keeping you until 9 o'clock?-- Commissioner, if it was an hour and a half, I do have these two cases booked on Thursday afternoon, and obviously my patients are important, but if I had notice I could possibly start my list at, say, 3 o'clock in the

afternoon and do from one until three or something for your convenience rather than-----

Dr Molloy, long experience has told me never to make arrangements on the basis of counsel's estimates. That's not meant as a criticism to anyone, and I've done it hundreds of times myself. You think you'll be an hour and three hours later you're still asking questions?-- Okay.

I think it's much safer to assume we start at 4.30 and, as I say, we hope that we'll have you home before 9 o'clock on Thursday?-- Thank you for your consideration. It's much appreciated.

Thank you. Lady and gentlemen, as regards tomorrow, I've spoken with Mr Andrews about the witnesses available. Perhaps, Mr Andrews, you might just care to remind me who we're expecting to see.

MR ANDREWS: I understand that tomorrow morning we might have Dr Fitzgerald - we have Mr O'Dempsey to begin with, of course, then perhaps Dr Fitzgerald.

MR FARR: I understand some further witnesses are being arranged whilst we've been here.

COMMISSIONER: Splendid.

MR FARR: I think Miss Huxley is hopefully available for evidence tomorrow. I just don't know off the top of my head.

MR ANDREWS: I know that a representative of Wavelength will be available.

COMMISSIONER: During the afternoon?

MR ANDREWS: During the afternoon, yes.

COMMISSIONER: I was going to suggest, if it's acceptable to everyone, if we resume at 10.30 tomorrow rather than 9.30. I say that simply because it may seem to the public that we proceed at a fairly leisurely rate, but what goes on in this room is actually just the tip of the iceberg. People have to be preparing statements and interviewing witnesses and so on, and given that we're sitting here until 10 past nine, it makes it very hard for people to be ready to fire up again at 9.30 in the morning. Would 10.30 suit everyone?

MR ASHTON: Thank you, Commissioner.

COMMISSIONER: We'll adjourn until 10.30 tomorrow.

THE COMMISSION ADJOURNED AT 9.09 P.M. TILL 10.30 A.M. THE FOLLOWING DAY