QUEENSLAND

COMMISSIONS OF INQUIRY 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DAVID JOHN FARLOW

I, David John Farlow, Director of Medical Services, Proserpine Hospital of c/ Proserpine Hospital, 26/234 Taylor Street, Proserpine, in the State of Queensland acknowledge that this written statement by me dated 18 AUGUST 2005 is true and correct to the best of my knowledge and belief.

This statement is made without prior knowledge of any evidence of information held by the Commission of Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

Qualifications and Experience

1. I hold an MBBS obtained from the University of Queensland in 1983. I also hold an Advanced Certificate in Obstetrics and Gynaecology (DRANZCOG) obtained in 1989 and a Fellowship to the Australian College of Rural and Remote Medicine (FACRRM) obtained in 2000.

2. I also hold qualifications in Early Management of Severe Trauma (EMST) to assist in trauma management, Ultrasound, and I am qualified as a Government Medical Officer to enable me to perform post mortems, assessment of rape / assault and provide expert testimony in any court case that may arise from these investigations.

3. From 1984 to 1988 I worked in what is now known as the Northern Zone at the Mackay Base Hospital, progressing from intern to Resident Medical Officer, Senior House Officer and Principal House Officer during this time.

4. In 1988 I was appointed as Medical Superintendent, as the position was then known, at Proserpine Hospital.

5. At this time there was only 1 medical position with a reliever on the basis of 1 in 3 weekends off call. The unrealistic after hours cover was the major reason for moving into private practice.

6. In 1989 I commenced practice as a general practitioner ("GP") in private practice and remained in private practice for approximately seven years. During my time in private practice, I was still involved with the Proserpine Hospital performing procedural medicine in Obstetrics along with emergency support.

7. In 1997 I returned to Queensland Health ("QH") at the Proserpine Hospital as Director of Medical Services ("DMS") and as Executive Officer for the Whitsunday Health District and I have been employed in that role since that time to current. I decided to return to the public sector full time for a number of reasons including the fact that Proserpine Hospital over time had increased medical staff and therefore there was more medical support, hospital work in the acute setting was more rewarding in my view than office based GP work and hospital work offered more opportunities for teaching.

8. In total, I have had approximately 21 years experience in rural medicine delivering medical services within the private and public sectors.

9. Over time, I have had the opportunity to use my clinical expertise to conduct various clinical investigations for QH. For example, I have reviewed the medical services of Ingham and Atherton Hospitals.

10. Attached and marked **DF-1** is a copy of my Curriculum Vitae ("CV").

11. As DMS at Proserpine Hospital I provide clinical leadership in all aspects of the medical services of the Whitsunday Health Service / Proserpine Hospital. My role requires me to have a thorough broad-based theoretical knowledge of all the specialty areas and key practical skills, including procedural medicine. I also have a clinical workload. My role is essentially a .5 clinical workload position. Although I do not

attend to routine general outpatients, I have a referred booked outpatient clinic and operating theatre list. I participate in the after-hours on-call roster and am also available in times of emergency or outpatients as needed. I also conduct ward rounds with my medical and senior nursing staff on a daily basis.

12. Some of my major areas of clinical responsibility are Obstetrics, General Surgery, Anaesthetics, Emergency Medicine, General Medical Supervision, Hands-on clinical, ward rounds, outpatients and theatre and as Government Medical Officer.

13. My role as Executive Officer for the Whitsundays Health Services District is an administrative role and is the single point of accountability for all matters relating to the service, including the service's budget of $6.1 million. The role also requires active involvement in the District Executive of the Mackay Health Service District. The District Executive is responsible for leadership for the Mackay Health Service District in support of the District Manager. This role has also expanded to a number of District, Zonal and State-wide responsibilities through involvement in various committees.

Rural Medicine Defined

14. The label "rural" is useful when one is comparing metropolitan and non-metropolitan hospitals. However, it has been my observation that there has been a tendency over time to use "rural medicine" as an umbrella term. Using the blanket term "rural" in the context of attempting to provide solutions for quality patient care is not always helpful as it implies that there is a one size fits all approach for all facilities that are given this label. The needs of rural hospitals are as diverse as their locations and the patient populations they service.

15. The main characteristics that define a rural hospital, are the remoteness and the population size. The rural facility will not be geographically near to other hospitals that have the staff, equipment and infrastructure to deal with a wide range of complex patient conditions. The other characteristic is the "generalist" nature of the services offered due to remoteness, population profile and demographic. A rural hospital will not necessarily have a sheer volume of patients coming to their hospital for a

particular medical condition/procedure due to differing demographics, but it is essential that rural people receive care for their particular condition that is of equal quality to that offered by major metropolitan centres. It is accepted by rural people that not all complex care can be achieved at a rural facility (and thus may require transfer), but the majority of clinical care can be offered locally, such as obstetrics and emergency medicine.

16. For the above reasons, the Service Capability Framework ("SCF") introduced by QH is a more useful tool in providing insight into service provision in the various regions across Queensland as opposed to having a strictly urban – non-urban reference. The SCF looks at every facility and determines what services are to be provided at that facility being mindful of the infrastructure (staff, equipment etc) that is available at the facility.

Proserpine Hospital – Staffing and Structure

17. Proserpine Hospital is part of the Mackay Health Service District. It is a 35-bed facility focusing on acute and specialty services. The hospital's service catchment area runs to Bowen in the north, to Bloomsbury and takes in the Whitsunday coastal townships and islands. The hospital delivers over 250 babies per year, has over 500 theatre cases and has a daily occupancy of 20 to 24 inpatients. There has been a marked increase in accident and emergency presentations (greater than 300%) in the last 5 years.

18. The Proserpine Hospital has one Senior Medical Officer (SMO), one Principal House Officer (PHO), and one PHO who performs relieving work for other Medical Officers who may be on leave. Assisting this structure are four GPs. Three perform obstetrics work, one performs anaesthesia work and they all provide a "backup" service for any major incidents. They also support our junior doctors in after hours situations.

19. The Proserpine Hospital is critically dependant on procedural GPs. All GPs who are not full time employees of Queensland Health who work at the Proserpine Hospital have their own private surgeries. After hours, the GPs can see the private patients at the public hospital depending on what venue is chosen by the patient. Whilst this

arrangement works well in areas of the size of Proserpine Hospital or smaller, I am vehemently opposed to GPs having complete management of the public patients in the larger rural facilities [population 3,000 to 20,000] as the procedural components required would make service delivery very difficult to be done in a timely manner due to their private commitments. This would be unsustainable and would impact on patient care and safety.

20. Proserpine Hospital also has an outreach service whereby the private sector and Mackay Base Hospital provides outreach_Visiting Medical Officers (VMOs) to help provide services for more complex cases in particular specialty clinical areas. The public VMOs are employed full time by Queensland Health at the Mackay Base Hospital and have their own patients at that hospital., These doctors also regularly come to care for patients in the Proserpine Hospital catchment area. An orthopaedic surgeon, two general surgeons, an endoscopic surgeon, paediatrician, psychiatrist and an obstetrician and gynaecologist regularly attend Proserpine Hospital as VMOs .

21. The doctors who are employed full-time by Queensland Health at the Proserpine Hospital are classified as rural generalists, that is, they are given "privileges" so that they can perform low to medium risk procedures within the SCF set for Proserpine Hospital by QH. The VMOs provide an invaluable service in treating more complex patient cases that the rural generalist practitioner cannot treat.

22. Where patients present with a complex condition that is beyond the SCF set for the Proserpine Hospital, and a VMO is not immediately available to treat the patient, the patient is transferred out to the nearest hospital that can provide the level of care required safely. Once the patient received the relevant specialised treatment at the larger facility, the patient may be returned to the Proserpine Hospital.

23. A relatively new innovation in assisting to provide specialist care is the Telehealth initiative. This initiative was implemented several years ago, but has only recently gained momentum as a part of the restructure of Queensland Health which I understand occurred early last year. Telehealth is overseen by the Innovation and Workforce Reform Directorate which was formed as a part of this new structure. The Telehealth initiative is useful in the rural context as it provides the patient with the opportunity to

see a specialist in another centre by way of video-link allowing a specialist and patient to communicate face to face without the need to travel long distances.

Challenges to Practicing in a Rural Setting within Queensland Health

- **Providing a defined career path for medical graduates wanting to pursue a career in rural medicine**

24. Rural medicine is one of the most satisfying and challenging careers anyone could pursue in medicine in my view. If a medical graduate wants to become a specialist, then generally they are a specialist in one area of specialty. Becoming a rural generalist means that you get a wide range of work to do. Added to that is the satisfaction of working in a small community where you often see the babies you deliver grow up and you essentially become part of the community as the community is very close to their regional health providers.

25. There is an expectation for rural hospitals to still provide the full range of clinical service to the rural community. Therefore, doctors in rural hospitals need to be trained across a number of specialties in order to provide the "rural generalist" service that the populations in non-metropolitan areas demand.

26. In order to encourage practitioners to pursue a career in rural medicine, there was a particular need to provide a structured career path for medical graduates to pursue the very specialist area of rural generalist medicine. In the past, a number of students had asked me "how could I become a rural doctor?". Over the years, Dr Dennis Lennox, myself and other like minded rural practitioners have explored a number of initiatives to address the challenge that is faced by medical students who may wish to become specialised in rural medicine. The Australian College of Rural and Remote medicine (ACRRM) has a flexible training program, but require coordinated support from QH to provide positions and hospital base training similar to the general specialties. Currently, Proserpine Hospital takes on a number of second and fourth year students from the James Cook University who receive training from the hospital as part of their studies. Further, sixth year students from James Cook University are often trained as interns as part of finalising their studies. All students and interns are all supervised by suitably qualified medical practitioners during their time at Proserpine Hospital.

27. A specific training and career pathway has evolved as part of ACRRM, but there is no coordination within QH to support such a pathway. The graduates who manage to complete this flexible training program are then given membership to the Australian College of Rural and Remote Medicine (ACRRM), which is a general practitioner college. ACRRM is not yet considered a Specialist College by the Australian Medical Council.

28. I am aware an application to have ACRRM recognised by the Australian Medical Council is currently being given due consideration.

29. If the Australian Medical Council agrees to grant ACRRM specialist accreditation to call itself a specialist college, this would be a useful marketing device to give the specialty official professional recognition and to reinforce the image of rural medicine as a viable and concrete professionally recognised and supported career path for Australian medical graduates to provide services to the rural community.

30. In years past there has been no breeding ground for rural generalists. In my view, if a more defined career path was offered to Australian medical graduates who wanted to specialise in rural medicine that may go some way to encourage more Australian trained graduates to rural areas who are committed to a career in rural medicine.

31. Whilst these initiatives will help to encourage Australian graduates, it has been my observation in recent years that the use of overseas trained doctors has become a necessity to fill the workforce shortages that have presented within areas of need. In my experience, the main stream of overseas trained doctors provide an invaluable service to patients and QH. However, the problems with overseas trained doctors has come to a head in my view due to the increased numbers that have been employed and due to the fact that the worldwide shortage of doctors has meant that the more experienced doctors are more difficult to locate and recruit to rural areas.

- **Credentialing and Privileging in a rural setting**

32. I am the chair of the Northern Zone Rural Credentialing and Privileging Committee ("Committee"). This Committee was established in the late 1990s at the direction of

Dr John Youngman, former Director-General of Queensland Health. There are currently 4 members of the Committee. There are three "active" members and one practitioner provides "backup" for the quorum when one "active" member is absent. The three "active" members are Dr Bruce Cameron, President of ACCRM and GP at Atherton, Dr Grant Manypenny, GP at Atherton / Mareeba and myself. Dr Tony McLellan is the "backup" GP to assist with Committee matters when one of the other members is absent.

33. Credentials represent the formal qualifications, training and clinical competence of medical practitioners. Clinical privileges represent the range and scope of clinical responsibility that a practitioner may exercise in the facility and may relate to areas of clinical practice, use of facilities or specialised equipment, or the performance of specific operations or procedures. The extent of privileges may vary between facilities depending on the resources available and the role of the service.

34. In summary, the role of the credentials and clinical privileges committee is to assess the credentials of an applicant and recommend clinical privileges having regard to the capability and requirements of the facility.

35. The Northern Zone Rural Committee meets once every three months. When this Committee was formed, the numbers of applications for credentialing and privileging were fairly small and a quarterly meeting was sufficient. However, as the number of applications increase, meeting only once every three months will prove a difficulty in the assessment of credentials and the granting of privileges. Often, scrutinising a doctors "on paper" qualifications is not sufficient to assess whether that doctor has the necessary skills and experience to undertake the specialty for which they are applying for privileging. This is especially the case for overseas trained doctors. Rural facilities are often more reliant on overseas trained doctors and due to their clinical ability being untested in this country, the credentialing and privileging process becomes more urgently required, and is an essential requirement. The need for a better process for credentialing and privileging was highlighted in a report for QH which I authored in conjunction with Dr Andrew Johnson, DMS of the Townsville Base Hospital in 2001. In my view, the Committee needs to be better resourced to enable meetings to be held

more frequently. In addition, the credentialing and privileging process needs to become part of the recruitment process of overseas trained doctors.

36. It is difficult for the rural committees to conduct quick privileging assessments on a more "ad hoc" basis when a new application for privileging is received. This is because the doctors at rural facilities need to be "generalists". Therefore to gauge their competence, a range of procedures across different specialties needs to occur. To obtain this broad view can often take some time and it is often difficult to co-ordinate a supervisor from a major hospital.

37. If it is not possible to assess whether that doctor has such necessary skills and experience, as is often the case with overseas trained doctors,_ the doctor must undergo a period of supervision by a specialist in that area or areas of medicine before being given privileges. A report is then written by the supervisor and presented to the credentialing and privileges committee.

38. I understand from my knowledge of QH policy on credentialing and privileging over time that temporary privileges can be granted to a practitioner by the DMS of the Facility or the District Manager pending full assessment by the committee. In my view, it is unfortunate that the rural hospitals are reliant on the temporary privileging process because, arguably, it is in rural areas where the absence of appropriately qualified doctors is more acutely felt as often rural hospitals do not have sufficient staff to provide back up to the vacant position . In my experience in the Northern Zone, in all but one facility in this Zone, applications for credentialing and privileging are coming in after the doctors have been recruited to their positions. In the Northern Zone, temporary privileges are only granted for General Practitioner work and not for the subspecialties such as anaesthetics and obstetrics. A full assessment by the Committee must be undertaken before full privileges are granted in these areas. Full assessments are difficult to arrange in the rural setting. For example if a doctor at Proserpine Hospital wants to obtain privileges in obstetrics or surgery or anaesthetics then they will be sent to a larger regional hospital, such as Townsville Hospital, that has a capability to perform a wide range of these procedures. To obtain privileges, competency must be assessed and therefore, a number of procedures, often of the same

procedure, needs to be performed. Often in the two weeks set aside, the doctor has not had the opportunity to perform the number of operations required to confidently assess competency.

39. The credentialing and privileging process is undergoing change and evolution. However, in the ideal model, there should be linkages to the Medical Board process and the recruiting process and links with the larger hospitals to assist to provide timely assessment of doctors.

40. Upon attaining clinical privileges, periodic reviews of clinical privileges are then to be undertaken by the credentials and clinical privileges committee. However, for the reasons set out, it is often difficult for the rural generalist to obtain sufficient peer review over time and across the range of procedures to give a full picture of the competence of the practitioner.

- **Continuing Medical Education for Rural Practitioners**

41. Another challenge to the rural medical workforce is to ensure that their medical knowledge is kept up to date. In a rural setting, the problem of continuing medical education is highlighted by the fact that the one doctor will need to have skills that are current across five or six specialties and therefore need more time off to attend a greater range of continuing medical education courses than other practitioners may need.

42. To address the currency of skills of doctors, every twelve to eighteen months, I ensure that doctors from Proserpine Hospital go to Mackay Base Hospital or some other larger hospital in the district to perform a procedure under the observation of a specialist in a particular area to ensure that skills remain current.

43. At Proserpine Hospital we are fortunate to have a structure that allows a staff member who wishes to take study leave to update their skills to be readily accommodated as I have been able to arrange for sufficient staff backup. However, I am aware that in some other rural areas, replacement staff are not as readily located or obtained.

44. The problem of obtaining approval for another full-time equivalent staff member to cover the workload is often difficult in itself. Although I have not had to undertake the process to obtain another full-time equivalent staff member, it is not uncommon for other rural areas to require this resource. If I had to undertake this process of requesting another full time equivalent, or any expenditure above and beyond what is provided for in the budget, it would be quite involved and time consuming requiring the DMS to write a business plan for presentation to District Management for consideration by various levels of corporate officers.

45. Public and private sector interplay is important in the context of continuing medical education. The VMO s are private practitioners and specialists in their field and have the expertise and current knowledge who, in the process of their treating public patients, are able to pass on this knowledge to the doctors at the public hospital. I believe that rural "generalists" should avail themselves of every opportunity to learn from the specialist VMOs where they can.

46. To assist with the hospitals continuing education, I have recently arranged for a paediatrician to do a chart audit of around thirty patient charts to evaluate the care provided and provide feedback as to aspects of care done well and aspects that perhaps required some improvement. I aim to request assistance from VMOs across the range of specialties provided at the hospital so that we can further draw on the knowledge of the VMOs, apply this knowledge to our treatment of patients and learn from that experience. However, the VMOs who attend Proserpine Hospital are often clinical directors of their area of medicine at the Mackay Base Hospital and their workloads do not present them with the opportunity to perform such audits

- **Recruitment and Retention of Doctors to rural areas**

47. Another challenge for rural medicine is the recruiting and retention of appropriately qualified and experienced medical practitioners.

48. I have previously discussed how I believe more Australian trained medical graduates may be attracted to a career in rural practice. However, until these graduates came into

the system in sufficient numbers, the system is going to continue to need overseas trained rural practitioners.

49. In my view, the salaries paid to rural doctors need to reflect the skills and responsibility they offer QH for patient care. Currently there is no real incentive to make rural service a more attractive option for medical practitioners. There needs to be an acknowledgement that there is a shortage of doctors in the global market and providing a larger financial incentive may go some way to attract medical staff.

50. However, increased salary on its own cannot address this problem. Having rural medicine recognised as an area of specialty and given approval for college status will increase the professionalism as it will then be seen as a specialist pathway and will attract staff who have made a conscious decision to provide a service to our local community and who are trained to do this. Further, with College recognition comes the more defined support network of mentors and likeminded professionals.

51. In my experience, it is often the small things that make doctors leave the rural setting. Accommodation is one aspect of this. Looking after doctors and your rural personnel in general is important and I try to assist the doctors with accommodation issues in any way that I can. I also try to ensure that applying for study and conference leave is not made an onerous task.

52. Currently, many health care professionals, including junior doctors, do not have dedicated study and conference leave in their award. In my view, training that can better the practitioners can only benefit the Hospital. Therefore, I have established a trust fund to assist any health care staff at the Proserpine Hospital, including allied health staff and junior doctors, with furthering their medical education and this trust fund is drawn upon whenever a staff member requests to attend such study and conference leave. The funds are obtained from public donations and from training monies.

- **Nature of the role of being a DMS in a rural setting**

53. My combined role of DMS and Executive Officer is a challenging one in that I have an overarching responsibility to ensure safety and quality from a clinical perspective, however the role involves a budgetary focus also. My position as DMS and Executive Officer is not a common one in Queensland Health, but has evolved to this point over time.

54. It has been my experience that it is sometimes difficult to balance these often competing interests. It is understood that hospitals cannot have an open cheque book but I believe safety and quality assurance should dictate budgetary decisions. I believe that it should be the role of the DMS to have a purely clinical focus in providing safe and quality care to patients. I believe the DMS should have a role in providing information on clinical matters to the District Manager who should then have an obligation to take account of the recommendation of the DMS when making the final budgetary decisions. It is my view that the DM should have the ultimate responsibility for accommodating safety and quality issues within the budget.

- **Changing the SCF to be more relevant to rural facilities**

55. Another challenge to practicing medicine in a rural setting is to ensure that the service capability frame work is made relevant to rural facilities within the specific regard to the population demographic and the remoteness of a particular area. The SCF is a generic document that needs to evolve, in my view, to become more prescriptive as to the procedures that can be safely performed at each facility given the infrastructure and staff available to perform such work. This will require some acknowledgement that some hospitals, especially in small rural areas, are not capable of safely providing a continuous service for one or more types of procedure, and are perhaps more capable of "specialising" in particular procedures that have been specifically identified in the SCF for that facility. Having a set or group of procedures defined for all practitioners and administrators to refer to will leave none with any doubt over what procedures can be performed at the hospitals and what procedures need to be specifically planned for and funded.

- **Measuring and ensuring Patient Safety and Quality Care in the rural setting**

56. In my role as Member of the State Safety and Quality Board and as Chairperson of the Mackay Health Service District Clinical Risk Management Committee it was my observation over time, that a challenge was presenting itself for staff to get past the blame for medical mistakes and to foster a culture of encouragement and support to report problems in clinical practice to ensure future patient safety.

57. This must have been an identified concern also for senior Queensland Health management over time as in the restructure of QH last year, the Innovation and Workforce Reform Directorate was formed and I understand this directorate will oversee reporting of adverse events and assist practitioners in reporting incidents to ensure support is provided to prevent similar incidents occurring in the future. The State Quality and Safety Board was established as part of the new structure and is governed by the Innovation and Workforce Reform Directorate. This Board may be a "centralised" initiative, however, I believe the appointment of the Patient Safety Officers who will have an active presence in the Districts and an invaluable role in providing feedback to the Board, will ensure that regional concerns are accounted for as well. The Board meets once a month and although in its infancy, has shown in my view, great potential to ensure adverse events, complaints and credentialing are properly managed and in ensuring that clinical governance is done properly at all facilities across Queensland.

58. The Mackay Health Service District Clinical Risk Management Committee was the first committee of its type outside Brisbane, to be gazetted. The gazettal occurred in 2002. I was instrumental in facilitating the gazettal of the Committee as it then could provide a forum for medical staff to talk openly about issues with medical care and treatment and give the chance to the practitioners to have the complaint dealt with without the culture of blame.

- **Support for Rural Practitioners and Rural Medicine**

59. I am involved in an informal rural network with Directors of Medical Services from other hospitals across various districts which have a similar population size and demographic to Proserpine Hospital. A number of these challenges have been discussed by the other directors informally over time and having this network provides the opportunity to be provided with feedback to these various challenges from other hospitals facing similar situations.

60. The Rural Doctors Association provides a yearly conference which is essential from a rural doctors point of view for networking and provides the opportunity to network with other rural practitioners. I understand the Rural Doctors Association was formed as there was the perception amongst rural practitioners that they were not being heard by the relevant people on issues relevant to them. The Rural Doctors Association performs similar functions to a union, but it has no official recognition by the Courts or any Industrial Commission. It is effectively a "voice" for rural practitioners and supports the spouses of rural practitioners as well by facilitating the Queensland Family Rural Network. I recall when I was involved with the Association it met with the Director-General of Queensland Health on a quarterly basis and with the Minister on a bi-annual basis. The Director-General and the Minister would give the Association a "hearing" but I recall that the same issues kept coming up (e.g career paths, accommodation, etc) and I became more frustrated with feeling that there were no changes occurring, despite the efforts of the Association.

61. Dr Dennis Lennox and a number of other senior rural practitioners have recently been instrumental in providing a rural collaborative of like-minded District Managers and rural Medical Superintendents across 19 health service districts to discuss issues particularly felt in the rural setting and to "become a voice" in corporate office for rural issues. One of the problems I have observed over time is that often rural issues do not get to the board of management within Queensland Health.

62. I believe the challenge of having a voice for rural issues within Queensland Health corporate office has provided the rural facilities with the opportunity to seek out other avenues of support at a local level. For example Roma Hospital recently managed to

recruit four Australian trained doctors by approaching the local council to ask whether there was some "joint venture" that could be embarked upon to attract staff to the area. The Roma Hospital in conjunction with the local council arranged to fly certain doctors and their families to the area to present the opportunities the area offered (in terms of jobs, schools, infrastructure etc).

63. I believe this example demonstrates that there are the opportunities to engage the local community to assist to support the hospital to attract the best staff and in turn help themselves to provide the best possible medical services.

64. I have been employed by Queensland Health in the previous structure with the hospital boards and under the current district system. The district system that we have currently is not the best model of service delivery for rural patients as the emphasis in Districts is taken away from the individual needs of each rural facility. That said, the hospital board model was also not the best model in that there was too much interference at an operational level by local communities in hospitals. I believe there is scope to go back to some form of regional board model to enable community input into hospitals. There are other models which may be considered.

David John Farlow (Dr)

DF-1

PERSONAL DETAILS

NAME: David John Farlow

BORN: Emerald, Queensland

DATE OF BIRTH: 25.07.59

MARITAL STATUS: Married, with 5 children

HOBBIES: Golf and fishing

ACADEMIC QUALIFICATIONS

1983 M.B.B.S., University of Queensland.

1984 Advanced Diploma in Obstetrics and Gynaecology (DRANZCOG)

1985 Fellow of the Australian College of Rural and Remote Medicine [FACRRM].

There is currently medico/political debate as to whether a FACRRM is required for rural practice and this is being sorted out at the Federal level however from a practical perspective I believe this job does require membership of either the College of GPs or the College of Rural and Remote Medicine.

FURTHER QUALIFICATIONS

- Early Management of Severe Trauma (EMST) required to assist in trauma management.
- Ultrasound, although this is not a mandatory requirement for the position, theoretical and practical knowledge primarily for emergency use is a significant advantage in supporting a broad range of sub-specialty services.
- Government Medical Officer, this requires extensive training and the ability to perform post mortems, assessment of rape / assault, education and knowledge of the court system to be an expert witness.

EMPLOYMENT DETAILS:

1997 to Present

DIRECTOR MEDICAL SERVICES, PROSERPINE HOSPITAL

EXECUTIVE OFFICER, WHITSUNDAY HEALTH SERVICE

The Proserpine Hospital is a 35-bed facility focusing on acute and specialty services. The hospital's service catchment area runs to Bowen in the north to Bloomsbury takes in the Whitsunday coastal townships and islands. The hospital delivers over 250 babies per year, has over 500 theatre cases and has a daily occupancy of 20 to 24 inpatients. There has been a marked increase in accident and emergency presentations (greater than 300%) in the last 5 years.

My position has TWO distinct roles:

- **MEDICAL SUPERINTENDENT OF THE PROSERPINE HOSPITAL.**

This role is to provide clinical leadership in all aspects of the medical services of the Whitsunday Health Service / Proserpine Hospital.

The Proserpine Hospital is an acute facility and has a broad range of sub-specialty services. A major part of the role of clinical leadership is clinical governance. The clinical services must be conducted within a framework that considers quality, patient safety, adverse event management and other legislative requirements associated with medical practice.

As well as the requirement to have a thorough broad-based theoretical knowledge of all the specialty areas, key practical skills are required including procedural medicine. A brief outline of my major clinical responsibilities are:

- **Obstetrics**

  Full range of obstetric procedural services including caesarean section, forceps and ventouse.

- **General Surgery**

  Including appendicectomy, ectopic, skin cancer flaps, vasectomy, tubal ligation, skin grafts etc.

- **Anaesthetics**

  Regional anaesthetics such as epidurals, spinals and sedative anaesthetics.

- **Emergency Medicine**

  Ability to manage all emergencies including cardiac arrest, major trauma etc.

- **General medical supervision** which involves support teaching of junior medical staff and students;

- **Hands-on clinical, ward rounds, outpatients and theatre.**

  Although I do not do routine general outpatients, I have a referred booked outpatient clinic and operating theatre list. I participate in the after-hours on-call roster and am also available in times of emergency or outpatients as needed.

- **Government Medical Officer** services which include post mortems and assessment of sexual assaults.

Rural medicine by its very nature requires an extensive knowledge of all areas of medicine. This is one of the most challenging aspects of rural medicine. There is an expectation to be able to offer a wide range of services. It is impossible to have specialist level knowledge and experience in each and every specialty area however extensive broad-base knowledge is a pre-requisite.

To be a rural medical practitioner within an acute setting requires extensive experience across the sub-specialty areas. Independent or solo practice in any sub-specialty area such as obstetrics, anaesthetics and emergency requires a significant time commitment to learn the skills of those areas.

EXECUTIVE OFFICER, WHITSUNDAY HEALTH SERVICE:

This is an administrative role and is the single point of accountability for all matters relating to the service (budget of $6.1 million).

The role of Executive Officer is diverse in providing local accountability for all aspects of the service (workforce, finance, corporate services). The role also requires active involvement in the District Executive of the Mackay Health Service District. The District Executive is responsible for leadership for the Mackay Health Service District in support of the District Manager. **This role has also expanded to a number of District, Zonal and State-wide responsibilities** *(see attached list of Committee memberships/participation).*

The key skill or ability required for the administrative role is leadership. This is a more difficult area to qualify but includes leading by example, good communication skills, integrity and honesty. Leadership requires the ability to gain respect from staff as opposed to demanding respect.

1989 to 1997

PARTNER PRIVATE PRACTICE
WHITSUNDAY DOCTORS SERVICE

During this time the Whitsunday Doctors Service expanded from a 4 to a 7-partner practice with 2 employed associates or trainees through the Royal Australian College of General Practitioners. The period saw the Whitsunday Doctors Service increase to 3 surgeries at Proserpine, Cannonvale and Airlie Beach. It also serviced and conducted clinics on several of the Whitsunday Islands including Long Island, Daydream, Lindeman (Club Med) and South Molle. It offered comprehensive 24-hour medical care with wide-ranging sub-specialities.

During this time I was also a VMO at the hospital assisting in most major accidents and emergencies, as well as providing a procedural service for obstetrics.

1988 to 1989

PROSERPINE HOSPITAL
MEDICAL SUPERINTENDENT

Medical Superintendent of the Proserpine Hospital. At this time there was only 1 medical position with a reliever on the basis of 1:3 weekends OFF call. The unrealistic after hours cover was the major reason for moving into private practice.

1983 to 1988

MACKAY BASE HOSPITAL

Advanced from intern to Resident Medical Officer, Senior House Officer and Principal House Officer over a 5-year period. I was a principal house officer for 3 years. A broad spectrum of experience was obtained. When on call or after hours the P.H.O. was singularly accountable for the complete medical supervision of the hospital including intensive care, obstetrics and accident and emergencies. Proficiency was gained in all of the procedural aspects of medical practice including caesarean section, forceps, appendicectomy etc.

Experience in the following specialities:

- Accident and Emergency.
- Paediatrics.
- Orthopaedics.
- Ophthalmology.
- Obstetrics and Gynaecology.
- Intensive Care.
- Anaesthetics.
- General Medicine.
- General Surgery.
- E.N.T.

COMMITTEES [CURRENT]

- Chair, **Whitsunday Health Service Management Committee**
- Chair, **Mackay Health Service District Clinical Risk Management Committee**
- Chair, **Northern Zone Rural Credentials and Clinical Privileges Committee**
- A/Chair, **Northern Zone Clinical Review Committee**
- **Medical Interest Based Bargaining (EB6)**
- **Regional Medical Officer for Queensland Ambulance**
- Member, **Clinical Director's Committee**
- Member, **District Consultative Forum**
- Member, **District Quality Committee**
- Member, **Mackay Health Service District Executive**
- Member, **Mackay Health Service District Finance Committee**
- Member, **Trauma Review Committee**
- Member, **Rural Health Advisory Committee (Ministerial body)**
- Member, **Northern Zone Perinatal Mortality Committee**
- Member, **Northern Zone Medical Workforce Advisory Group**
- Member, **Queensland Health Medical Workforce Focus Group**
- Member, **State Safety and Quality Board**
- Member, **Whitsunday Health Service Auxiliary**
- Member, **Whitsunday Shire Counter Disaster Committee**
- Member, **Queensland Emergency Medical Systems Committee**

FURTHER ACHIEVEMENTS

DECEMBER 2000 TO JANUARY 2001

INVESTIGATION INTO ANAESTHETIC DEATH - CHARTERS TOWERS HOSPITAL

Investigation Officers:

Dr David Farlow
Director of Medical Services
Proserpine Hospital

Dr Andrew Johnson
Executive Director Medical Services
Townsville Health Service District

MAY 2002

OPERATIONAL REVIEW – INGHAM HEALTH SERVICES

Investigation Officers:

Dr David Farlow
Director of Medical Services
Proserpine Hospital

Medical Superintendent Susan Keleher
Nursing Director
Medicine & Oncology
Townsville Health Service District

Mr Kieran Keyes
A/Executive Director of Business Services
Townsville Health Service District

SEPTEMBER 2003

REVIEW OF OPERATING THEATRES – CLONCURRY HOSPITAL

Investigation Officer:

Dr David Farlow
Director of Medical Services
Proserpine Hospital

MAY 2005

REVIEW OF MEDICAL SERVICES - TABLELANDS HEALTH SERVICE DISTRICT

Investigation Officers:

Dr David Farlow
Director of Medical Services
Proserpine Hospital

COMMUNITY BASED ORGANISATIONS:

1991 to 1994

Member of Mackay Regional Health Authority. The regionalisation of Queensland Health occurred in 1991. This body was the legislative authority to oversee the delivery of all health services to the Mackay region, which included Middlemount, Dysart, Moranbah, Clermont, Sarina, Mackay and the Whitsundays. The body undertook extensive community consultation with development of a strategic plan that was used as a blueprint for health planning.

1991 to 1994

WHITSUNDAY PRIMARY HEALTH CARE COUNCIL

Chairman of the Whitsunday Primary Health Care Council, which was a community based organisation responsible for consulting the community and making recommendations to the Regional Health Authority, (now District Health Council).

1999 to Present

NETWORKING THE NATION

Chair of a committee formed at Proserpine to obtain funds from Networking the Nation to set up a modern, telecommunications/videoconferencing/internet link between the communities of the Mackay District, including the Whitsunday Islands and the Moranbah District.

The project will be completed at the end of the year 2002. It will enable improved videoconference communication between the various centres, improving acute clinical assessment and subsequent treatment.

Funding successful – 12-99 – Grant - $400,000.

REFEREES

Dr. Bert Sadlier.

Director Accident and Emergency

Mackay Base Hospital

Phone: +61 7 4968 6000

Dr Andrew Johnson

Executive Director Medical Services

The Townsville Hospital

Phone: +61 7 4796 1003