COMMISSION OF INQUIRY NO. 1 OF 2005
MEDICAL BOARD OF QUEENSLAND

This is the annexure marked **"EMC-7"** mentioned and referred to in the Statement of **ERICA MARY COHN** dated this 17th day of May 2005.

"EMC-7"

Agenda

THE MEDICAL BOARD OF QUEENSLAND

Agenda Paper – Meeting – 11 February 2003

1. Action List

* Action list from previous Minutes will be **circulated**.

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2. Confirmation of Minutes

Confirmation of Minutes of 28 January 2003.

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4. Health Assessment and Monitoring

* [No. 1] DR M CORONEOS (804182)

- Letter from Minter Ellison Lawyers received 23/01/03
- Conditions – Medical Assessment Tribunal dated 15/08/00

For consideration – Board to consider the recommendation from Minter Ellison that it accept the amount of $1,017.20 on the condition that it is paid within 14 days of acceptance.

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* [No. 2] DR S F NEWTON (830228)

- Health Assessment Activity Sheet
- Extract from Minutes of the Health Assessment and Monitoring Committee meeting of 3/12/02
- Additional Undertakings signed by Dr Newton on 20/01/03
- Dr Newton's Schedule of Undertakings
- Draft letter to Dr Newton

For consideration – Recommendation that the draft correspondence, advising Dr Newton that the Board accepted the additional three (3) undertakings she agreed to, be endorsed and despatched.

[No. 3] MR H W CAUDLE (972398)

- Letter from Phillips Fox Lawyers dated 17/01/03

For noting.

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5. Complaints

[No. 4] A S REECE (870332)

Attached is a facsimile received 31 January 2003 from Minter Ellison regarding mediation with Dr Reece. The Board's lawyers sought urgent instructions with respect to a Board member to participate in the mediation process. Dr Toft nominated Dr Cohn to be the Board's nominee.

For ratification.

[No. 5] R BA PE (950562)

Attached is correspondence from Dr Ba Pe dated 3 December 2002 regarding Notice of Decision to Impose Conditions, and Notice of Investigation.

For information.

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* J B DOUGLAS (704258)

The report of the Complaints Investigation Committee is to be forwarded under separate cover.

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6. Registrations

Registration Advisory Committee

The report of the Registration Advisory Committee meeting on 3 February 2003 will be circulated.

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13. Correspondence

* [No. 6] AUSTRALIAN MEDICAL COUNCIL (M191) / PGMEFQ – ACCREDITATION OF INTERN TRAINING PROGRAMMES (M74B)

Attached is correspondence dated 24 January 2003 from the Australian Medical Council (AMC) regarding the new National Training Guidelines for Junior Medical Officers. The AMC request the Board to advise whether it endorses the revised national guidelines.

For consideration.

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15. Ordinary Business

* [No. 7] RESTRICTED TITLES (M232)

Attached is a memorandum dated 29 January 2003 from the Executive Officer regarding a referral from the Physiotherapists Board relating to the use of the title "Dr" by Ms Tyack, a registered chiropractor.

For consideration.

[No. 8] INSPECTORS / INVESTIGATORS (A17) / DELEGATIONS (M426)

Attached is a memorandum dated 29 January 2003 from the Executive Officer seeking delegation to appoint inspectors and investigators pursuant to the *Medical Practitioners Registration Act 2001* and the *Health Practitioners (Professional Standards) Act 1999.*

On 29 January 2003, Dr Toft approved such delegation.

For ratification.

[No. 9] M H GOLDEN (703461)

Attached is the Notice of Decision of the Health Practitioners Tribunal in relation to Dr Golden dated 23 December 2002 and copy of judgment.

For information.

[No.10] P J RICKARDS (935823)

Attached is the Notice of Decision of the Health Practioners Tribunal in relation to Mr Rickards dated 18 November 2002 and copy of judgment.

For information.

A MAINI (971851)

The Board noted advice from the FOI Officer that an FOI application has been received from Dr Maini seeking access to documents on his HAM file since his previous FOI application dated 16 October 2002.

For information.

MinterEllison 61 7 31191000
LAWYERS

13 December 2002

WATERFRONT PLACE 1 EAGLE STREET BRISBANE
PO BOX 7844 WATERFRONT PLACE QLD 4001 AUSTRALIA
DX 102 BRISBANE www.minterellison.com
TELEPHONE +61 7 3119 6000 FACSIMILE +61 7 3119 1000

Acknowl.....
HAMC 4/2/03
MB .....

RECEIVED
23 JAN 2003
HAM Unit

Jackie Cunningham
Medical Board of Queensland
Level 19 Forestry House
160 Mary Street
BRISBANE QLD 4000

Dear Jackie

Dr Michael Coroneos - High Cour costs

We refer to your telephone conversation with Erin Finn on 8 November 2002 and confirm your instructions to prepare an 'in-house' assessment of the Board's costs in relation to the abandoned High Court appeal and to try and reach agreement with Dr Coroneos for payment.

We provided our assessment to Dr Coroneos in the sum of $1,849.30. Mr di Carlo has advised that he has considered our assessment and will strongly recommend to his client accepting an amount of $1,017.20.

Given the additional time and cost involved in having the costs formally assessed, and the remaining (and far more significant) costs that are currently being assessed, we recommend agreeing to accept that amount, on the condition that it is paid within 14 days of acceptance.

We look forward to your instructions.

Yours faithfully
MINTER ELLISON
Minter Ellison

Contact: Erin Finn Direct phone: +61 7 3119 6495 Direct fax: +61 7 3119 1495
E.mail: erin.finn@minterellison.com
Senior Associate responsible: Shane Evans Direct phone: +61 7 3119 6450
Partner responsible: Ron Ashton Direct phone: +61 7 3119 6351
Your reference: 804182

Dr Coroneos – MAT order15 August 2000 previous conditions
Diagnosis: [ ]

	MAT Orders	Check list	Jobs to do	Delegated to	Completed Date	Comments & Recommendations
1	The practitioner must participate in treatment with a psychiatrist of his choice to be selected by him from a list of five provided by the Board for a period of 3 years from today;					
2	The practitioner must attend treatment at a frequency to be determined by that treating psychiatrist;					
3	The practitioner must provide the treating psychiatrist with a copy of the tribunal's judgment and reasons of 7 August 2000 and with any further material the treating psychiatrist shall reasonably require;					
4	The practitioner must consent to the treating psychiarist reporting to the board immediately if there is a termination of treatment or a significant change in his health but otherwise on a quarterly basis regarding dates of attendance only;					
5	The practitioner must attend for review by a psychiatrist nominated by the Board at the Board's expense at such times as the Board may from time to time determine but no more frequently that at 6 monthly intervals;					
6	The practitioner must consent to the psychiatrist nominated by the Board reporting to the Board following each such review assessment;					
7	(a) The practitioner must engage a practising neurosurgical peer to act as his support colleague; (b) For 3 years from today the practitioner must attend meetings at least monthly with the support colleague to discuss his cases and surgical procedures particularly those cases on his operating lists; (c) The practitioner must participate in neurosurgical morbidity and mortality meetings either with the support colleague or as arranged by the support colleague; (d) The practitioner must jointly with the support colleague submit a six monthly report to the Board which report must include details of: (1) The date and duration of his meetings					

Dr Coroneos – MAT order15 August 2000 previous conditions
Diagnosis: [ ]

	with the support colleague; (2) The dates and places of neurosurgical morbidity and mortality meetings participated in by the practitioner; (3) The dates, places and nature of other eduction activities engaged in by the practitioner					
8	The practitioner must meet the annual CME requirements of the Royal Australasian College of Surgeons with a maximum of one overseas meeting per year to count towards those CME requirements and with at least 75 percent of the requirements counted to be in fields related to neurosurgery.					
9	The practitioner must submit a diary of CME activities to the Board each six months commencing by 31 January 2001 in respect of the period to 31 December 2000					
10	The practitioner must do all in his power to further his application to rejoin the Neurosurgical Society of Australasia and to maintain any such membership granted to him.					

ractitioner : **830228 - Dr Newton, Susan Frances**

iagnosis : Psychiatric - Depression

omplaint Numbers : (None Recorded)

eating Doctors : B N Psych : 981669 DR Calder-Potts, Kevin Robert, Ment/SVisor : 870092 DR Beall, Trevor John, Treat GP : 890285 DR East, Joanna Mary, Treat Psych : 772582 DR Kimbell, Brian John Livingstone

ate	Folio	Activity Type	Comments
10/2002	216	Minutes (Committee)	Health Assessment Activity Sheet Running Sheet re Board Expenses BNP Report from Dr Ruth Gough dated 11/2/02 Extract from Minutes of the Health Assessment and Monitoring Committee meeting of 5/3/02 File Note from Ms Billie Ward dated 30/9/02 Letters (2) from Dr Susan Newton dated 30/9/02 Neuropsychological Report from Dr Jan A Ewing dated 16/7/02 Compliance Report Draft letter to Dr Newton. RESOLVED that: 1) Dr Newton's return to work be approved with certain provisos, one being that she work no more than 3 sessions per week, where each session is 3 to 4 hours duration 2) Dr Newton be released from her undertaking to refrain from medical practice 3) Dr Newton next attend for review with Dr Kevin Calder-Potts when her review is due in January 2003 3) the draft correspondence, advising Dr Newton that her return to work (with certain provisos) has been approved, be endorsed and despatched.
10/2002	201-213	Letter	From Dr Ruth Gough. Re attach letter & Neuropsych. Report (Dr JA Ewing)-appoint. for assessment.
10/2002	214	Letter	To Dr N. Ack receipt of signed Authority re new treat GP.
10/2002	215	Letter	To Dr Joanna East. Re authority - term treat and significant change in health status plus future meds.
/10/2002	217-220	Letter	To Dr Newton. Committee decision that she may RTW. Enc RTW checklist - to be returned to the Board. Notification of Undertakings form must also be returned. Committee nominated Dr Kevin Calder-Potts as BNP in January 2003.
/10/2002	221	Letter	To Laurie Monaghan, HIC. Req that the PSR on Dr Newton be removed.
2002	222	Return to Work	FAXED from Dr N. Re comments work-nursing home visits, Buderim.
11/2002	223	Minutes (Committee)	The Committee considered: Health Assessment Activity Sheet Running Sheet re Board Expenses Extract from Minutes of the Health Assessment and Monitoring Committee meeting of 1/10/02 Letter to Health Insurance Commission dated 15/10/02 Compliance Report. RESOLVED that it be recommended to the Board that undertaking (3) which states "I will refrain from the practice of medicine until released from this undertaking by the Board", be deleted from Dr Newton's Schedule of Undertakings.
/11/2002	224-225	Letter	To Dr N. Ack receipt corr for HAM Committee on 3/12/02. Matter of undertaking not to practice will be before the Board on 26/11/02.
/11/2002	226	Notification forms	From Dr N. Re signed Notification to employer-undertakings.

ractitioner : **830228 - Dr Newton, Susan Frances**

agnosis : Psychiatric - Depression

mplaint Numbers : (None Recorded)

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ate	Folio	Activity Type	Comments
/11/2002	227	Minutes (Board)	The Board considered the health assessment summary and various information as outlined in the agenda summary.The Board noted Dr Newton's concern in presenting the "Notification Form" with the list of undertakings, especially undertaking 3, to any prospective employer for signature. It was noted that at its meeting on 1 October 2002, the Health Assessment and Monitoring Committee resolved to release Dr Newton from undertaking 3 to refrain from medical practice.RESOLVED that the Board ratify the decision of the Health Assessment and Monitoring Committee on 1 October 2002 to delete undertaking 3 from Dr Newton's registration, which states: "I will refrain from the practice of medicine until released from this undertaking by the Board".
/11/2002	228	Letter	To Dr Newton ack receipt of Notification from Dr Trevor Beall.
/2/2002	229	Letter	To Dr Newton meeting on 26 November recomenedation to remove Undertaking 3 and list a current list of undertakings.
/2/2002	235	Minutes (Committee)	The Committee considered: Health Assessment Activity Sheet Running Sheet re Board Expenses Extract from Minutes of the Health Assessment and Monitoring Committee meeting of 1/10/02 Letter from Dr Newton dated 4/11/02 Letter to Dr Newton dated 12/11/02 Notification of Undertakings signed by Dr Trevor Beall dated 14/11/02 Compliance ReportThe Committee noted that Dr Newton has now commenced practice at the Eckersley medical Centre.RESOLVED that:1) Dr Newton be requested to enter into the following additional undertakings regarding her return to work:a) "I will work only in a position approved by the Board, and will adhere to any work restrictions (including hours of work, nature of clinical practise and number of patients treated per day) placed upon me by the Board"b) "I will advise my employer/Supervisor/partner/Medical Superintendent or any prospective employer/Supervisor/partner/Med Super of these undertakings"c) "I will provide the Board with the name of the person I have advised and authorise the release of reports from that person to the Board as requested by the Board"2) approval be given for Dr Newton to conduct nursing home visits, but not home visits
/2/2002	230	File Note	Re: BNR with Calder-Potts on Thursday 9 January .
/2/2002	231	Letter	To Dr Newton enclosing Review Questionaire.
/12/2002	232 - 234	Letter	To Dr Kevin Calder-Potts re Dr Susan Newton. Dr Newton has recently contacted me to advise that she ahs made an appointment with you for review on 9 Jan 2002 at 1pm.
/1/2003	236	File Note	From HAAO(mw). Rang Dr Newton to request that the Review Questionnaire which was forwarded at the beginning of December 2002 be completed and returned. Dr Newton advised that she would post or fax it to us shortly.
/1/2003	237-243	Review Questionnaire	FAXED from Dr N. Re signed R/Questionnaire.
/1/2003	244	Review (Board-nom)	To Dr Calder-Potts. Enc copy Review Questionnaire for BNR 9/1/03. Report still reqd by 28/1/03.

actitioner : **830228 - Dr Newton, Susan Frances**

gnosis : Psychiatric - Depression

mplaint Numbers : (None Recorded)

ating Doctors : B N Psych : 981669 DR Calder-Potts, Kevin Robert, Ment/SVisor : 870092 DR Beall, Trevor John, Treat GP : 890285 DR East, Joanna Mary, Treat Psych : 772582 DR Kimbell, Brian John Livingstone

te	Folio	Activity Type	Comments
1/2003	245-247	Letter	To Dr N. Re Committee resolved that she sign 3 additional undertakings re RTW. To be signed and returned by 20/1/03.
01/2003		Bring-Up	Dr Newton to see Dr Calder-Potts for BNR (see Minute 1/10/02)
01/2003	248-249	Undertakings	FAXED from Dr N. Copy undertakings and note that copy signed by JP/CD will be faxed tomorrow.
01/2003	250-251	Undertakings	FAXED from Dr N. Signed and witnessed undertakings.
01/2003	252	Letter	To Dr N. Ack receipt Signed undertakings.
1/2003	254-263	Report	From Dr Calder Potts. Re BN Review Report-review 9 January 2003.
01/2003	253	Letter	To Dr N. Enc copy BNR report and req any comments by 31/1/03.

** End of Report **

EXTRACT OF MINUTES FROM THE HEALTH ASSESSMENT AND MONITORING COMMITTEE MEETING OF THE MEDICAL BOARD OF QUEENSLAND ON TUESDAY, 3 DECEMBER 2002

Newton, Dr S F (830228)

The Committee **considered:**

- Health Assessment Activity Sheet
- Running Sheet re Board Expenses
- Extract from Minutes of the Health Assessment and Monitoring Committee meeting of 1/10/02
- Letter from Dr Newton dated 4/11/02
- Letter to Dr Newton dated 12/11/02
- *Notification of Undertakings* signed by Dr Trevor Beall dated 14/11/02
- Compliance Report

The Committee **noted** that Dr Newton has now commenced practice at the Eckersley medical Centre.

***RESOLVED** that:*

1) *Dr Newton be requested to enter into the following additional undertakings regarding her return to work:*
   a) *"I will work only in a position approved by the Board, and will adhere to any work restrictions (including hours of work, nature of clinical practise and number of patients treated per day) placed upon me by the Board"*
   b) *"I will advise my employer/Supervisor/partner/Medical Superintendent or any prospective employer/Supervisor/partner/Med Super of these undertakings"*
   c) *"I will provide the Board with the name of the person I have advised and authorise the release of reports from that person to the Board as requested by the Board"*

2) *approval be given for Dr Newton to conduct nursing home visits, but not home visits*

4/2/03

UNDERTAKINGS

I, Dr Susan Newton, a registered Medical Practitioner in the State of Queensland, agree to enter into the following undertakings with the Medical Board of Queensland:

1. You will work only in a position approved by the Board, and will adhere to any work restrictions (including hours of work, nature of clinical practice and number of patients treated per day) placed upon you by the Board.
2. You will advise your employer/Supervisor/partner/Medical Superintendent or any prospective employer/Supervisor/partner/Medical Superintendent of these undertakings.
3. You will provide the Board with the name of the person you have advised and authorise the release of reports from that person to the Board as requested by the Board.

I understand that the undertakings listed above are in addition to the undertakings previously given to the Board and will remain in force for until the previous undertakings expire.

I understand that failure to comply with any of these undertakings is a ground for disciplinary action.

Signed: S Newton 21/1/03 S Newton Date: 20/1/03
Dr Susan Newton

Signed: B Supple J.P (B. SUPPLE) Date: 21/1/03
(Commissioner for Declarations/Justice of the Peace)

SCHEDULE OF UNDERTAKINGS
Dr Susan Newton

1. I will submit to the medical supervision of an experienced general practitioner who should prescribe and supervise all medications other than those prescribed by treating specialists. I will keep the Board informed of the name of my current treating GP and authorise him/her to notify the Board if I fail to attend for treatment or review or if there is a significant change in my health status.

2. I will attend for treatment by a psychiatrist of choice, at a frequency to be determined by the treating psychiatrist, at my own expense. I will authorise the treating psychiatrist to inform the Board of termination of treatment or if there is a significant change in my health status.

3. I will attend for review by a doctor or doctors nominated by the Board, as requested by the Board. I will agree to meet the cost of these reviews.

4. I will not prescribe for self-medication, nor self-refer for investigative procedures.

5. I will authorise the Medical Board of Queensland to release information regarding my progress on the Health Assessment and Monitoring Program to my employer.

6. I will authorise the Medical Board of Queensland to release information regarding my progress on the Health Assessment and Monitoring Program to my treating psychiatrist and treating GP.

7. I will work only in a position approved by the Board, and will adhere to any work restrictions (including hours of work, nature of clinical practice and number of patients treated per day) placed upon me by the Board.

8. I will advise my employer/Supervisor/partner/Medical Superintendent or any prospective employer/Supervisor/partner/Medical Superintendent of these undertakings.

9. I will provide the Board with the name of the person I have advised and authorise the release of reports from that person to the Board as requested by the Board.

830228:jc

DRAFT MBQ 11 FEBRUARY 2003

Date

Dr Susan Newton
18 Kent Court
BUDERIM QLD 4556

Dear Dr Newton

At its meeting on 11 February 2003, the Medical Board of Queensland accepted the following three undertakings that you have agreed to provide:

1. You will work only in a position approved by the Board, and will adhere to any work restrictions (including hours of work, nature of clinical practice and number of patients treated per day) placed upon you by the Board.

2. You will advise your employer/Supervisor/partner/Medical Superintendent or any prospective employer/Supervisor/partner/Medical Superintendent of these undertakings.

3. You will provide the Board with the name of the person you have advised and authorise the release of reports from that person to the Board as requested by the Board.

The undertakings listed above are in addition to the undertakings you previously gave to the Board and will remain in force until 15 November 2004.

I have enclosed a complete schedule of your current undertakings with the Board for your information and 2 standard forms (Notification of Undertakings for Employer and Return to Work Checklist). The Return to Work Checklist must be completed and returned to the Board when you are negotiating a new position. The Notification of Undertakings for Employer form is to be signed by the person you have advised of your undertakings and returned by **date.**

Please do not hesitate to contact me on 3234 0199 if you have any questions regarding the Board's decision.

Yours sincerely

Jackie Cunningham
Acting Co-ordinator HAM

Enc: Schedule of Undertakings

phillips fox

Our ref: LMN:ARF:0207683
Your ref: 972398.jc

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Adelaide
Brisbane
Canberra
Melbourne
Perth
Sydney
Auckland
Wellington
Hanoi
Ho Chi Minh Cit

17 January 2003

Jackie Cunningham
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4001

Dear Jackie

Henry William Caudle

I refer to my letter of 28 November 2002 and provide you with an update regarding the conduct of this matter.

You may recall from my previous letter that Mr Caudle was to be sentenced in relation to charges of writing fraudulent prescriptions on 6 December 2002. I have been informed by a solicitor in the office of the Director of Public Prosecutions that Mr Caudle received a non-custodial sentence of 2 years, that has been suspended for 3 years.

However, Mr Caudle currently remains in custody in relation to other matters including his breach of bail conditions.

The solicitor with the conduct of this matter on behalf of the DPP informed me that he had asked the District Court judge for a period of imprisonment. In his opinion, Mr Caudle's conduct amounted to a gross breach of trust which needed to be deterred. He was disappointed with the sentence and intends to retain conduct of the matter so that the Magistrate hearing the further charges (in relation to possessing and manufacturing dangerous drugs) is fully informed of Mr Caudle's recent conduct.

The charges in relation to possessing and manufacturing drugs have been set down for an ex-officio mention in the Magistrates Court on 30 January 2003. I have asked that we be kept informed of the outcome of that hearing.

I am in the process of obtaining a certificate of conviction in relation to the fraud charges. Following a conviction and sentencing in relation to the dangerous drugs charges I will obtain a certificate of conviction and seek your instructions to amend the referral notice. Depending on whether Mr Caudle agrees to enter a plea in relation to the dangerous drugs charges, he may be convicted and sentenced in those matters as early as March.

I will provide you with a further update following the ex-officio mentioned.

If in the meantime you have any queries, please do not hesitate to contact me.

Yours sincerely

Louise Nixon
Solicitor
Direct +61 7 3246 4081
Email louise.nixon@phillipsfox.com

Andrew Forbes
Senior Associate

870332 4

MinterEllison
LAWYERS

WATERFRONT PLACE, 1 EAGLE STREET, BRISBANE QLD 4000, DX 102 BRISBANE

To Jim O'Dempsey
Medical Board of Queensland
Facsimile 3225 2527

From Erin Finn
E.mail erin.finn@minterellison.com
Facsimile +61 7 3119 1495
Direct line +61 7 3119 6495
Our Ref ELF SGE RSA 40-1429039

Date 31 January 2003
Number of pages (including this one): 3

Subject **Dr Stuart Reece**

Jim,

As discussed, your early instructions would be appreciated so that we can secure suitable dates for the mediation.

Regards

Erin

MinterEllison
LAWYERS

31 January 2003

WATERFRONT PLACE 1 EAGLE STREET BRISBANE
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DX 102 BRISBANE www.minterellison.com
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Attention: Jim O'Dempsey/Victoria O'Brien

Board Members
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4001

Dear Board Members

Dr Stuart Reece

I am pleased to advise that Dr Reece has finally agreed to participate in a mediation with Ian Hanger QC. Dr Reece will also now be represented at the mediation by a barrister, Stephen Durley.

In terms of the process, we plan to hold a preliminary conference of all parties to allow the mediator to set some ground rules and to settle any procedural issues at an early stage. I think a preliminary conference is important in this case to ensure that time allocated for the mediation itself is not wasted debating procedural issues. Following that meeting, and in accordance with our previous agreement with Dr Reece, we will allow two days for the mediation.

We have made preliminary inquiries as to the availability of Mr Hanger QC, Mr Devlin and Mr Durley and propose to schedule the mediation on 5 - 6 March with a preliminary meeting on 12 February.

It is important that a Board member participates in the mediation as a representative of the Board. This will involve attendance at both the preliminary conference and the mediation. We expect it will also be necessary to have a conference with the Board's nominee and Mr Devlin in the week prior to the mediation to canvass the issues involved in the case and to discuss a strategy for the mediation. The Board member must be able to express the views of the Board about the particular issues involved and be in a position to make decisions on behalf of the Board on the day. In this regard, I wonder if it would not carry more weight with Dr Reece for the Board's representative to be a general practitioner.

Would you please advise us of the Board's nominee as soon as possible and we will make the necessary arrangements directly with that person.

In terms of costs of the mediation, Mr Hanger QC's fees for conducting mediations are $4,950 per day (inclusive of preparation). Prior to finalising the arrangements we will seek confirmation that Dr Reece will pay half of Mr Hanger QC's fees and half the cost of preparing the mediator's brief.

Although I am encouraged to see the involvement of advisers on Dr Reece's side, I would still not be confident in saying at this stage that the entire matter can be resolved at a mediation. However, the prospect of at least narrowing the issues in dispute, and therefore reducing the time and cost of the adjourned Tribunal hearing, remain significant incentives for the Board to participate in the proposed mediation.

I look forward to receiving your instructions shortly. Please do not hesitate to call us if you wish to discuss this matter further.

Yours faithfully
MINTER ELLISON

Ron Ashton

Contact: Erin Finn +61 7 3119 6495 erin.finn@minterellison.com
Senior Associate responsible: Shane Evans +61 7 3119 6450
Partner responsible: Ron Ashton + 61 7 3119 351
Our reference: ELF SGE RSA 40-1429039

3/2/03
D/W DR TOFT.

DR Cohn to be approached – if she is available put to Board for ratification at next meeting.

3/2/03
D/W Dr Cohn who has agreed to be Board representative.
Advised Minter Ellison

3/2/03
Robyn Schall

Please prepare for Board ratification and advise Victoria O'Brien that Reece brief now not required.

Dr R Ba Pe
Grand Plaza Family Medical
Centre
1 Grand Plaza Drive
Browns Plains Q 4118

3 December 2002

9/12/02
Victoria O'Brien
Please note and advise Board.

Mr Jim O'Dempsey
Executive Officer
Medical Board of Queensland
GPO Box 2438
Brisbane Q 4001

Re: Notice of Decision to Impose Conditions
Notice of Investigation

I refer to your letter of 29 November 2002.

I shall abide the conditions imposed by the Board.

I have retained Andrew Boe from Boe Callaghan Lawyers to act on my behalf. His contact details are 143 Melbourne Street, South Brisbane Q 4101, Ph. 3844 7575, Fax 3844 9821 and email aboe@boecallaghan.com.au.

I will have Mr Boe contact you when the criminal charges are resolved. Please do not hesitate to contact me or my lawyers concerning any aspect of the matter.

Noted VOB.
13.12.02.

Yours faithfully

Dr Reggie Ba Pe

MB ✓

INCORPORATED
ABN 19 814 243 263
PLEASE ADDRESS ALL CORRESPONDENCE TO
THE EXECUTIVE OFFICER AUSTRALIAN MEDICAL COUNCIL PO BOX 4810 KINGSTON ACT 2604 AUSTRALIA

QUOTE REFERENCE NUMBER 1/7/18

24 January 2003

Mr J O'Dempsey
Executive Officer
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4000

Dear Jim

NATIONAL TRAINING AND ASSESSMENT GUIDELIENS FOR JUNIOR MEDICAL OFFICERS (PGY1 / 2)

The President of the Australian Medical Council (AMC) has been provided with a copy of the new National Training Guidelines for Junior Medical Officers that has been developed by the Confederation of Postgraduate Medical Education Councils (CPMEC) and the (Commonwealth) Medical Training Review Panel (MTRP).

The new national guidelines are intended to replace the "National Guidelines for Intern Training and Assessment" that were produced by the AMC in 1996, following the implementation of mutual recognition. The new national guidelines incorporate the experiences of the States and Territories in intern training and assessment and reflects current best practice. In addition the revised guidelines have been extended to include the PGY 2 component of post-basic medical training.

The new guidelines were developed by an Advisory Committee of CPMEC with funding from the MTRP. The AMC was invited to nominate a representative to the Advisory Committee and Dr Joanna Flynn, President of the Medical Practitioners Board of Victoria, was appointed. Dr Flynn had been a member of the AMC working group that had developed the original 1996 intern training guidelines.

The Commonwealth Department of Health and Ageing is proposing to release the new national guidelines as a joint CPMEC – AMC document. However, the document has not yet been seen by the AMC or by the State and Territory Medical Boards and I enclose a copy of the new national guidelines for consideration by your Board.

I would be grateful if you could let me know, in due course, whether your Board endorses the revised national guidelines.

Yours sincerely

IAN FRANK
EXECUTIVE OFFICER
O:\Committees\JMBAC\2003JMONatGuidelines.doc

28/1/03
Michael Denny Gerace
For Board consideration please

National Training and Assessment Guidelines for Junior Medical officers (PGY 1 & 2)

CPMEC / AMC

CONFEDERATION OF POSTGRADUATE MEDICAL EDUCATION COUNCILS
Postgraduate Medical Council of Victoria Inc–
The Postgraduate Medical Institute of Tasmania –
The Northern Territory Postgraduate Medical Council –
The Postgraduate Medical Council of New South Wales –
Council for Early Postgraduate Training in South Australia –
The Postgraduate Medical Education Foundation of Queensland –
The Prevocational Training and Accreditation Committee in Western Australia
–
& The Australian Medical Council.

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Overview

Junior doctors work in supervised training positions and have a key role in Australian hospital-based healthcare delivery. The first *National Guidelines for Intern Training and Assessment* were published by the Australian Medical Council in November 1996. Since then there have been considerable changes in both the processes and expectations for prevocational medical education, hospital training and professional development of junior doctors. There have also been changes in rates of movement of medical undergraduates and junior doctors between States within Australia. In response to recommendations by the Medical Training Review Panel (MTRP), there are now Postgraduate Medical Councils (PMCs) in each State and a national body, the Confederation of Postgraduate Medical Education Councils (CPMEC) that play a key role in coordinating, planning, resourcing and accrediting the training of intern and PGY2.

In 2001 an advisory committee with broad representation was set up under the auspices of CPMEC to review and update the national guidelines for the training and assessment of junior doctors in their intern year (PGY1) and to develop general principles in relation to the second postgraduate year (PGY2).

Each State and Territory medical board has established intern training and assessment procedures and are guided by their respective legislation. These national guidelines are not intended to replace state-based programs or standards. Rather they are intended to provide general principles which may be considered to achieve the broad aims and objectives of the prevocational years. Each state and territory should use the guidelines as a framework for informing their processes and for identifying gaps in specific goals and objectives. The guidelines are informed by examples of best practice and experiences in each state.

It is intended that these national guidelines will be available electronically with related websites and key resource documents for use by junior doctors, their supervisors, medical educators, hospital administrators and professional bodies concerned with overseeing standards of junior medical officer education. These revised guidelines can be downloaded as a .pdf file using Adobe Acrobat (www.adobe.com) or you can simply browse a relevant section: *Accreditation of training programs; Roles and responsibilities of parties involved in medical education; Education and professional development; Skills acquisition, proficiency and rotations; Supervision, assessment and feedback; Welfare of junior medical staff; Selection and retention; Ethical and legal issues; Overseas trained doctors and Monitoring and Evaluation.*

Nomenclature relating to prevocational trainees differs across states and territories and in these guidelines we interchangeably use the terms PGY1, PGY2 and Junior Medical Officer (JMO) to refer to prevocational trainees. CLICK HERE to view a table developed by the MTRP explaining the nomenclature used in each state. [insert link to resource 1].

The development of these national guidelines comes from a commitment from CPMEC,PMCs, MTRP and the AMC to promote national standards, to share information on education, training and workforce issues of relevance to prevocational trainees, their supervisors and hospital managers and to facilitate interstate movements of trainees. There were many organisations and individuals consulted in the review of the guidelines. CLICK HERE to view a list of stakeholders consulted. [insert link to resource 2]

National Advisory Committee

Professor Barry McGrath, Chair of Committee, Postgraduate Medical Council of Victoria
Dr Haida Luke, Research Fellow, Monash University & Project Officer, CPMEC
Dr Jo Hely, Postgraduate Medical Council of New South Wales
Dr Joanna Flynn, Representing the Australian Medical Council
Ms Faye Stephens, Commonwealth Department of Health and Ageing
Dr Linda Sheahan, Representing the Australian Medical Association
Dr Melissa Tanner, Junior Medical Officer, Western Australia
Dr Peter Roeser and **Ms Jennifer Willett,** Postgraduate Medical Education Foundation of Queensland

"Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician."
Hippocrates 460-400 B.C.

1. Organisations involved in prevocational medical education and training

1.1 National and State bodies

There are a number of national and state-based bodies concerned with the setting of standards for accreditation, education and training, professional development and workforce planning in relation to prevocational medical graduates in Australia. The Australian Medical Council (AMC) is a national standards body for basic medical education and training. It accredits the Australian and New Zealand medical schools and courses and specialist medical training programs, assesses overseas trained medical practitioners seeking to practice in Australia, advises State and Territory medical boards on uniform approaches to the registration of medical practitioners, and advises the Health Ministers' Advisory Council (AHMAC) on registration issues and on the recognition of medical specialties. For more information on the Australian Medical Council CLICK HERE: http://www.amc.org.au

The Medical Training Review Panel (MTRP) was established by the Commonwealth Government in December 1996 and first met in March 1997. Its primary function is to compile information on training opportunities for hospital medical officers and to monitor the impact of the provider number legislation. The main focus of the work of MTRP is to monitor the supply and demand for vocational training places. It is also charged with identifying and addressing the training needs of young Australian doctors affected by the provider number restrictions, namely those in their first two postgraduate years (PGY1 and PGY2), as well as non-vocationally trained Hospital Medical Officers in postgraduate year three (PGY3) and beyond. For more information on the Medical Training Review Panel CLICK HERE:

http://www.health.gov.au/workforce/meducatr/mtrp/mtrp.htm

The Postgraduate Medical Councils (PMCs) in each State and Territory are responsible for supporting and developing the training requirements of practitioners in their early postgraduate years and hospital medical officers who are not in vocational training programs. ThePMCs have a range of responsibilities, which vary between states and may include accreditation of PGY1 and PGY2 positions, allocation of junior medical staff to hospital positions, workforce planning, development of curriculum frameworks, evaluation of terms/rotations, provision of educational resources and promotion of educational and training programs. CLICK HERE to find out more about the role of each State and Territory postgraduate medical council:

Postgraduate Medical Council of Victoria	http://www.pmcv.com.au
Postgraduate Medical Institute of Tasmania	http://www.healthsci.utas.edu.au/pgmit/pgmit.htm
Northern Territory Postgraduate Medical Council	http://ntpmc.org.au
Postgraduate Medical Council of New South Wales	http://www.medesery.com.au/pmc/

Postgraduate Medical Education Foundation of Queensland http://www.pmefq.com.au
Council for Early Postgraduate Training in South Australia http://www.ceptsa.org.au
Prevocational Training and Accreditation Committee, Western Australia
http://www.ptac.org.au

The Confederation of Postgraduate Medical Education Councils (CPMEC) established in 1998, is a national body representing the State and Territory Postgraduate Medical Councils. It develops, monitors and evaluates postgraduate medical education and training from a national perspective. The CPMEC through its membership interacts with the Medical Training Review Panel, the Australian Medical Council, AMA (Doctors in Training), Australian Medical Students Association (AMSA), Committee of Presidents of the Medical Colleges (CPMC) and the Deans of the Medical Schools.

All State and Territory medical boards require medical graduates to undertake a year of supervised clinical training before they are registered unconditionally for practice. Each Council has a responsibility to their respective Medical Board, reporting to the Board on the adequacy of intern programs in training hospitals. CLICK HERE to access contact details for medical boards in Australia. [insert link to resource 3]

2. Accreditation of Training Programs [1]

Each State and Territory that provides intern training has in place an accreditation process for monitoring programs and training standards across its health services or networks. The aim of the accreditation process should be to ensure that all hospitals employing Junior Medical Officers (JMOs) offer sufficient experience, education, training and supervision to enable the JMOs to meet the objectives of their training program.

In each State or Territory that provides training for prevocational trainees there should be a designated authority for monitoring the standards of intern and PGY2 training this may be the medical board or another body delegated with the responsibility such as a Postgraduate Medical Council. The accreditation process should involve periodic on-site assessment by professional and trained peer review teams. There should be provision for monitoring standards between the formal site visits.

[1] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 14-15.

State guidelines for prevocational training should be published and updated regularly to reflect changes in other phases of medical education and in medical practice. They should be consistent with these national guidelines.

State accreditation guidelines should include standards and criteria for the following:

- organisation and administration of the training and education program;
- structure and content of the training and education program;
- supervision of JMOs;
- assessment of JMOs;
- feedback from JMOs about their programs and supervisors; and
- procedures for ongoing evaluation of the training program.

The accreditation criteria must be sufficiently explicit for there to be a possibility of non-accreditation or limited accreditation. As failure to satisfy the accreditation standards and a result of non-accreditation could lead to no junior staff being allocated and to workforce issues for the institution, there should be opportunities for a hospital to address its deficiencies and to be re-evaluated for accreditation.

2.1 The Intern Year [2]

The medical internship is primarily one of clinical apprenticeship and is principally based on inservice training across a range of supervised hospital posts that provide a broad base of experience and training. While it is a necessary condition for registration, completion of the intern year is insufficient preparation for independent practice of medicine.

Given the pivotal role of internship in the transition from basic medical education to vocational training, it is desirable that the intern year provides:

- a learning environment in which the intern is supported and supervised in the development of their professional values and identity;

[2] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 8-12

- opportunities for an intern to consolidate and develop further the knowledge, clinical skills and professional attitudes acquired during their undergraduate years;
- experience of a range of medical practices and advice in choosing career options;
- assistance to the intern to develop a sound basis for life-long education;
- allocation to units where registrars and consultants have a demonstrated commitment to JMO training;
- supervision by an experienced medical practitioner responsible for monitoring the progress of the intern;
- appropriate rostering and after hours supervision;
- sufficient contact between supervisors and interns to permit an adequate assessment of performance and to ensure early warning of the need forremediation; and
- supervisors with an outline of their responsibilities and regular feedback about their performance as supervisors.

CLICK HERE for information on JMO Survival tips [insert link to resource 4]

2.2 The PGY2 year

The second postgraduate year (PGY2) should not be viewed in isolation from the PGY1 year. PGY1 and PGY2 should provide continuous learning opportunities with PGY2 allowing for greater independence, flexibility in terms, encouragement to accept greater responsibility and to be an active participant in the learning process. The MTRP has highlighted the need for medical practitioners to have a balanced and generalist orientation in their first two postgraduate years which will alllow them access to vocational training offered by medical colleges.[3]

It is essential that the internship and other prevocational training in the succeeding year provide a sound general basis from which specific vocational training may proceed. It is expected that those trainees who have made a choice regarding their ultimate vocational training program will

[3] Medical Training Review Panel, Second Report, November 1998, p.38

have the opportunity during their PGY2 year to acquire limited experience in their chosen field, without compromising their own opportunity to consolidate their general clinical training or to change their vocational career choice. (See also Section 4.1 – The Aims and Objectives of the first two postgraduate years).

3. Roles and responsibilities of parties involved in medical education

3.1 The Junior Doctor

The junior doctor is a fundamental team member involved in: initial assessment of the patient, communication with the patient (or their legal guardian or 'person responsible'), communication with senior medical staff and other members of the team providing care to the patient and coordination and facilitation of diagnosis, management and discharge planning for the patient. Research skills and training are also a fundamental aspect to any professional career and should be a component of the JMOs' professional development. CLICK HERE for the sample position descriptions [insert link to resources 5 & 6] which may assist junior medical staff and their supervisors in clarifying the roles and duties of a JMO.

There is an expectation that JMOs must conscientiously make time for educational activities. This may involve attending educational activities, or making a particular effort to attend all clinical teaching opportunities; these activities may be offered within working hours or outside of rostered working hours. A commitment to life-long education and self-assessment should be developed through involvement in audit and peer review, journal clubs, attendance at programmed educational activities and use of the library, computers and other resources. Postgraduate Medical Councils in each State mandate the levels of support.

The success of prevocational training and any subsequent vocational training will depend on the junior doctors capacity for self-assessment and self-learning. There are a number of areas of educational opportunity which junior doctors should utilise to their benefit:[4]

Increasing knowledge, skills and proficiency in patient management through: taking case histories; making physical examinations and establishing the diagnoses; planning patient management; managing patients with specific conditions; seeking feedback from patients; developing discharge plans for patients; comparing their patient management with those of their peers; accepting increasing responsibility during each term; reviewing relevant published literature; and informatics and computer literacy.

[4] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 12-13

Addressing deficiencies in knowledge by: seeking assistance from registrars, consultants, colleagues, nursing staff and other health professionals; using other resources such as the library and critically evaluating the information received.

Monitoring own progress by: maintaining a self-assessment checklist or portfolio; and self-appraisal of level of empathy and tolerance, and of professional attitudes and philosophy.

Participating in educational activities by: attending educational sessions; giving presentations; and teaching others.

Participating in the assessment process by: meeting weekly with the supervisor to discuss progress and to receive constructive feedback on performance' discussing with the supervisor at half-term and end-of-term meetings; assessment of own progress; discussing the completed assessment form at end-of-term meetings, and participating in the evaluation of each completed term.

Learning to be an effective member of the health care team by: becoming familiar with hospital and ward procedures; developing communication skills; availing themselves of mentors when necessary; and utilising effective time management.

3.2 The Clinical Teacher

Clinical teachers play an integral role in the training and educational development of junior doctors. Clinical teachers should be expected to, among other things:[5]

- discuss the learning objectives of the term with the junior doctor at the start of term;
- supervise junior doctors;
- participate in the Postgraduate Clinical Education Program by providing on the job teaching appropriate to their clinical caseload in the hospital/community facility;
- assist junior doctors to develop study and research skills relating to particular patient presentations; and

[5] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001, pp 14-15.

- provide regular feedback on the junior doctor's performance during the term. This may include a mid-term formative appraisal and should include formal written assessment at the completion of each term.

Clinical teachers can assist to develop the clinical and good doctoring skills of Junior Medical Officers through:

- modelling good clinical practice, including the building and maintenance of professional relationships with patients and staff;
- promotion of individual responsibility for self-evaluation and development among junior doctors;
- assisting in the development and refinement of clinical skills and practice in accordance with the PGY1 and PGY2 curriculum and provide guidance in the day-to-day management of patients;
- provision of career guidance to junior doctors based on a critical assessment of their abilities, potential and professional goals; and
- encouragement of the development of critical abilities in the provision of health care in order to facilitate the cost-effective use of medical resources.

In conjunction with other members of the hospital staff (eg HMO Supervisors, Medical Education Officers), they may also facilitate the orientation of the junior doctor into the new working environment upon commencement of a new term by providing an orientation to the facility, and access to relevant information.

3.3 The Registrar

Registrars usually have a responsibility for facilitating the teaching and learning experience of junior staff in hospitals. The registrar has a central role in this process, being the key team member with whom the JMO interacts. Hospitals should support and ensure appropriate training of registrars in order to fulfil this role. It is expected that registrars: [6]

[6] The following section has been adapted from "Education, Training and Supervision for New Doctors", Medical Council of New Zealand, November 2001, p.47.

- provide the JMOs with a comprehensive orientation at the beginning of the term/rotation.
- be enthusiastic in their role as teachers and instructors;
- give informal teaching on ward rounds and during acute admitting days;
- provide appropriate feedback verbally throughout the term/rotation;
- understand their responsibilities for supervision of JMOs clinical work, procedural skills development, test ordering and interpretation, reports, and discharge summaries;
- identify aspects of poor performance early to the appropriate supervisor;
- encourage and actively assist junior doctors to attend education sessions regardless of other commitments;
- encourage active participation of JMOs in ward rounds, continuing medical education activities, departmental meetings, X-ray sessions and the like;
- encourage JMOs to attend outpatient clinics, laboratories and theatres; and help make these good learning opportunities; and
- encourage JMOs to share duties so that they can leave the ward at designated times for educational experience.

3.4 The Employer Hospital [7]

It is expected that each hospital employing prevocational doctors demonstrates a commitment to their development through the provision of appropriate administrative and organisational support and infrastructure. This should include providing an orientation program in paid time for junior doctors at the commencement of their employment.

The orientation program should be organised by the primary allocation or parent hospitals. In the case of interns, this orientation program will be conducted at the beginning of each year or as part of the trainee internship. In the case of PGY2 doctors, an orientation program will be conducted at the commencement of their employment.

It is expected that secondment or rotation hospitals will provide a general hospital orientation in conjunction with the specific term orientation to junior doctors at the commencement of their secondment.

Hospitals should provide documentation that will include at least the following components:[8]

- an outline of the Postgraduate Clinical Education Program (see also Section 4.5) relevant to their level, including the role of the key educational staff;
- information on the hospital's organisational structure and lines of communication;
- a statement of the general clinical duties of junior doctors and the standard of clinical duties required;
- a statement of the learning responsibilities of junior doctors eg to attend educational programs on a regular basis and to participate actively in seeking learning opportunities;

[7] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001, pp 16-17.

[8] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001and the WA Accreditation Guide, PTAC, Draft 6, June 2001.

- a statement of the assessment procedures to be used in the Postgraduate Clinical Education Program;
- personnel issues, including information about employment and award conditions, leave procedures, salaries, medical indemnity; professional associations;
- personal support procedures or mechanisms; and
- other policies and procedures of relevance to the junior doctors.

CLICK HERE to view a recommended list of topics for inclusion in the JMO handbook. [insert link to resource 7].

CLICK HERE to view guidelines for effective patient handover:
http://www.rcplondon.ac.uk/pubs/handbook/gpt/gpt_handbook_app4.htm

3.5 The Postgraduate Clinical Training Committee

It is expected that a body such as a Postgraduate Clinical Training Committee will be established in each hospital with JMOs to organise, develop and monitor the postgraduate education and training program. Membership of this body should include representatives of junior medical staff, administration and clinical teachers. CLICK HERE to view a copy of the guidelines for a Postgraduate Clinical Training Committee [insert link to resource 8].

3.6 Director of Clinical Training [9]

Each institution should have a director or supervisor of clinical training who has both a clinical and educational role. A Director of Clinical Training (DCT), appointed and supported by adequate resourcing by a hospital, is responsible for developing, coordinating and promoting the clinical training of JMOs in association with JMO staff management and the Postgraduate Clinical Training Committee. The DCT should have clear authority to fulfil the educational and administrative responsibilities for the prevocational training program. The DCT plays a major role in the planning, delivery and evaluation of JMO education, and should provide counselling on career options and professional development. They can also facilitate feedback to JMOs about their performance; and liaison with Term Supervisors regarding JMO issues. They also have an

[9] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

important role as an advocate for JMOs by interacting with hospital management and administration and as such should not participate in the assessment of the JMOs. CLICK HERE to view a copy of a Position Description for the Director of Clinical Training [insert link to resource 9]. The DCT has a pastoral role and helps identify junior doctors with special needs and ensures that effective systems of support are implemented.

3.7 Term Supervisor [10]

JMOs are expected to be under the supervision of a Term Supervisor who is responsible for ensuring the adequacy and effectiveness of supervision and support in order for the JMO to function safely within the term. Term or unit supervisors have a responsibility for ensuring that junior medical staff are provided with an orientation to the unit or term, discuss with the JMO the skills, knowledge and experience to be gained during the term, ensure there is appropriate supervision and support, and to provide formal and informal assessment and feedback during the term. CLICK HERE to view a copy of a Position Description for a Term Supervisor [insert link to resource 10]. (See also Section 6 – Supervision, Assessment and Feedback)

3.8 Medical Education Officer

In those States that employ Medical Education Officers (MEOs) their role is to facilitate the continuing education of prevocational doctors. They work with Senior Medical Staff responsible for the supervision and education of prevocational medical staff to maximise and promote teaching and learning for this group. The role of the MEO is unique to each setting and responsive to the needs of that setting. CLICK HERE to view a copy of a Position Description for a MEO (hospital based) [insert link to resources 11 and 12]. In Victoria, a MEO works in the office of the PMC. CLICK HERE to view a copy of the Position Description for a central MEO (non-hospital based) [insert link to resource 13].

[10] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

3.9 Other doctors, health care professionals and the Government [11]

All doctors on a team to which JMOs are attached, should provide a good example of the professional attitudes expected of a doctor. The interest and commitment of consultants and members of the medical team are critical to the creation of high quality JMO posts. Every consultant and registrar in the team shares educational responsibility for: teaching and guiding JMOs, providing feedback on clinical progress and the welfare of JMOs. Other doctors in the team may also share these responsibilities and should take an interest in the progress of JMOs. All members of the medical team should discuss areas of concern with JMOs and, if problems persist, should alert educational supervisors to any deficiencies in performance. The views of nurses and other health care professionals about the clinical progress being made by JMOs will be particularly valuable to trainees and their educational supervisors. Other health care professionals may also have particular skills to impart to JMOs, and such inter-professional educational and learning opportunities should be encouraged. Constructive feedback should be discussed with trainees and educational supervisors should be alerted whenever there are significant deficiencies or problem areas identified (see also Section 7.3 on Personal Health).

Health authorities are responsible for identifying the health needs of the local population and for developing a strategy to meet these needs. Health authorities should bear in mind the pivotal contribution which medical staff, particularly JMOs, make to the attainment of their health care goals. In relation to JMO training, high standards of clinical service, educational facilities and organisational support are required to form the basis of high quality training. Trainees are recognised as a valued resource and should have access to good support systems and facilities.

4. Education and Professional Development

4.1 Aims and objectives of the first two postgraduate years

Many of the challenges for JMO training lie in the clarification of the key skills, knowledge and procedures required for the first two years of clinical training. It is imperative that all hospitals and medical educators demonstrate a commitment to the development of JMOs. This can be demonstrated by ensuring that: [12]

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[11] The following section has been adapted from the publication by the General Medical Council, UK, "The New Doctor", April 1997, pp 35-36.

[12] The following section has been adapted from "A Guide for Interns in Victoria", a joint publication of the Postgraduate Medical Council of Victoria and Medical Practitioners Board of Victoria, December 2001, p.5.

- there are policies and programs in place that demonstrate a commitment to learning;
- the hospital has a suitably trained and supported Director of Clinical Training;
- JMOs are actively encouraged to assume responsibility commensurate with their own personal skills and experience;
- JMOs are actively encouraged to develop their own personal and professional education and to develop a sound basis for life-long continuing medical education;
- JMOs have access to confidential counselling and career advice; and
- educational programs are coordinated between the allocation or parent hospital and secondment or rotation hospital.

The first two postgraduate years should be viewed at a national level as a period in which all medical graduates gain appropriate knowledge, attitudes and skills, which will equip them to proceed to general, or specialist vocational training. Emphasis should be placed on practical experience so that competence is attained through caring for patients who have a broad range of medical and surgical conditions. In particular, therapeutic and procedural skills need to be developed under appropriate supervision. Teaching needs to be linked to, but not totally dependent upon, the service requirements of internship and residency. Much of the JMOs' learning will occur at the bedside; hence they need to feel comfortable in seeking guidance from their senior colleagues.

By the end of the first two years of postgraduate training, the JMO should be able to demonstrate:[13]

- honesty, integrity and reliability in dealings with patients and colleagues alike;
- adequate knowledge of basic and clinical sciences, and application of this knowledge to the care of patients with a broad range of common and important medical and surgical conditions;

[13] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

- appropriate clinical skills, including history taking and physical examination, to permit sufficient definition of the patient's problems in order to make a provisional diagnosis and formulate an appropriate plan of investigation and the ability to interpret commonly used investigations and tests;
- the ability to organise, synthesise and act on information gained from the patient and other sources so as to exhibit sound clinical judgement and decision-making;
- the ability to use information technology to access key information, clinical practice guidelines and evidence based medicine;
- the ability to act effectively in emergency situations;
- an understanding of preventive care and the importance of modification of risk factors and life style in plans of management for patients and their families;
- the ability to perform simple procedures competently, understanding the indications for, and risks of the procedures undertaken;
- the ability to work effectively within a team of health care personnel, including other doctors, nurses, allied health professionals and undergraduate students;
- effective time management;
- a commitment to self assessment and continuing medical education and an ability to locate and critically appraise biomedical literature relevant to everyday clinical practice; and
- a willingness to be involved in teaching of others, including undergraduate medical students, nurses and allied health professionals.

4.2 Consolidation of communication and counselling skills [14]

Communication and counselling are best practiced and consolidated after graduation when the JMO assumes responsibility for patient care. Issues such as bereavement, modification of life style, and care of the elderly require effective communication with patients, their families and other health care personnel. By the end of the first two years of postgraduate training, the JMO should be able to demonstrate:

- an ability to communicate effectively with patients and their families using techniques that have been shown to affect outcome in terms of reduction of patient anxiety and apprehension, risk factor modification and compliance with medication;
- an ability to counsel patients and their families, particularly with respect to prognoses of death, dying and disability; and
- ability to work effectively within a team of health care personnel, to contribute appropriate knowledge and expertise and to value the contributions of other team members.

4.3 Use of diagnostic and consultant services with increasing discrimination [15]

Clinical practice is becoming increasingly complex. Technological development has led to a widening array of options for investigation and effective therapy of patients yet increasing pressure is being brought to bear on health care personnel to take responsibility for the provision of cost-effective services. Issues of resource allocation and utilisation are likely to have an even greater impact on clinical practice in the future. By the end of the first two years of postgraduate training the JMO should be able to demonstrate:

- a commitment to critical appraisal, quality assurance and peer review;
- an understanding of the use of common investigations, including knowledge of how diagnostic test characteristics influence the selection of investigations and interpretation of their results;

[14] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

[15] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

- the ability to seek expert consultation thoughtfully, having first, under appropriate supervision, appraised the clinical situation and initiated appropriate investigation and management; and

- responsibility for their actions in human and economic terms so as to achieve the desired clinical outcome for the patient to the lowest cost to the community.

4.4 Formal education [16]

Junior medical staff must be provided with appropriate formal education opportunities which are relevant to JMOs needs, and to clinical needs and based on adult learning principles. Each hospital should:

- provide structured education programs specifically for PGY1/2;

- provide education programs that are accessible to junior medical staff and are 'protected' from excessive intrusions from clinical responsibilities;

- ensure that education programs have a focus on clinical skills acquisition;

- ensure that education programs are evaluated to meet the needs of junior medical staff; and

- ensure that JMOs have access to appropriate facilities and educational resources to support and maintain self-learning activities (such as internet access at work).

It is also necessary within a best learning environment and educational framework that:

- education sessions are interactive and not unduly didactic;

- immediate written evaluation forms are completed at the completion of the teaching session (these should be consolidated by a third person and fed back to the presenter);

[16] The following section has been adapted from the Victorian Intern Accreditation Standards, 2001

- specific sessions for PGY1s emphasise clinical problems of direct relevance to their daily work and seek to consolidate and expand their student learning; and

- education sessions for PGY2s provide exposure to different disciplines which reflect their long term career goals.

Wherever possible, educational sessions should take place within rostered hours, with formal teaching sessions of about 3 hours per week for PGY1s and, for PGY2s, at least 1-2 hours per week. These sessions should be specifically designed to meet the needs for PGY1s and, to a lesser extent, for PGY2s. It is important that there is a clear expectation that the PGY1/2 will attend and arrangements are made to minimise interruptions eg formal ward rounds are not scheduled and wards know that trainees should be paged only for urgent problems. During the specific teaching sessions it is desirable that arrangements be made for someone else to hold the trainee's beeper and the trainee is disturbed only for emergencies and not for routine calls initiated by relatively junior staff.

Valuable learning opportunities exist outside the structured training sessions. These teaching sessions for PGY1 and 2 may include: [17]

- discussion of particular clinical problems demonstrated by patients on the ward with active participation by the PGY1 or PGY2 either before or after a ward round;

- Department or unit meetings where the PGY1/2 presents patients and Grand Rounds or other division or hospital-wide educational activity;

- Radiology and/or pathology demonstrations;

- X-ray meetings;

- Mortality and morbidity audits; and

- clinical skills sessions.

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[17] The following section has been adapted from the publication by the General Medical Council, UK, "The New Doctor", April 1997, p. 40.

4.5 Postgraduate Clinical Education Program

It is expected that a hospital will provide and maintain a satisfactory Postgraduate Clinical Education Program. The principles of a Clinical Education Program include: [18]

- an integrated approach to training in the first two years, encompassing clinical experience, on-the-job training and formal education;
- a focus on specific term objectives for the relevant level of training;
- provision of junior doctors with terms of appropriate length, quality and content, as well as adequate levels of supervision and education sessions;
- core terms of surgery, medicine and emergency medicine during PGY1;
- offer further experience in the PGY2 year, for example in adult or paediatric medicine, emergency/critical care medicine, surgery and rural/community medicine;
- development of a collaborative approach between the primary allocation and secondment hospitals to ensure that the learning opportunities available for junior doctors are accessible and effectively integrated; and
- preparation for junior doctors for practice in a wide variety of settings, for example, both urban and rural settings.

5. Skills Acquisition, Proficiency and Rotations

The skills and knowledge that JMOs could be expected to learn during their first two postgraduate years vary according to hospital, supervisors and training terms. Curriculum frameworks and a Clinical Training Portfolio have been developed which can assist Directors of Postgraduate Medical Education, Unit Heads and DCTs to identify clinical and procedural skills and thus discuss with JMOs learning objectives to be achieved during a term or rotation. The learning objectives within the curriculum framework covers areas including: procedural skills, emergency care, first line management of common primary presentations, patient assessment skills, professional knowledge and skills, preventive care skills, communication skills and

[18] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001

professional development. The curriculum framework can be viewed at: http://www.pmefq.com.au

It is important that educators regularly evaluate clinical skills to take into account emerging themes in medicine. This may include:

- genetics (such as genetics as a screening tool vs genetics in selected families or ethical implications and insurance implications);
- patient safety (computer assisted prescribing, correct management of drug reactions);ethics and privacy (attention to the ethics and privacy of computer records/ databases); and
- antibiotic resistant bacteria (hand washing skills).

CLICK HERE to view a list of skills and knowledge which could be acquired during the JMO years. [insert link to resource 14)

5.1 Term Rotations

Each term should have clearly articulated educational objectives with the opportunity for any additional objectives to be negotiated between the JMO and the supervisor. A mix of terms, both core and non-core, should reflect the educational objectives of the PGY1 or PGY2 program, should provide for meeting the appropriate medical registration requirements and meet the interests of the prevocational trainee. CLICK HERE for a term description template [insert link to resource 15.

The internship and early years of residency should provide the JMO with sufficient opportunities in clinical practice to enable meaningful decisions to be made regarding career choice and vocational training. Exposure to paediatrics, obstetrics, liaison psychiatry, general practice and other community based experience, and anaesthesia and intensive care is highly desirable to supplement the core experience in general medicine, surgery and emergency medicine. Hospitals and other training organisations should endeavour to improve JMO education and training by encouraging active participation of attending medical officers in educational programs, including bedside teaching. Career counselling regarding career choice and other matters should be available through term supervisors and the Director of Clinical Training.

Although registration is conferred at the end of the intern year, most medical graduates in their second postgraduate year remain within the network of hospitals to which they have been allocated as interns. This potentially allows a hospital sufficient time to develop comprehensive term rotations and broad educational programs.

5.2 Community and rural rotations

The MTRP recommended that JMOs be exposed to at least one rural and/or community based term. [19] Such terms enable junior doctors to broaden their experience and gain a greater understanding of how the health system operates outside large metropolitan teaching hospitals. Some of the identified aims of rural and community terms include:[20]

- an appreciation of the resources available in rural, district and referral health services, to maximise their efficient use of resources;
- opportunity to care for patients primarily in outpatient, ambulatory care or community settings, many of whom live with chronic illness;
- attainment of skills in the assessment of patients' health status and care needs and their implementation in a community context;
- development of an understanding of the responsibility of providing continuing care through practical experience;
- assessment and treatment of the acutely ill patient in the home;
- management of illness within a network of community-based health care professionals and services.

The wider clinical and health service experience offered by rural and community terms provides the necessary patient focus to contribute to the well-rounded, generalist orientation that characterises the first two years of postgraduate training.

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[19] Medical Training Review Panel, Third Report, August 1999, p.36.
[20] Community and Rural Terms for Junior Doctors in Australia", March 2002, Produced by the Postgraduate Medical Council of NSW, Funded by the Commonwealth Department of Health and Ageing.

CLICK HERE to view a copy of a report, *Rural and Community Terms for Junior Doctors in Australia – A National Review:* http://www.health.gov.au/workforce/pdf/report.pdf

6. Supervision, Assessment and Feedback

6.1 Supervision

Supervision in the prevocational years should allow for graded opportunities for independent decision-making. The proximity of supervision required in each work situation is predetermined by: the hospital setting, type of term, and experience and skill level of the JMO. It is important that the hospitals provide JMOs with adequate and appropriate supervision and encourages JMOs to ensure that they are adequately supervised according to the limitations of their knowledge and experience. Providing opportunities and supporting the training of supervisors is also very important to the educational and professional development process.

JMOs are expected to be under the supervision of the Term Supervisor who is responsible for ensuring the adequacy and effectiveness of supervision within normal term operations. All doctors providing supervision to JMOs should be made known to them. The process for contacting these supervisors must be clear to all involved. Greater supervision is required in PGY1. There should be relatively less direct supervision and more clinical responsibility in PGY2, preferably with greater exposure to sub-specialty terms.

Supervision should be provided as follows:[21]

- During the first week of the junior doctor's attachment, the clinical teacher/mentor will discuss with the junior doctor their role and responsibilities in the Unit(s) or facility, and highlight the responsibility of the junior doctor to be pro-active in their learning;

- Hospitals should provide direct supervision of PGY1 doctors by a registrar or other suitably experienced medical practitioner at all times. In hospitals where a registrar or equivalent is not employed, attending medical officers must be available at short notice for the supervision of JMOs;

- Direct supervision may not be required for PGY2 doctors but their supervisors must be readily available;

[21] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001.

- The position description for all staff responsible for supervising Junior Medical Officers clarifies their role and responsibilities for supervising Junior Medical Officers;

- Each clinical teacher/mentor should ensure that their contact with each junior doctor is sufficient to permit a valid assessment of the junior doctor's performance by *direct* observation;

- Supervision of junior doctors should allow for increasing opportunities for independent decision-making; and

- The adequacy and effectiveness of Junior Medical Officer supervision is evaluated.

6.2 Assessment

Hospitals are required to facilitate regular assessments of junior doctors. A range of individuals should contribute to the assessment and feedback process including consultants, registrars, nursing staff and other health professionals. Assessment in each term/rotation should be:[22]

- the responsibility of the assigned clinical supervisor in conjunction with other unit staff (medical, nursing and allied health);

- a valid, reliable process explained to junior doctors at the commencement of each term as required;

- based on observations of the junior doctor's performance; include a mid-term formative assessment process for all terms greater than 5 weeks;

- continuous, both on a formal and informal basis, leading to a written report from the clinical teacher to the Medical Superintendent via the SIT or DCT at the end of each term;

- a transparent process which includes opportunity for both self-assessment and access to the supervisor's report by junior doctors; and

[22] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001.

- accompanied by ongoing feedback and guidance from the supervisor.

Each hospital should have a mechanism in place that clearly explains the criteria, process and timing of assessment and feedback to junior medical staff, which must be known to the junior doctor.

6.3 Feedback

Provision of continuous feedback to JMOs is fundamental. Hospitals should clearly explain the criteria, process and timing of assessment and feedback to JMOs at the commencement of each term. There should be opportunity for both formal and informal assessment and both mid-term and end-of-term feedback. CLICK HERE to view a copy of the JMO Attachment: Feedback and Appraisal Form (JAFA) and JMO Progress Review Form developed by the Postgraduate Medical Council of NSW. [insert link to resources 16 & 17]

Junior Medical Officers are encouraged to take responsibility for their own performance, and to seek feedback from their supervisors in relation to improving their performance. It is very important that the progress of JMOs is monitored, and that Supervisors and Directors of Clinical Training and JMOs themselves consult with Term Supervisors regarding individual performance where appropriate.

6.4 Unsatisfactory performance [22]

The routine monitoring and evaluation of the progress of junior medical staff by each hospital and across its network is critical. Where problems are identified, or there is unsatisfactory performance, including remediation and reassessment, the procedure for supervision and counselling must be explicit and must be known to the JMO The hospital needs to maintain the confidentiality of the JMO receiving personal support. The hospital needs to balance the privacy of the JMO with the need to engage additional support to ensure patient care and safety.

[22] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

7.0 Welfare of junior medical staff

7.1 Safe Working Hours [23]

Safe working hours influence the way doctors practice. Traditionally, non-specialist doctors, including residents and interns, registrars and career medical officers, employed in a hospital environment have worked long hours usually in shifts. The resulting fatigue restricts performance, and its effects are well documented. Concentration, data processing and short-term memory are impaired, variability of performance increases and decision-making is erratic. Inevitably, tired doctors make errors, fail to spend adequate time with patients, fail to communicate effectively with them and neglect to complete appropriate case notes. Of note, fatigue is not available in law as a defence for negligence by a doctor in a legal action by a patient (Nocera and Strange Khursandi, 1998).[24] There are therefore safety and quality, humanitarian and legal reasons to limit excessive hours, which in recent times have been recognised in other nations and other industries in Australia. CLICK HERE to view details of the AMA's Safe Hours Project which seeks to raise an awareness of the problems and risks associated with the hours of work of junior hospital doctors:
http://www.ama.com.au/web.nsf/doc/SHED-5G3D4Y

7.2 JMO Management [24]

Hospitals need to provide effective organisational structures for the management of JMOs. Policies and procedures for the management of grievances need to be documented and freely available to junior medical staff. Hospitals and the relevant staff need to comply with occupational health and safety obligations. In supporting JMOs, hospitals should encourage JMOs to take responsibility for their self-care and provide access to personal support mechanisms to ensure the well being of JMOs. For JMOs with special needs, it is essential that hospitals identify and support JMOs with special needs. Having the hospital provide an accessible, safe, comfortable recreational area with a range of amenities (such as residents

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[23] The following section has been taken from The Australian Medical Workforce, Department of Health and Aged Care, *Occasional Papers, Series No. 12*, August 2001, pp 93-95. This paper was prepared by Monica Pflaum with input and assistance from Catherine Wall, Beth Slatyer, Clare Boutchard, Rhonda Jolly and Katherine Harris, Commonwealth Department of Health and Aged Care.

[24] Nocera A and Khursandi DS, 1998, Doctor's working hours: can the profession afford to let the courts decide what is reasonable?, *Medical Journal of Australia*, 1998, Vol.168, pp 616-618.

[24] The following has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

lounge for on call shifts, study area and computer resource room) supports the well being of all JMOs.

7.3 Personal health

Medicine can be a stressful experience and counselling and support services should be readily available. Peer support and opportunities for junior doctors to share their experiences are of fundamental importance. Junior doctors should have their own general practitioner to help them stay healthy. JMOs with a health problem should consult their general practitioner first. JMOs with professional and personal problems should consult their Supervisor or Director of Clinical Training for advice.

Medical boards have established processes for the assessment, reporting and rehabilitation of doctors whose health has impaired, or may impair, their ability to practice medicine.

The CPMEC conducted a Symposium in July 2001, "The Student and Junior Doctor in Distress". The proceedings of this Symposium have been published as a supplement to the*Medical Journal of Australia,* Vol.177, 1 July, 2002. CLICK HERE to view a copy: http://www.mja.com.au/public/information/supplements.html

8. Selection and retention of junior medical staff

8.1 Principles of selection and appointment [25]

The process for selecting and appointing JMOs to training programs and posts should be open and systematic. It must be free from discrimination and comply with equal opportunity legislation. This can be facilitated by providing selectors with advice on anti-discrimination and equal opportunity legislation.

Wherever possible:

- Training opportunities should be advertised and appointments made on the basis of open competition;
- Job descriptions, including person specifications and selection criteria, should be available when training programs or posts are advertised;

[25] The following section has been adapted from the publication by the General Medical Council, UK "The Early Years Recommendations on SHO Training".

- The service commitments and educational opportunities of training programs and posts should be made explicit in job descriptions;
- Standardised open references should be used;
- Those involved in selection and appointment should receive training in interviewing techniques;
- Selection should include a process of short-listing that involves all who expect to interview candidates;
- Interviews should follow a consistent, structured pattern using standardised questions that give all candidates the opportunity to demonstrate their suitability for the program or post;
- A record should be kept of each interview;
- Candidates should be told at interview how and when they will be informed of the selection panel's decision;
- And unsuccessful candidates should be given the opportunity to receive professional feedback following interviews.

8.2 Flexible training options

Flexibility at work is becoming increasingly a factor to be considered in the medical workforce due to technology, globalisation, social changes and expectations. There is increasing recognition of the importance of balancing life and work, of balancing the needs of both the employers and employees. Hospitals are encouraged to think about ways of developing more flexible family-friendly work arrangements, which could be achieved through rostering, job-share, part-time work or flexible work hours. (See also section 8.3 - Retention of Junior Medical Staff)

Until recently internship has generally been regarded as a full-time experience but Medical Boards and State PMCs recognise the desire of some graduates to complete their intern year on a part-time basis. Such placements can only be achieved after careful negotiation between individual interns and the relevant hospital. The CPMEC has developed broad principles to guide employing institutions at the State and Territory level in consideration of individual requests for the completion of internship on a part-time basis. These principles are:

- Each instance must be documented and approved by the relevant hospital and reported to the appropriate State/Territory Medical Board;
- Requirements for internship must be completed within two years from the date of commencement with the equivalent of 48 weeks intern experience;
- The intern must be able to participate in training activities for at least 50% of a full-time trainee (ie a minimum of 20 hours per week)
- The intern must participate in pro-rata educational activities;
- The intern must participate in pro-rata out of hours work;
- In general, part-time internship should be conducted in partnership with another intern and share rosters

There are some specific requirements established by Medical Boards in some states and prospective interns seeking part-time internship should be advised to check these requirements.

In all cases, part-time training must be of the same quality and equivalent duration as full-time training and normally requires negotiation with the employing hospital.

CLICK HERE for access to the Australian Medical Association's publications and research on work/life flexibility:
http://domino.ama.com.au/AMAWeb/IRRemun.nsf/Work+Life+Flexibility

8.3 Retention of Junior Medical Staff[26]

JMO training places great demands upon junior doctors and can be a very challenging period. The Federal and State Health departments, the Postgraduate Medical Councils, colleges, universities and hospitals need to explore ways of retaining the commitment of trainees to medicine. Wherever possible, training programs should be tailored to meet the needs of individual trainees. Trainees should be provided with career guidance, which will assist their personal and professional development. Such guidance is particularly important for trainees who have fulfilled the aims of JMO training and are waiting in anticipation to begin higher specialist training. Practical steps, which could be taken to make training less rigid, include:

[26] The following section has been adapted from the publication by the General Medical Council, UK "The Early Years Recommendations on SHO Training".

- Introducing working patterns, which are compatible with outside commitments, for example flexible training and opportunities for career breaks (e.g. Parental leave for men and women) or when training on a full-time basis is not practical (eg family or personal responsibilities);

- Encouraging junior doctors to gain a breadth of experience beneficial to their professional and personal development, for example by working in a cognate specialty that complements their intended career;

- Establishing systems that allow JMOs to gain experience overseas as part of their training;

- Developing training schemes that help JMOs to keep their knowledge and skills up to date during career breaks, or help them to return to work following a career break (including part time training, appropriate child care, breastfeeding facilities, career/ College training support).

9. Ethical and legal issues relating to medical practice

JMOs are accountable for their actions and have legal responsibilities in areas such as medical record keeping and the issuing of medical certificates. Informed consent and confidentiality, issues discussed in medical school, must now be dealt with in daily practice. Administrative competence must also be gained and time must be managed effectively and efficiently. Critical review of medical records by senior staff is essential and should be sought by the JMO. By the end of the first two years of postgraduate training the JMO should be able to demonstrate:[27]

- an awareness of the important ethical principles (such as patient confidentiality) that govern clinical practice and an ability to work within that framework;

- competence in medical record keeping by maintaining clear, complete, concise and accurate records on each patient under his or her care;

- knowledge of pertinent areas of law relating to the practice of medicine eg the relevant State Medical Board Act(s) as amended;

- the ability to manage time effectively and efficiently; and

[27] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

- the ability to follow correctly the administrative policies and procedures of the institution in which he or she works.

10. Overseas trained doctors

This section deals principally with doctors who trained and qualified outside Australia. Overseas trained doctors seeking to practice medicine in Australia should contact the Australian Medical Council or their relevant state medical board. CLICK HERE to access the AMC website http://www.amc.org.au/. CLICK HERE to access contact details for medical boards in Australia [insert link to resource 3]

10.1 The Australian Medical Council process

The Australian Medical Council administers the national examinations of overseas trained medical practitioners seeking to practise medicine in Australia. The AMC examinations are designed to assess, for registration purposes, the medical knowledge and clinical skills of overseas trained doctors whose basic medical qualifications are not recognised by State and Territory Medical Boards; that is, doctors trained in medical schools that have not been formally reviewed and accredited by the AMC.

The standard of the AMC examinations is defined as the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to commence intern training.

10.2 Guidance for overseas trained doctors who wish to train in Australia [28]

Overseas trained doctors make a valuable contribution to the health workforce in Australia. Those seeking to undertake part of their training in Australia should be:

- provided with clear, up to date and comprehensive information about working and training opportunities in Australia;

[28] The following section has been adapted from the publication by the General Medical Council, UK "The Early Years Recommendations on SHO Training"

- provided with comprehensive information about the types of registration available to them in Australia
- encouraged to develop their educational objectives before applying to train in Australia; and
- able to easily access contact details for those individuals and organisations, both locally and nationally, who are in a position to help and advise them.

Overseas trained doctors will also require additional careers and training advice tailored to their particular needs, together with support while working in an environment, which may be quite different to what they have previously encountered. Hospitals, in collaboration with the AMC, should ensure that the induction programs for overseas trained doctors new to Australia provide:

- an orientation to the system they are to work in;
- opportunities to develop their communication skills, including English language skills needed to work with peers and supervisors and to communicate with patients and other staff; and
- an introduction to the principles of professional practice set out by the Australian Medical Association, Australian Medical Council and CPMEC.

11. Monitoring and evaluation [29]

The monitoring and evaluation of training and assessment processes for JMOs can be best achieved in an integrated way through cooperative endeavours between JMOs, their hospitals, and the various state and national organisations involved in prevocational education and training. Each State PMC has a key role in accreditation of training positions, surveillance and promotion of educational programs, workforce planning and research. Each PMC needs to ensure equity of access to quality training programs, continual development of programs, evaluation and research into their efficacy.

[29] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, pp 15-17

Personnel involved in development and delivery of education and training programs, including JMOs themselves, are encouraged to be active participants in committees, planning groups and to attend workshops and conferences at the State and national level.

State and Federal Departments of Health are expected to provide adequate funding to support the education and training needs of junior doctors.

11.1 Monitoring [30]

These guidelines provide an outline of the general principles which may be considered to achieve the broad aims and objectives of the prevocational years. Each State or Territory PMC and/or individual hospital can use these general principles as a framework for identifying more specific goals and standards to suit their local circumstances.

There may be variation in the importance which each state or territory PMC and hospital attaches to the different elements of training, and many of the gaols and standards selected may be context-specific. For example, future opportunities for junior doctors to gain experience in a community or rural setting will lead to changes in their clinical experience. Reform of work practices may lead junior medical doctors to gain more or less experience in carrying out certain procedures. The monitoring focus may concentrate on some of thee changes in order to ensure that they are practical, useful and acceptable. Where there is evidence that such changes are valued, careful monitoring can help to maintain them.

Once the specific goals and standards have been decided upon, a variety of approaches can be taken to the collection of information concerning the success of training programs:

- Evidence from accreditation surveys that training hospitals are providing high quality programs;
- Evidence that junior doctors are achieving agreed levels of competence as measured by supervisor's structured feedback;
- Feedback from junior doctors about the quality of their experience. (The collection of such feedback provides an excellent opportunity for monitoring across the states);

[30] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, p. 17

- Feedback from directors/supervisors of clinical training;
- Feedback from medical administrators concerning the training-service balance and workforce issues; and
- Evidence that junior doctors experiencing difficulties are being recognised and assisted in a timely and effective way.

Each State and Territory is encouraged to prepare an annual report on their training program as a means of reviewing the program and ensuring continuous improvement.

States are strongly encouraged to develop and use instruments which have established validity and reliability to assist in evaluating the success of the training programs. Examples are junior doctor assessment forms and surveys on the quality of the education programs, and on the term/rotation experience. There has been developmental work in many of these areas in several States.

At the national level the CPMEC has a role to ensure monitoring of the quality of the prevocational training programs, to identify key national issues and foster information sharing and education research.

11.2 Evaluation [31]

Annual reporting by each State and Territory PMC as recommended above would allow the States to document their success and to learn from the experiences of others.

A reasonable match between graduating numbers and appropriate training opportunities in clinical service positions at a national level is a worthwhile goal. While individual States or Territories may be faced with a mismatch between graduate numbers and available positions, a national goal must be to provide the best available training in the right number of positions.

The requirement for each training term to have clear, identifiable and achievable learning objectives is likely to improve the quality of each term and acts as a measurable indicator of compliance. At the hospital level there needs to be an acceptable balance between balancing the service needs and the training and professional development needs of the junior medical staff.

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[31] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, p. 17

Another matter of special interest is the retention rates for junior doctors during the first two years after graduation and each State and Territory should ensure appropriate systems exist to monitor and report to relevant State and Commonwealth agencies on the reasons why junior medical staff are remaining within, moving between or leaving the healthcare system.

Flexible training and opportunity for part-time completion of prevocational training or job sharing is an emerging issue to which States and Territories are encouraged to respond. Monitoring changes to work practices is also important in this regard.

Each State and Territory, through the CPMEC, and the Australian Medical Council could collaborate to develop instruments, to collect, at regular intervals, feedback from junior doctors, directors/supervisors of clinical training, clinical supervisors, training colleges and medical administrators.

This form of evaluation could provide useful information to be used by each State in setting its own goals and standards. It has been suggested that patient outcomes could be included in such a list (for example patient satisfaction with junior doctors working in new training settings).

Occasional surveys of junior doctors satisfaction with their training could be undertaken some time after graduation (say five years) and would help to identify the components of training considered by them to be the greatest value.

An approach to identifying and assisting junior colleagues in difficulty, without threatening their professional development and career choice is an important outcome measure. This is a complex area, where interstate communication on successful initiatives would be invaluable.

The Advisory Committee for the National Guidelines for Junior Medical Officer Training and Assessment.

9 January 2003

References

[1] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 14-15.

[2] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 8-12

[3] Medical Training Review Panel, Second Report, November 1998, p.38

[4] The following section has been adapted from the "National Guidelines for Intern Training and Assessment", AMC, November 1996, pp 12-13

[5] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001, pp 14-15.

[6] The following section has been adapted from "Education, Training and Supervision for New Doctors", Medical Council of New Zealand, November 2001, p.47.

[7] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001, pp 16-17.

[8] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001and the WA Accreditation Guide, PTAC, Draft 6, June 2001.

[9] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

[10] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.

[11] The following section has been adapted from the publication by the General Medical Council, UK, "The New Doctor", April 1997, pp 35-36.

[12] The following section has been adapted from "A Guide for Interns in Victoria", a joint publication of the Postgraduate Medical Council of Victoria and Medical Practitioners Board of Victoria, December 2001, p.5.

[13] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

[14] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

[15] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.

[16] The following section has been adapted from the Victorian Intern Accreditation Standards, 2001 and 2002.

[17] The following section has been adapted from the publication by the General Medical Council, UK, "The New Doctor", April 1997, p. 40.

[18] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001

[19] Medical Training Review Panel, Third Report, August 1999, p.36.
[20] Community and Rural Terms for Junior Doctors in Australia", Produced by the Postgraduate Medical Council of NSW, Funded by the Commonwealth Department of Health and Ageing, March 2002.
[21] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001.
[22] The following section has been adapted from the "Accreditation Standards for Junior Doctor Education (PGY1&2)", Postgraduate Medical Education Committee, Queensland, 2001.
[22] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.
[23] The following section has been taken from The Australian Medical Workforce, Department of Health and Aged Care, *Occasional Papers, Series No. 12*, August 2001, pp 93-95. This paper was prepared by Monica Pflaum with input and assistance from Catherine Wall, BethSlatyer, Clare Boutchard, Rhonda Jolly and Katherine Harris, Commonwealth Department of Health and Aged Care.
[24] Nocera A and Khursandi DS, 1998, Doctor's working hours: can the profession afford to let the courts decide what is reasonable?, *Medical Journal of Australia*, 1998, Vol.168, pp 616-618.
[24] The following section has been adapted from the "Standards for Junior Medical Officer Education and Supervision", Postgraduate Medical Council of NSW, Fourth Edition, 2002.
[25] The following section has been adapted from the publication by the General Medical Council, UK "The Early Years Recommendations on SHO Training", http://www.gmc-uk.org/med_ed/sho.htm
[26] The following section has been adapted from the publication by the General Medical Council, UK "The Early Years Recommendations on SHO Training", http://www.gmc-uk.org/med_ed/sho.htm
[27] The following section has been adapted from the WA Accreditation Guide, PTAC, Appendix B, Draft 6, June 2001.
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[29] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, pp 15-17.
[30] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, p. 17.
[31] The following section has been adapted from the "National Guidelines for Intern Training and Assessment," AMC, November 1996, p. 17.

PREVOCATIONAL AND VOCATIONAL TRAINING POST DEFINITIONS
MTRP TERMINOLOGY COMPARED WITH STATE DEFINITIONS [1]

MTRP/AMWAC Terminology Defines Posts	SA Based on Union Award with SASMOA (SA Salaried Medical Officers Association)	QLD Supports Proposed Terminology	TAS Industrial Award Basis	NT Industrial Award Basis 24 Levels	NSW	WA Paid on Position not years	VIC
Postgraduate Year 1 (PGY1)	INTERN AMC (passed MCQ)	INTERN	INTERN Medical Practitioner in Training L1 (MPT)	INTERN Y1 L1	INTERN (PGY1)	INTERN (L1)	HMO Y1 (Hospital Medical Officer)
PGY2-5 ↓	Medical Practitioner 7 increments graded on years of experience	Junior House Officer (Y1) ↓ Senior House Officer (Y2) ↓	Resident Medical Officer (MPT L II) Registrar Medical Practitioner L II) MP 6Y* MP L III 8Y* MP L IV (10Y*^)	Resident Medical Officer Y2+ L2-5	RMO (PGY 2-4) Unstreamed Senior Resident Medical Officer (SRMO) (PGY2-4)	Resident Medical Officer Y 1 2 3 (L 2-4)	HMO Y 2 –3 HSMO Y1 (≡ HMO Y4) Senior HSMO Y5 ≡ HMO Y8
General Training Post (PGY2 – 5) General Trainee Not enrolled in specialist program elected not to enter waiting to enter entered a program but changing posts	Medical Practitioner (as above)	Principal House Officer	Resident Medical Officer Registrar Senior Registrar MP L II – L IV	Resident Medical Officer	SRMO Unstreamed Unaccredited Registrar/SRMO (PGY2-4) Senior Registrar (Post defines the status)	Supervised Medical Officer (Hospitals have their own individual terminology)	↓
Specialist Training Post Specialist Trainee specialist program to be designated) Includes those enrolled and those with PtI, PtII and completing requirements	Medical Practitioner (if not registered as specialist) Senior Registrar (if registrable as specialist)	Registrar (specialist in training until completes specialist training)	Senior Registrar Specialist Medical Practitioner in Training L1 (2Y)* SMPT LII	Registrar L4-8 Senior Registrar (has specialist qualifications)	Basic Surgical Trainee Basic Medical Trainee Following Graduation as Specialist Δ Accredited Registrars Δ Advance Trainee or Δ Provisional Fellow	Registrar	Hospital Registrar Y1 (1st year of training) ↓ HR Y4 SRY5 Principal Registrar >Y5
Career Medical Officer**	Senior Medical Practitioner	Senior Medical Officer (covers all Medical Supervisors, Specialists and Non specialists)	Career Medical Officer	HMO L6-16 or (Rural/Community Medical Officer) SHMO L6-18	CMO	CMO Supervised Medical Officer	HMO
			SMP L1-IV (4Y*) – 12Y* *refers to years postgraduate experience	Specialist L15-24			

d/or A Medical Officer working in hospital or institution who has professional experience and expertise in a particular area recognised by peers
d/or A Medical Officer appointed as a Career Medical Officer to a post designated as such by an industrial award.
A Medical Officer with specialist Qualifications who chooses to work in an area outside their specialist qualification field.

3 In all states individual hospitals have their own terminology, which needs to be equated to the state classification, which then needs to be equated to the MTRP/AMWAC terminology.

Resource 2: Key Stakeholders Contacted

Committee of Medical School Deans
Committee of Presidents of Medical Colleges
American Medical Association
Medical Council of Canada
General Medical Council (UK)
Irish Medical Council
Swedish Medical Council

VIC
Dr Eleanor Flynn
Carol Jordon
Prof Barry McGrath

NSW
Margaret Banks
Dr Simon Willcock

CNB
Ian Frank

WA
Kaye Harnwell

SA
Dr Adrian Anthony
Dr Wilton Braund
Prof Geoffrey Dahlenburg
Dr Mitra Guha
Karen Grace
Ken Hand
Michael Jelly
David Morris

VIC MEOs
Joan Benjamin
Amy Fraser
Jenny Gough
Ms Geraldine Marsh
Greg Jemsek
Sarah Hawkins
Megan Morse
Dr Heather Smith
Debbie Paltridge
Desley Reid-Orr
Susie Sangas
Bronwen Upston

NSW DCTS
Dr Stephen Myers
Dr Dennis Cordato
Dr Elli Michaelides
Dr Narelle Shadbolt
Dr Tim Spicer
Dr Andrew McDonald
Dr Susan Paul
Dr Ashley Watson
Dr Peter Bortz
Dr Paul Thomas

Dr Andrew Biankin
Dr Lynne Mann
Dr Debbie Hawkins
Dr David Brown
Dr John Napoli
Dr Theresa Beswick
Dr Carolyn Cooper
Dr David Curran
Dr Geoff Eather
Dr Peter Love
Dr Simon Abel
Dr Peter Grant
Dr Tomiko Barrett
Dr Mark McLean
Dr Cameron Dart
Dr Deborah Lewis
Dr Louis Christie
Dr David Jankelson
Dr Tony Bonaventura
Dr Catherine Stewart
Dr Georgina Gibson
Dr Scott Murray
Dr Brian Nankivell
Dr Jan Maree Davis
Dr Sally Somi
Dr Ilona Cunningham
Dr Peter Reed
Dr John Glass
Dr Diana Learoyd
Dr Steve Flecknoe-Brown
Dr Tom Heaney
Dr Nick Ryan
Dr Darry Mackender
Dr Andrew McDonald
Dr Joseph Lizzio
Dr Scott Fortey
Dr Eddy Fischer
Dr Annette Britton
Dr John Burrell
Dr Peter Landau
Dr Ian Macdonald

QLD DCTS
Dr Annabel Alcock
Dr Nick Buckmaster
Dr Peter Cleary
Dr Geoff Copeland
A/Professor Steven Coverdale
Dr Bas Gouweloos
Dr John Hadok
Dr Julie Joyner
Dr Don Kane
Dr Gerard Meijer
Dr Kees Nydham
Dr Sharon O'Rourke
Dr Elizabeth Powell
Dr David Salter
Dr Sue Shiels
Dr Peter Stride
Dr Graham Steel

Professor Bill Egerton
Dr Robert McCrossin
Dr Mark Erian
Dr Natacha Sorour
Dr Peter Keary

QLD MEOS
Libby Black
Brian Fowler
Angela Ham
Julie Harris
Gemeah Howarth-Hockey
Rebecca Licastro
Kirsten Mayne
Dr Chris Murray
Dr Angela O'Connor
Brigitte Prince
Penne Purslow
Lynne Raw
Barbara Swadling
Helen McKeering
Elizabeth Ware

WA DCTS
Dr Antonia Bagshawe
Dr Andrew Gardner
Dr Stephen Richards
Dr Margaret Sturdy
Dr Richard Tarala
Dr Alistair Vickery
Dr Barry Vieira

Resource 3: State & Territory Medical Boards

Australian Capital Territory
Medical Board of the Australian Capital Territory
6th Floor
FAI House
197 London Circuit
Civic ACT

PO Box 976
Civic Square ACT 2608
Registrar:
Mr R Bradford
Phone: (02) 6205 1600
Fax: (02) 6205 1602
Email: bob.bradford@act.gov.au

New South Wales
New South Wales Medical Board
Off Punt Road (grounds Of Gladesville Hospital)
GLADESVILLE NSW 2111

PO Box 104
Gladesville NSW 2111
Registrar:
Mr A E Dix
Phone: (02) 9879 6799
Fax: (02) 9816 5307
Email: nswmb@nswmb.org.au
Web site:
http://www.nswmb.org.au

Northern Territory
Medical Board of the Northern Territory
2nd Floor
Harbour View Plaza
Corner Bennett & McMinn Street
DARWIN NT 0800
AUSTRALIA

PO Box 4221
Darwin NT 0801
Registrar:
Ms S Williams
Phone: (08) 8999 4157
Fax: (08) 8999 4196
Email: healthprofessions.ths@nt.gov.au
Web site:
http://www.nt.gov.au/health/org_supp/prof_boards/prof_licensing_auth.shtml

Queensland
The Medical Board of Queensland
19th Floor, Forestry House
160 Mary Street
BRISBANE QLD 4000

GPO Box 2438
Brisbane QLD 4001
Registrar:
Mr J Greenaway
Phone: (07) 3234 0176 (general enquiries)
Fax: (07) 3225 2527
Email (general):
medical@healthregboards.qld.gov.au (registrar):
Web site:
http://www.medicalboard.qld.gov.au

South Australia
Medical Board of South Australia
91 Payneham Road
ST PETERS SA 5069

PO Box 359
Stepney SA 5069
Registrar:
Mr D H Wilde
Phone: (08) 8362 7811
Fax: (08) 8362 7906
Email: admin@medicalboardsa.asn.au
Website:
http://www.medicalboardsa.asn.au/

Tasmania
The Medical Council of Tasmania
AMA House
2 Gore Street
South Hobart TAS 7004

PO Box 8
SOUTH HOBART TAS 7004
Registrar:
Ms A McLean-Aherne
Phone: (03) 6233 5499
Fax: (03) 6233 7986
Email: mct@our.net.au

Victoria
Medical Practitioners Board of Victoria
Level 16, 150 Lonsdale Street
Melbourne VIC 3000

GPO Box 773H
Melbourne VIC 3001

Chief Executive Officer
Mr I Stoney
Phone: (03) 9655 0500
Fax: (03) 9655 0580
Email: mpbofv@mpbofv.org.au

Web site:
http://www.medicalboardvic.org.au

Western Australia
Medical Board of Western Australia
8th Floor, London House
216 St George Terrace
PERTH WA 6000

GPO Box 2754
Perth WA 6001

Registrar:
Mr S Hood
Phone: (08) 9481 1011
Fax: (08) 9321 1744
Email: registrations@wa.medicalboard.com.au
Info@wa.medicalboard.com.au
Website:
http://www.wa.medicalboard.com.au

Resource 4: Survival Tips for JMOs

(Adapted from " A Handbook for Medical Residents", Queensland Medical Education Centre 1997 and "An Information Package for Junior Medical Officers", Council for Early Postgraduate Training in South Australia, 2001).

FEAR IS NORMAL. There are probably a few of you who won't admit it, but everyone's scared on their first day. Internship is about transition, taking that first step onto the hierarchical ladder of the medical professions. By virtue of the arduous years at medical school, you are now equipped with sound medical knowledge and skills that should stand you in good stead during your intern year. IF IN DOUBT, CALL. Registrars and Consultants can seem pretty distant and uninterested at times, but I can guarantee any abruptness or condescension you may experience in response to a question will in no way compare to the disaster of not seeking help in time. If you are faced with a medical problem you cannot deal with, remember that those on the rungs of the ladder above you are there to lend a hand, even though at times they may appear a little intimidating. There to offer assistance and guidance is a host of other staff members within the hospital environment with whom you must endeavour to get onside as early as possible. These are nurses, clerical staff, radiographers, physiotherapists, dieticians, security guards and so on. During our years as interns, we were able to learn from and were aided by, all of these people. Remember good manners make the doctor and respect others. Be both gracious and humble when it's time for you to accept guidance and help. No intern could ever be criticised for trying to get along with everyone else.

ORGANISATION. For those of you who are naturally well organised, you will never succeed in organising you day exactly how you want- it's not you fault, it's the job. For those of you who are not naturally well organised, write it all down, and tick it or cross it when it's done/checked etc. Although as interns you will start off at the 'bottom of the ladder', your role is an important one. You are there to hold the ladder firm and stable. Junior medical officers are vital players in the everyday running of the hospital system. You have more contact with patients and their families than any of the other medical staff because you are the interface between medical, nursing and paramedical care.

A good intern will coordinate the different facets of patient management to ensure a truly holistic approach to treatment. No longer will you bring up the tail of ward rounds; rather yours will be an up-front, hands-on role in patient care and you will be surprised at how quickly you will learn from your experiences.

DON'T LET IT FESTER. If you are having troubles with your Registrar or Consultant don't just let it go. People do fail intern years. Personality clashes or simple differences in management can be enough to cause very negative end of term assessments, by which time it's too late. If you want to learn and enjoy the field you're working in, get along with your Registrar and Consultant. If you want to enjoy your job, and feel good about getting up in the morning, get along with the nursing staff. If you want to get things done, get along with the clerical and technical staff. JUST DON'T DO IT. If you don't feel comfortable doing something, don't do it. This includes consenting for a procedure you're not familiar with. This also includes being asked to do procedures, or function in a role you are not prepared for such as a Relieving Surgical Registrar. If you feel your Hospital is not standing up for you, contact your State medical council or AMA. IF YOU'RE SICK, TAKE SICK LEAVE. If you come to work you will be expected to perform at 100%. If you can't you will only cause yourself and your patients grief. You will also infect the rest of your peers.

GO HOME. The cover is there for a reason. If you're paged to do 3 jelcos at 1655, you can hand them over. It may seem it would only take you 15mins to do them all, but there's always something that means you'll still be there at 6pm. Your peers can be an amazing support. FOOD IS ESSENTIAL. Half an hour taken for lunch will make you an hour faster in the afternoon. YOU ARE NOT PERFECT. As an intern you have by definition less than 1 years experience at being a doctor, so you should not compare yourself to your Consultant or senior Registrar. You are not the Medical Consultant for your surgical unit. If you are out of your depth there is always someone who can help. During this time, you should be familiar and comfortable with your limitations as a junior doctor. There will always be supervision and guidance on hand, but there will be times when you will need to specifically seek it out. You should never feel isolated in a medical situation, irrespective of the time be it day or night. SPILL. If you don't tell someone when you're in trouble no one will be able to help. Almost every intern has moments of extreme self-doubt, and will question their career path. Usually

this is because of problems in the system eg long hours, or lack of support from your seniors. It may seem hard to believe, but things can actually change if you speak to the right people.

For most of you the intern year should be a positive and exciting experience. But don't be surprised if I tell you that you will all fall on times of disenchantment, frustration and great fatigue. Don't take criticism from consultants or registrars too personally, but learn from whatever advice you are given. No one is infallible. We have all made mistakes at some stage, but the key is to better oneself by learning from our experiences and not repeating the mistakes. Doctors must be sensitive. Reach out and impact positively on your patients and their loved ones. Recognise your limitations in trying to battle the inevitable outcome that befalls everyone. Talk about your sad experiences with your peers, friends and families, this can be extremely therapeutic. In retrospect we now look back upon our junior medical officer years as a year of self-discovery. It is about working to live, not living to work. This is the year that you have been waiting for. No more end-of-year exams to contend with. Set yourself new personal goals. Embark on a life that is not solely centred around medicine. Take up extracurricular activities for enjoyment and relaxation. Remember that old familiar saying that embodies a commonly accepted observation, a healthy body makes for a healthy mind, do something about it before it's too late and you need doctoring yourselves.

Resource 5: Sample Position Description PGY2/3 – Cardiology Unit

(Adapted from a position description provided by the Director of Clinical Training, Box Hill Hospital, Victoria, 2001)

POSITION DESCRIPTION – HMO2/3 CCU

Reports to: Head of Unit Director/Director of Clinical Services (Medical)
Qualifications: MB BS (or equivalent)

Position Summary:

The HMO is responsible for coordinating and documenting the admission, management and discharge planning of patients admitted to his/her unit. All decisions concerning the patients should be executed through the HMO.

Learning Objectives for this Rotation:

The HMO is expected to take an active part in defining his/her education needs and to obtain help in meeting them.

Particular objectives for Cardiology are:

1. Develop your skills in the assessment of patients with chest pain and other cardiac presentations
2. Gain skills in the management of common cardiac conditions
3. Further develop your communication skills with patients and families
4. Gain skills in resuscitation procedures
5. Develop and understanding of risk factors and the ability to discuss these with patients and families

Duties and Responsibilities:

Patient Care

6. Complete a comprehensive patient history by obtaining a history from the patient and from other relevant sources (eg family, medical record, general practitioner, ambulance transfer sheet). It is important to distinguish between factual and presumed information, and to verify presumed past diagnoses.
7. Document the full history, physical examination and progress notes for all patients you admit. Legible, accurate and signed progress notes must be written every day and particularly after every ward round
8. Formulate a management plan for each patient.
9. Ensure that appropriate investigations are ordered and checked and that the management plan is altered as necessary.
10. Design a discharge plan containing clearly identified and attainable goals.

Organisation

11. Prioritise your work, ensuring that the sickest patients are seen first. Check results of important tests of the day and that decisions made earlier in the day have been carried out. Hand over information about very sick patients to the covering HMO.
12. Do a daily ward round of all patients with the registrar. The registrar is the first contact for any patient issue you have. Notify the Registrar and appropriate consultant of any serious change in a patient's condition or a patient's death.
13. Develop and maintain good communication with nursing and allied health staff.
14. Be especially aware of the need for culturally sensitive communication with patients, families and other care providers. Ensure that the patient's relatives are aware of the patient's condition.
15. Communicate with each patient's General Practitioner; especially about discharge plans and post discharge follow up.
16. Ensure that discharge medication is written up the day before discharge and the discharge summary on the day of discharge. Ensure that the discharge summary is sent to the patient's GP and any other doctors/hospitals involved in the patient's previous or subsequent care.

Education

17. Attend appropriate education meetings and unit education sessions.
18. Develop a learning plan for the rotation, covering technical skills development and management of specific conditions.
19. Be able to describe the management of common conditions seen on this rotation.

Other Duties

20. Take part in the after-hours and weekend rosters
21. Inform Clinical Services (Medical) and your consultant of any issues related to patient care or general hospital organisation about which you have concerns.
22. Other duties, including covering ill or absent colleagues, as directed by the Director of Clinical Services (Medical).

Resource 6: Sample Position Description – Intern Medicine

(Adapted from a position description provided by the Director of Clinical Training, Box Hill Hospital, Victoria, 2001)

POSITION DESCRIPTION - Intern Medicine

Reports to: Head of Unit Director/Director of Clinical Services (Medical)
Qualifications: MB BS (or equivalent)

Position Summary:
The intern is responsible for coordinating and documenting the admission, management and discharge planning of patients admitted to his/her unit. The intern is responsible for the day-to-day assessment and management of the patients in his/her unit. All decisions concerning the patients should be executed through the intern.

Learning Objectives for this Rotation:
The intern is expected to take an active part in defining his/her education needs and to obtain help in meeting them.

Particular objectives for Medicine are:
- Develop good time management and be able toprioritise tasks
- Develop your ability to perform and document aproblem oriented history and examination
- Improve your ability to provide a concise summary of a patient's illness and management for the consultant ward rounds
- Increase your clinical perspective; develop an understanding of which conditions or symptoms require urgent management and which are less urgent.
- Develop good communication skills with patients, families,nursing and allied health staff.
- Improve your basic Procedural skills, e.g. IVs, catheterisation

Duties and Responsibilities:

Patient Care

1. Complete a comprehensive patient history by obtaining a history from the patient and from other relevant sources (e.g. medical record, family, nursing home, general practitioner,ambulance transfer sheet). It is important to distinguish between factual and presumed information, and to verify presumed past diagnoses. Many patients have chronic illnesses or functionalproblems which impact on their social situation, so it is important to gain a full social and psychological history.
2. Document the full history, physical examination and progress notes even if a covering HMO admits the patient. Legible, accurate and signed progress notes must be written every day and particularly after every ward round
3. Formulate a management plan for each patient.
4. Ensure that appropriate investigations are ordered and checked and that the management plan is altered as necessary.
5. Design a discharge plan containing clearly identified and attainable goals.

Organisation

6. Prioritise your work, ensuring that the sickest patients are seen first. Check results of important tests of the day and that decisions made earlier in the day have been carried out. Hand over information about very sick patients to the covering intern/HMO.
7. Do a daily ward round of all patients with the registrar. The registrar is the first contact for any patient issue you have. Notify the Registrar of any serious change in a patient's condition or a patient's death.
8. Develop and maintain good communication with nursing and allied health staff. Be especially aware of the need for culturally sensitive communication with patients, families and other care providers. Ensure that the patient's relatives are aware of the patient's condition.
9. Communicate with each patient's General Practitioner; especially about discharge plans and post discharge follow up. This includes patients seen in outpatients.

10. Ensure that discharge medication is written up the day before discharge and the discharge summary on the day of discharge. Ensure that the discharge summary is sent to the patient's GP and any other doctors/hospitals involved in the patient's previous or subsequent care.
11. Ensure that death and cremation certificates and discharge summaries are completed as soon as possible for patients who die.

Education

12. Attend weekly intern education meetings and unit education sessions.
13. Develop a learning plan for the rotation, covering technical skills development and management of specific conditions.
14. Be able to describe the management of common conditions seen on this rotation.
15. Be involved in teaching and supervising medical students on the unit.

Other Duties

16. Take part in the after-hours and weekend rosters.
17. Inform Clinical Services (Medical) and your consultant of any issues related to patient care or general hospital organisation about which you have concerns.
18. Other duties, including covering ill or absent colleagues, as directed by the Director of Clinical Services (Medical).

Resource 7: Recommended JMO Handbook Contents
(Adapted from the Postgraduate Medical Council of New South Wales publication, Standards for Junior Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix I)

The following list is not comprehensive and should be used by a hospital to develop a Handbook to meet the needs of the JMOs and the hospital.

SUGGESTED CONTENTS FOR JMO HANDBOOK

Hospital Organisation including:
- The role of the hospital and its relationship with other health services
- Key hospital staff and relevant contacts

JMO Management
- Overview of the JMO management unit
- Roe of Director or Supervisor of Training, General Clinical Training Committee/Postgraduate Education Committee
- Role of Term Supervisors and term descriptions
- Awards and conditions of employment – duty, rosters, leave and holidays
- Performance review and assessment
- Grievance procedures
- Employee assistance programs and staff health and counselling services
- Dress code

JMO and staff facilities
- Library and other educational resources
- Quarters, lounge and dining facilities
- Car parking
- Mail and communication
- Child care
- Professional Associations

Education Program
- Outline of Clinical Education program
- Educational resources

General information
- Accessing specialist services
- Clinical records
- Clinical review and quality assurance
- Medico-legal issues and medical indemnity

Patient care issues:
- Contacting supervisors
- Admission, transfer and discharge policies
- Informed consent
- Confidentiality
- Unit protocols
- Management of aggressive patients
- Procedures following death of a patient
- Infection control procedures
- OH&S issues
- Allied health services

Disaster and emergency procedures
- Management of cardiac arrest and other clinical emergencies
- Disaster plans
- Bomb threats

- Fire emergencies
- Other common acute conditions

Resource 8: General Clinical Training Committee – Terms of Reference

(Adapted from the Postgraduate Medical Council of NSW publication, Standards for Junior Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix E)

MODEL TERMS OF REFERENCE

Role

To support the mission of the Postgraduate Medical Council to ensure that JMOs are clinically competent for safe practice and quality patient care in their first two years of postgraduate employment. The Committee will achieve this aim through working towards the following Accreditation Goals:

a) The hospital ensures JMOs have the appropriate knowledge, experience and skills for quality patient care.
b) The hospital provides a wide range of educational and training opportunities for JMOs to ensure that they are competent and safe.
c) The hospital promotes the welfare and interests of JMOs.

Operation

A General Clinical Training Committee is established and appropriately constituted with delegated authority. The Committee meets regularly and complies with its terms of reference. There is a designated Secretary to ensure accurate records of meetings and follow-up.

Function

The General Clinical Training Committee:

a) determines the specific training and educational needs of JMOs;
b) develops, implements, monitors and evaluates the clinical training programs for the JMOs;
c) advises on educational resources needed to support education programs;
d) monitors the progress of the JMO;
e) reviews and evaluates the role and function of the Director of Clinical Training; and
f) reviews the hospitals compliance with the relevant JMO accreditation standards.

Membership

The membership shall include a broad range of expertise and backgrounds. The wide membership and effective functioning of the committee will ensure that all relevant departments of the hospital develop a sense of responsibility for the education, training and development of their JMOs.

The Committee will include representatives of:

- JMOs;
- Hospital management;
- JMO management;
- the Medical Staff council;
- representatives from associated universities, colleges and other training programs (as appropriate); and
- the Director of Clinical Training.

The Committee may co-opt members to the committee and/or establish working parties as may be necessary.

Lines of Responsibility

- The Committee is responsible to senior hospital management;
- The senior hospital management will ensure that the committee has authority for a range of relevant activities;
- The GCTC will be provided with adequate secretarial and administrative support;
- A person is nominated and held accountable for the preparation of agendas and the distribution of minutes and committee papers;
- Minutes of meetings are to be kept and circulated to members of the Committee and the senior hospital management after each meeting.

Resource 9: Sample Position Description - Director of Clinical Training
(Adapted from the Postgraduate Medical Council of NSW publication, "Standards for Junior Medical Officer Education and Supervision", Appendix D, Fourth Edition, 2002; Adapted from the Postgrdaute Medical education Foundation of Queensland publication, "Accreditation of Junior Doctor Education", 2002))

POSITION DESCRIPTION – DIRECTOR OF CLINICAL TRAINING

Position title: Director of Clinical Training
Responsible to: General Manager (through the General Clinical Training Committee)

Background:
[insert - Name of Hospital]
[insert - Mission of hospital (2-3 sentences)]
[insert brief role of DCT in achieving the mission (2-3 sentences)]

Key Functional Relationships:
Regular liaison with JMOs and Term Supervisors and Attending Medical Officers, the General Manager and administrative staff as required.

Summary of Competencies and skills:
An understanding of the concepts of adult education, performance monitoring and quality improvement; an ability to analyse and distil information; superior interpersonal skills, ability to work in a team and work towards improving the quality of education and training offered by the hospital; a commitment to the mission and goals of the State PMC.

Position Summary:
The Director of Clinical Training is expected to:

1. Develop, coordinate and promote the clinical training of JMOs, in association with JMO staff management and the General Clinical Training Committee;
2. Promote a sense of professional responsibility and ethics among JMOs;
3. Act as an advocate for JMOs;
4. Offer career advice and counselling to JMOs;
5. Facilitate feedback to JMOs about their performance;
6. Liaise with Term Supervisors regarding JMO issues;
7. Liaise with those involved in the administration of junior doctors in matters relating to JMO education and training;
8. Liaise with other DCTs in the network;
9. Act as a resource and mentor for clinical teachers;
10. Assist the General Clinical Training Committee evaluate training programs, clinical teachers and educational resources;
11. Identify junior doctors with special needs and ensure systems of support are implemented and effective; and
12. Be involved in a DCT succession plan;
13. Participate in accreditation visits to other hospitals;
14. Assist the hospital maintain its accreditation status with the PMC;
15. Attend relevant State-wide DCT meetings/conferences, and support initiatives generated through such meetings and conferences; provide a relevant report of these meetings to the GCTC;
16. Ensure that individual contact occurs with every JMO at regular intervals;
17. Play a major role in the planning, delivery and evaluation of JMO orientation programs.

Performance Evaluation:
Performance evaluation will occur annually. The performance of the Director of Clinical Training will be undertaken by the General Clinical Training Committee and evaluated by:

- JMO feedback
- Term Supervisor feedback
- Medical management feedback
- Efficiency of activities

- Performance indicators (to be developed)

Core competencies, skills and behaviours:
1. Confidence in ability to influence the quality of education and training offered by the hospital
2. A genuine interest in postgraduate medical education, a willingness to develop expertise in this area, and a demonstrated understanding of the importance of the continuum of medical education as a lifelong professional commitment
3. A commitment to the mission of the PMC and the ability to present and explain PMC goals.

Qualifications and experience:
1. Medical graduate with postgraduate qualifications and an affiliation with the hospital
2. An understanding of adult education and the concepts of quality improvement and performance monitoring.

Appointment process:
The DCT is recommended for appointment by the executive of the hospital with specific input from the General Clinical Training Committee (GCTC).

The appointment is for three years with subsequent extension for a further three years with approval of the appropriate body, if applicable (eg State Postgraduate Medical Council).

Resource 10: Sample Position Description - Term Supervisors

(Adapted from the Postgraduate Medical Council of NSW Standards for Junior Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix F)

POSITION DESCRIPTION - Term Supervisors

Background:
[Insert name of hospital]
[Insert Mission of hospital (2-3 sentences)]
Insert Role of Term Supervisor in achieving the hospital mission (2-3 sentences)]

Position title: Term Supervisor
Responsible to: The Director of Clinical Training

Key Functional Relationships:
With the JMOs on a daily basis and with Attending Medical officers, the Director of Clinical Training, Chairman of the General Clinical Training Committee, the General Manager and administrative staff as required.

Summary of Competencies:
An understanding of the concepts of adult education, performance monitoring and quality improvement and superior interpersonal skills, and an understanding of the mission and goals of the Postgraduate Medical Council.

Position Summary:
The Term Supervisor will assist the hospital to achieve its goals by:

1. Preparing and reviewing a term description in consultation with other Attending Medical Officers in the team, the Director of Clinical Training, JMO Management and JMOs, to describe the responsibilities and accountabilities of the JMO. This will include the skills required by a JMO to function safely within the term.
2. Defining, documenting and explaining specific knowledge and skills to be gained and/or enhanced during the term.
3. Determining the level and proximity of supervision required for each JMO in each work situation based on knowledge and observation of the skills of the JMO.
4. Supporting attendance at formal education programs and providing effective practice-based teaching.
5. Monitoring the progress and providing continuous constructive feedback to guide JMO professional development.
6. Providing formal documented assessment and feedback mid-term and at the end of the term.
7. Ensuring the systems of work and training minimise risks and support the safety of theJMOs.
8. Being available to discuss issues such as grievances and career guidance withJMOs.
9. Encouraging JMOs to develop progressively increasing independence.
10. Encouraging individual Attending Medical Officers to provide continuous constructive feedback to JMOs.

Performance Evaluation:
Performance evaluation will occur annually.

The performance of the Term Supervisor will be undertaken by the General Clinical Training Committee and will be evaluated by:

- DCT feedback
- JMO feedback
- efficiency of activities
- performance indicators (to be developed by the GCTC)

Specific Responsibilities:
The Term Supervisor will:

1. determine and document the skills required by a JMO to function safely within the term;
2. assess the skills of each JMO at the commencement of the term;

3. employ strategies to ensure the safety of care including combinations of graded supervision, training and personal support for the JMO(s) assigned to the term;
4. provide formal documented assessment and feedback mid-term and at the end of the term. These two formal assessments are a consensus developed by consultation with the team attending medical officers, registrars, nurses and other professional staff.

Core competencies, skills and behaviours:
A commitment to the mission of the Postgraduate Medical Council and the ability to present and explain the PMC goals.

Qualifications and experience
Medical graduate
A clinical appointment
An understanding of the principles of adult education and the concepts of quality improvement and performance monitoring.

Resource 11: Sample Position Description - Medical Education Officer
(Adapted from the Queensland Health PD for MEOs, October 2001)

POSITION DESCRIPTION: MEDICAL EDUCATION OFFICER

Location:	[insert name of hospital]
Classification level:	[insert classification eg PO3]
Reporting relationship:	[insert reporting relationship eg Reports to the Director of Clinical Training]
Date of review:	[insert date]

Purpose of the Position
To collaborate with the Director Clinical Training to manage the junior doctor training program and provide organisational direction and leadership in the provision of education for junior doctors. To provide educational expertise and assistance to develop initiatives to:

- *assess and evaluate teaching and learning strategies for the junior doctor training program and improve teaching and learning strategies;*
- *conduct educational activities for the development of an integrated two-year clinical training program for Postgraduate Years 1 and 2 (PGY1 and PGY2);*
- *promote quality learning and teaching with particular application to the professional development needs of junior doctors.*

Organisational Environment
[insert a description of the organisational environment – an example follows
The structure of Queensland Health is designed such that the accountability for policy development, funds distribution and program evaluation lies within the branches of Corporate Office. This structure enables the provision of corporate level strategic policy planning, direction, coordination and monitoring of health service delivery, against identified health outcomes.

Direct health service delivery is the responsibility of the Health Services Program, and managed by District Health Services under individual Service Agreements. District Health Services have been formed to manage hospital and community health services within defined geographical areas.

The Medical Education Officer is located in District Health Service and is closely aligned with other staff providing an education role and may share resources. The MEO consults and liaises with senior clinicians having supervisory responsibility for JMOs and networks with other MEOs.

Primary Duties and Responsibilities:
The Medical Education Officer is expected to:
1. Identify the educational needs of medical staff in PGY1 and PGY2 in accordance with prevocational accreditation standards.
2. Develop, implement and evaluate continuing medical education programs within the District.
3. Trial and evaluate educational resource material including curriculum frameworks and clinical training portfolios.
4. Develop and facilitate the application of an assessment framework that ensures valid methods of effective formative and summative performance assessment.
5. Maintain appropriate networks with other stakeholders.
6. Assist and direct junior doctors in career paths and planning through various consultative processes such as vocational expositions.
7. Take a leadership role on the General Clinical Training Committee (or equivalent committee) and provide high-level professional advice on matters relating to the junior doctor training program.
8. Consult and liaise closely with senior clinicians supervising the junior doctors.
9. Participates in networking activities with other Medical Education Officers and the Manager of the Postgraduate Medical Education Foundation.
10. Prepare program reports for the District and the Postgraduate Medical Education Foundation, and contribute to curriculum development.
11. Consult and negotiate with the Director of Clinical Training to expand the role to address program deficiencies as and when they are identified.
12. Monitor the standard of the program to ensure that it is consistent with other Districts and meets MBBS requirements.

13. Undertake other related responsibilities as directed by the Director of Clinical Training.
14. The MEO may be required to manage the program across the District Health Service at more than one facility within the District. The Medical Education Officer may be required to supervise administration officers and other support staff, such as technical officers, who support them to prepare, coordinate and deliver educational activities.

SELECTION CRITERIA
Possession of tertiary qualifications in an education, health or related discipline is essential

Experience in education and training program development, implementation and evaluation in the fields of health, education and/or research is required.

Demonstrated high level interpersonal skills including the ability to consult and negotiate with senior health professionals and other stakeholders to ensure the objectives of the program are met.

Demonstrated high level written and oral communication skills including the ability to research and write technical reports and submissions utilising appropriate technical computer applications.

Ability to work effectively both independently and as a member of a multi-disciplinary team.
Demonstrated commitment to working in an environment that supports qualityhuman resource management practices, including workplace health and safety, employment equity, anti-discrimination, ethical behaviour and best practice.

ADDITIONAL INFORMATION:
The MEO may be required to supervise administrative/technical staff who support them in their role.
The MEO may be required to coordinate and manage the training the program across more than one health service facility in the health district.

Resource 12 - Medical Education Officer Role
(First compiled in collaboration by the MEOs at St Vincent's Hospital Melbourne, the Royal Children's Hospital, North West Health Care Network, and the Austin and Repatriation Medical Centre. Revised October 2002, Debbie Paltridge & Carol Jordon)

MEDICAL EDUCATION OFFICER ROLE

Background:

A Medical Education Officer is generally responsible for facilitating the continuing education of prevocational doctors (specifically PGY1, PGY2 and those PGY3 not in vocational studies). They will work with those Senior Medical Staff responsible for the supervision and education of prevocational medical staff (eg DCT, Supervisors of Intern Training, physician and surgical training), to maximise and promote teaching and learning for this group.

A proportion of the work of the MEO role may be seen to be maintenance; that is, working towards the achievement of and continuos improvement of aspects of the hospital's performance in relation to the accreditation standards for junior doctor education and training.

A proportion of the work of the MEO may be seen to develop programs and improvements in junior doctor education related to the hospitals' identified priorities and/or the interests and expertise of individual MEOs.

1. Role of the MEO in relation to supporting the development of a junior doctor education and training program consistent with the accreditation standards.

The role of the MEO is multifaceted and will include activities related to the following accreditation standards:

1. Hospital environment and culture:
The MEO will contribute education expertise in the processes of teaching and learning to individuals and committees involved in Hospital postgraduate education and training. The MEO will work with appropriate staff in the units to develop, monitor and evaluate the teaching and learning that occurs in each unit. The focus is on setting objectives, appropriate teaching and learning strategies including 'teaching' ward rounds, provision of ongoing feedback and assessment of outcomes. The MEO may also be involved in planning activities regarding future rotations in terms of education opportunities for junior medical staff. Where parent hospitals second junior medical staff to external hospitals for rotations, the MEO will facilitate communication and collaboration on educational issues.

2. Orientation:
The MEO, in partnership with appropriate Hospital personnel, will develop, implement and evaluate programs for hospital-wide and unit -based orientation.

3. Education Programs:
In partnership with appropriate personnel, the MEO will develop suitable programs for the development of clinical and broader based professional skills. A range of evaluation strategies will be used in the continuous improvement of both formal and informal education programs.

4. Supervision:
In partnership with appropriate personnel, the MEO will contribute to the monitoring and improvement of the quality of supervision of trainees. Supervision includes teaching, giving feedback,facilitating learning, managing performance and making and communicating assessments. The MEO will develop in-service programs to support registrar and consultant staff improve the quality of supervision, feedback and teaching of junior doctors. These programs will draw on results of local evaluations and other sources of educational research.

5. Feedback and Assessment
In partnership with appropriate personnel, the MEO will contribute to developing a process to ensure there are appropriate learning objectives for rotations, The MEO will facilitate a process for trainees to be provided with feedback on their performance both mid term and at the end of a rotation In addition, the MEO will ensure that there are appropriate processes developed to ensure adequate monitoring of HMO performance and mechanisms to identify and assistHMOs who might be experiencing difficulties.

6. Evaluation
In partnership with appropriate personnel, the MEO will contribute to the development of appropriate evaluation instruments to ensure written feedback from trainees and supervisors about the Education Program and HMO rotations, review the evaluation and propose strategies to for improve the HMOs learning experiences in the following year.

2. Other postgraduate medical education initiatives

MEOs are encouraged to develop programs which may be generalisable to other hospital sites based on their area of interest and expertise. MEOs may also be asked to support and develop programs which met the strategic initiatives identified at their local hospital level in relation to PGY1, PGY2 and prevocational PGY3 doctors. (eg Clinical Training Portfolio, learning objectives for units/rotations, on-line skills learning programs/manual, a HMO website). These can be documented as activities to be completed during the funding period.

Resource 13: Central Council MEO Role
(Based on the role of the Central MEO position description, Postgraduate Medical Council of Victoria, 2001)

POSITION DESCRIPTION – CENTRAL MEDICAL EDUCATION OFFICER

Reports to:	Executive Officer, PMCV on a day to day basis; works closely with the Chair of Education subcommittee
Salary:	[insert salary and conditions]
Fraction:	Part-time
Duration:	Initially for 12 months; Subject to review and funding.
Location:	Offices of the Postgraduate Medical Council. There will be some travel involved to metropolitan and regional hospitals and approved costs will be met by the Council.

Organisational Overview:
The Postgraduate Medical Council of Victoria was established as an Incorporated Association in August 1999. The Council has a Board, responsible for managing the business and affairs of Council and a Committee, which has day-to-day responsibility for developing and implementing policies and programs which support junior doctor training and education. Representatives are drawn from the Australian Medical Association, the specialist Colleges, the Medical Practitioners Board, public hospitals, the two medical faculties, medical practitioners, the Department of Human Services, junior doctors and the Health Services Commissioner.

The work of the Council is carried out by its subcommittees. Four key sub-committees have been established, namely Accreditation, Workforce Planning, Education and Overseas Trained Doctors. This position will normally interact with the Education subcommittee but as there is some overlap in the work of the committees, other interaction may be necessary.

The Council currently employs two full-time staff – an Executive Officer responsible the administrative activity of the Council and an administrative assistant who has responsibility for the Computer Match functions (nurses, interns, HMOs and medical radiation) and provides day-to-day administrative and secretarial support.

This is a newly created position and the appointee will work from the offices of the Council. The appointee will establish links with the hospital - based MEOs, facilitate an exchange of ideas and information about issues impacting on the quality of education and training and identify and research projects of joint concern to Council and hospitals.

Currently MEOs are employed in 5 Victorian metropolitan hospitals (The Alfred, St Vincent's, The Royal Children's, The Royal Melbourne, and Western Hospital) and funding has been approved for other MEO appointments to occur at Box Hill and Geelong Hospital and in regional areas at Gippsland, Shepparton and Mildura. MEOs support the work of hospitals in ensuring that their educational programs are sound and those mechanisms are in place to achieve the required educational and training standards.

Role

The PMC MEO will:
Develop, under direction of the Education subcommittee, a needs analysis to identify the priority issues in relation to postgraduate education and training for hospital medical officers and overseas trained doctors in training positions (including senior staff in hospitals, MEOs, junior doctors, OTDs);

Develop, under direction of the Education subcommittee, a needs analysis to identify the possible ways in which the Council can support the activities of the hospitals and the MEOs;

Develop and facilitate the setting up of a network of MEOs to exchange ideas on matters pertaining to postgraduate and education (for example, how trainees can best provide feedback on each Rotation; development of clinical and broader based professional skills, supervision)

In conjunction with stakeholders, identify, research and develop pilots/projects which aregeneralisable and will lead to improvements in the delivery and outcomes of education and training programs;

Facilitate implementation of Council's objectives, including data collection and review of performance indicators and educational outcomes;

Identify and establish a catalogue of existing educational resources for use byMEOs/Supervisors of Intern Training/ Directors of Clinical Training in their role; and

In consultation with stakeholders, develop and organise relevant training/education Workshops.

Selection Criteria
The selection criteria for MEO appointment are:
a) A genuine interest in and commitment to postgraduate medical education.
b) A willingness to develop expertise in this area.
c) Excellent communication, interpersonal and problem solving skills.
d) Ability to work collaboratively in a team environment and with a broad range of professionals and organisations.
e) Ability and willingness to work flexible hours (eg to attend meetings after normal working hours.
f) Experience in policy development and research writing desirable.
g) Health background not essential although qualifications or experience in education and training desirable.

Employment conditions
This position is the equivalent of one day a week (ie 7.5 hours). The hours worked per day can range from 8.00am – 6.00pm. Any additional hours will be paid at the normal hourly rate or can be negotiated to be taken as time off in lieu but any overtime must be approved in advance with the Executive Officer.

The appointee shall be entitled to four (4) weeks annual leave (or pro rata equivalent) and during such leave shall be entitled to the normal remuneration. Leave shall be taken at such time or times as agreed between the Executive Officer of PMCV and the Officer.

Resource 14: An example of a list of Key Skills and Knowledge for JMO years

(Based on a CEPTSA publication, An Information Package for Junior Medical Officers, 2001, Appendix 1)

It is important to learn to perform almost all these skills throughout the first two postgraduate years. Those marked with an asterisk (*) are optional, depending on the particular terms in which the medical officer works. The list emphasises important skills junior doctors should acquire but they should also be encouraged to see and learn all common clinical skills.

Procedural Skills

Cardiovascular
- cardiopulmonary resuscitation (CPR)
- use of a defibrillator
- ECG recording and interpretation
- arterial puncture
- insertion of long and central lines
- venepuncture, IV cannulation and administration of IV fluids

Respiratory
- establishment and maintenance of oropharyngeal airway
- endotracheal intubation
- ventilation
- * insertion, removal and management of intercostal drains/catheters
- * administration of a general anaesthetic
- spirometry
- indirect laryngoscopy

GIT
- insertion of a nasogastric tube
- proctoscopy

ENT
- packing a nasal cavity
- aural toilet and packaging
- syringing wax from the ears
- removal of a foreign body from ear, nose or throat

Ophthalmology
- removal of ocular foreign body
- visual testing

Orthopaedic
- reduction of a simple fracture
- application of plaster to a closed fracture
- application of traction
- reduction of dislocation
- bandaging
- joint aspiration

O&G/Genitourinary tract
- * resuscitation of a newborn
- vaginal speculum examination
- bladder catheterisation

General
- basic x-ray interpretation
- abscess drainage

- intramuscular injections
- subcutaneous and intradermal injection
- lumbar puncture
- suturing and wound care
- collection and preparation of pathology specimens
- infiltration with local anaesthetic

Emergency care

First Line Management under supervision, of:

- Basic Life Support-
- pneumothorax
- incorporated in Basic Life Support
- common cardiac arrhythmias
- acute pulmonary oedema
- coma
- the acute abdomen
- strangulated herniae
- acute appendicitis
- bowel obstruction
- acute poisoning
- acute urinary retention
- renal colic
- acute blood loss
- shock
- stroke
- status epilepticus
- acute asthma
- meningitis
- head injury
- acute renal failure/ electrolyte disturbance
- acute psychiatric emergencies
- alcohol and drug intoxication
- the aggressive, non-cooperative patient
- the acutely confused patient, particularly the elderly

First Line Management of common primary presentations

- deleted as diagnosis of psychosomatic disorders and symptoms without organic cause require an experienced clinician.
- social problems
- abdominal pain
- peritonitis
- chest pain
- ischaemic heart disease
- heart failure
- acute respiratory distress
- respiratory tract infection, upper & lower
- dehydration
- diabetes
- vomiting/diarrhoea
- drug overdose
- foreign body in eye/ear/nose
- rectal bleeding
- common skin rashes
- oral contraception
- arthritis and other musculoskeletal problems
- hypertension
- urinary tract infection

JMOs should be able to assess the following conditions and be aware of appropriate treatments and management. They should also know when to refer.

Cardiovascular
- cardiac arrhythmia
- ischaemic heart disease
- chest pain
- heart failure
- shock - cardiac, septic, anaphylactic, hypovolaemic

Respiratory
- pneumothorax
- acute asthma
- respiratory failure
- acute respiratory distress
- upper and lower respiratory tract infection

GIT
- the acute abdomen
- peptic ulcer perforation
- strangulated hernia
- acute appendicitis
- bowel obstruction
- peritonitis
- rectal bleeding
- abdominal pain
- vomiting and/or diarrhoea

Neurology/Psychiatry
- the comatose patient
- alcohol and drug intoxication
- head injury
- meningitis
- the acutely confused patient
- cerebrovascular accident
- status epilepticus
- psychiatric emergencies
- aggressive patients
- depression and anxiety
- social problems

G/UT
- acute urinary retention
- renal colic
- acute renal failure
- urinary tract infections

General
- burns
- drug overdose
- skin rashes
- rheumatological and musculoskeletal conditions
- community acquired infections
- sexually transmitted diseases
- diabetes
- fluid and electrolyte disturbances

Paediatrics

- sepsis
- fluid status (dehydration)
- respiratory and airways disease
- trauma

Preventive Care Skills

With current trends towards community-based care, there is a growing emphasis on doctors becoming more conscious of preventive measures. When patients are admitted to hospital, JMOs should consider the following issues and discuss with the patient the impact they may have on their health:

- smoking
- alcohol abuse
- drug abuse
- diet-related illness such as obesity, hyperlipidaemia and diabetes
- hypertension risk factors
- preventable cancers such as skin cancer
- sexually transmitted diseases
- health risk recognition
- integration of primary, secondary and tertiary health care. ?
- counselling and communication skills
- facilitation of behaviour change
- smoking cessation ? include drugs including alcohol.
- dietary advice (obesity, hyperlipidaemia, diabetes)

Communication Skills

Good communication skills are vital to the doctor/patient relationship

Patients and relatives

- information transfer
- reassurance
- explanation of tests and procedures

The following points should be considered when interacting with patients:

- preparation for tests and procedures
- providing complete information about illness or treatment
- providing appropriate reassurance
- explaining tests and procedures
- preparation for tests and procedures
- providing support for bereaved relatives
- being available to speak to close relatives
- bereavement counselling
- counselling skills including effective listening skills

Peers and supervisors

- you need to be able to communicate effectively with your peers, supervisors, nurses and para-medical staff. Effective communication will reduce your workload and encourage harmonious working relationships.
- Teamwork skills
- * use of relevant resources in hospitals and the community

Professional Development

JMOs should demonstrate increasing proficiency in:

- time-management skills
- research and teaching skills
- the rational use of investigations and technical resources

- maintaining up to date medical records
- the critical appraisal of bio-medical information
- medical audit and peer review
- health economics and cost-benefit relationships
- medical ethics and medico-legal issues
- the ability to make a competent differential diagnosis
- patient management and planning skills, including the preparation and follow-up of patients and liaison with other disciplines
- Effective patient handover

- Become familiar with the concepts of
  - Basic clinical teaching skills
  - evidence based practice and critical appraisal
  - health economics, cost-benefit analysis
  - ethics and law in clinical medicine
  - medical record skills for clinicians
  - rational use of investigations and referral
  - administrative procedures for patient care and health service management

Resource 15: Term Description Template

(Based on the Postgraduate Medical Council of NSW Standards for Junior Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix H)

TERM DESCRIPTION			
Hospital:			
Term Name:			
Term Supervisor:		**Signature:**	
Date:			
Clinical Team: (please include contact details)			
Term Duration (weeks):			
Is the term a PGY1 or a PGY2 term (or both)? (please tick) **PGY 1** ☐ **PGY 2** ☐			
A: Overview of unit or service:			
Please provide details of the role of the unit, the range of care service, etc:			
B: Term Objectives:			
By the completion of this term the JMO may expect to acquire the following knowledge:			
By the completion of this term the JMO may expect to gain competency in the following skills:			
C: Requirements for commencing the term: (please identify the knowledge or skills required by the JMO before undertaking the term and how they will be assessed. (Eg: Paediatric resuscitation, assessed by demonstration).			
D: JMO responsibilities and daily tasks: Please list:			
Please attach a term/unit timetable			
Patient load: (average)			
Overtime:	Rostered: ____ (average hours/wk) Unrostered: ____ (average hours/week)		
E: Education and Supervision:			
1. Education sessions (please outline content and timing of unit based sessions and the arrangements for JMOs to attend hospital wide education sessions throughout the term):			
2. Educational resources (please outline the information resources available to JMOs during this			

term and how to access them):

3. AMO Teaching (please list the AMOs who will provide workface/bedside teaching to JMOs):

4. Registrar Teaching (please list the Registrars who will provide workface/bedside teaching to JMOs)

5. Supervision: Please identify staff members with responsibility for JMO supervision and the mechanisms for contacting them, particularly after hours:

6. Supervision: Does this term include participation in an after hours roster and if so please advise of supervision available after hours:

Rounds / Surgery:

No of AMO Rounds per week	
No of AMO Rounds attended by JMOs	
No of out of Hours Rounds attended by JMOs	
No of operating sessions per week	
No of operating sessions attended by JMOs	

Assessment and feedback:

The Term Supervisor will provide formal assessment and feedback using the Postgraduate Medical Council's Progress Review Form at mid-term and at the end of term. In completing the Progress Review Form, the Term Supervisor may consult with other members of the team (AMOs, registrars, nurses and other professional staff).

Additional Information: (Optional)

Resource 16: Junior Medical Officers Attachment: Feedback and Appraisal (JAFA)
(Postgraduate Medical Council of New South Wales, Standards for Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix L)

Note: Original copy in the file. This will need to be scanned.

Junior Medical Officers' Attachment: Feedback & Appraisal

INSTRUCTIONS:

- Use a blue/black biro or 2B pencil
- Do not use red pen or felt tip pen

Please MARK LIKE THIS ONLY: ○■○○

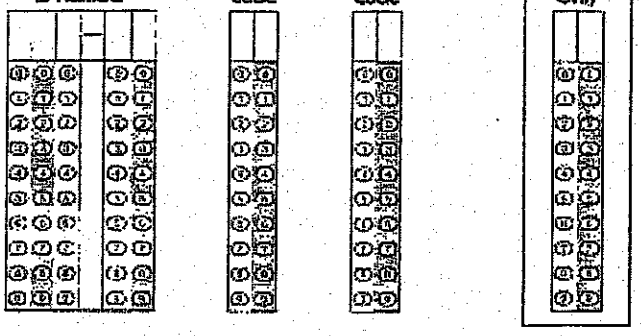
Example: Please write in boxes here, → then make oval corresponding to the number in each column.

Please fill in your ID Number, PAC Code and Hospital Code.

You are invited to provide your hospital and the Postgraduate Medical Council of NSW with feedback on how your term has enabled you to improve the quality of your medical care.

The information you provide will be de-identified and aggregated before release.

ID Number | PAC Code | Hospital Code | Office Use Only



Section A asks you questions about your term details, and Sections B-G ask you for feedback on your term.

A. Term Details

1 Term Number: (Mark ONLY ONE response)

○ Term 1 (January-March) ○ Term 2 (March-June) ○ Term 3 (June-August) ○ Term 4 (August-October) ○ Term 5 (October-January)

2 Position: (Mark ONLY ONE response)

○ PGY1 (Intern) ○ PGY2 (RMO1) ○ AMC Graduate (Overseas Trained Doctor)

3 Was this a split term? (Mark ONLY ONE response)

○ Yes ○ No

↓

If "Yes", please complete the following questions with respect to ONLY ONE part of your split term.
A separate form should be completed for the other part of your split term.

Page 1

A. Term Details (cont'd)

Mark **ONLY ONE** response

4 Term undertaken: (Mark **ONLY ONE** response)
Please contact Medical Administration if you are unsure which Team or Unit you were in. If there was only one Team or Unit for that specialty, mark "A".

	Team or Unit A	B	C	D	E
Anaesthetics	○	○	○	○	○
Community Term (please specify) _____	○	○	○	○	○
Emergency Medicine	○	○	○	○	○
General Practice	○	○	○	○	○
Intensive Care	○	○	○	○	○
Medicine; (please specify)					
Cardiology	○	○	○	○	○
Endocrinology	○	○	○	○	○
Gastroenterology	○	○	○	○	○
General Medicine	○	○	○	○	○
Geriatrics	○	○	○	○	○
Haematology	○	○	○	○	○
Infectious Diseases	○	○	○	○	○
Immunology	○	○	○	○	○
Medical Oncology	○	○	○	○	○
Neurology	○	○	○	○	○
Palliative Care	○	○	○	○	○
Radiation Oncology	○	○	○	○	○
Rehabilitation Medicine	○	○	○	○	○
Renal	○	○	○	○	○
Respiratory	○	○	○	○	○
Rheumatology	○	○	○	○	○
Other Medical Term (please specify) _____	○	○	○	○	○
Nights	○	○	○	○	○
O & G	○	○	○	○	○
Paediatrics	○	○	○	○	○
Psychiatry	○	○	○	○	○
Relief	○	○	○	○	○
Surgery; (please specify)					
Cardiothoracic	○	○	○	○	○
General Surgery	○	○	○	○	○
Neurosurgery	○	○	○	○	○
Ophthalmology	○	○	○	○	○
Orthopaedics	○	○	○	○	○
Plastics	○	○	○	○	○
Urology	○	○	○	○	○
Vascular	○	○	○	○	○
Other Surgical Term (please specify) _____	○	○	○	○	○
Other Specialty Term (please specify) _____	○	○	○	○	○

5 How many weeks were spent with this team or unit? (Mark ONLY ONE response)

- ○ 1-2 weeks
- ○ 3-4 weeks
- ○ 5-6 weeks
- ○ 7-8 weeks
- ○ 9-10 weeks
- ○ 11-13 weeks

PAGE 2

Please rate the following aspects of this term. (Please mark ONLY ONE response for each question.)

B. Orientation

		Poor	Fair	Satisfactory	Good	Very Good	Excellent
1	Orientation to the term	○	○	○	○	○	○
2	Discussion of term objectives and training goals with term supervisor	○	○	○	○	○	○

3 Did you receive a written term description? ○ Yes ○ No

4 Comments:

Office Use Only ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

C. Supervision

		Poor	Fair	Satisfactory	Good	Very Good	Excellent
1	Supervision in normal working hours from registrar	○	○	○	○	○	○
2	Supervision in normal working hours from consultant(s)	○	○	○	○	○	○
3	Supervision after hours (registrar and/or consultant(s))	○	○	○	○	○	○
4	Time spent with consultant(s)	○	○	○	○	○	○

5 Comments:

Office Use Only ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

D. Teaching & Learning

		Poor	Fair	Satisfactory	Good	Very Good	Excellent
1	On the job, patient based teaching (eg. bedside, clinics, OT etc.)	○	○	○	○	○	○
2	Opportunity to learn procedures (eg. lumbar punctures, pap smears, ascitic taps, arterial blood gases etc.)	○	○	○	○	○	○
3	Usefulness of regular team/unit based meetings (eg. weekly case conferences, multidisciplinary meetings etc.)	○	○	○	○	○	○
4	Ability to attend formal JMO education program	○	○	○	○	○	○
5	Usefulness of formal, hospital JMO education program	○	○	○	○	○	○
6	Access to educational resources (eg. library/intranet/internet)	○	○	○	○	○	○

7 Comments:

Office Use Only ① ② ③ ④ ⑤ ⑥ ⑦ ⑧

Please rate the following aspects of this term. (Please mark ONLY ONE response for each question)

E. Feedback

	Very Poor	Poor	Satisfactory	Good	Very Good	Excellent
1. Informal day-to-day feedback about performance during term by registrar	○	○	○	○	○	○
2. Informal day-to-day feedback about performance during term by consultant(s)	○	○	○	○	○	○
3. Formal feedback about performance at mid-term by term supervisor	○	○	○	○	○	○
4. Formal feedback about performance at end of term by term supervisor	○	○	○	○	○	○

5. Comments:

Office Use Only

F. Other

	Very Poor	Poor	Satisfactory	Good	Very Good	Excellent
1. Support from Director of Clinical Training if required	○	○	○	○	○	○
2. Support from medical administrators if required	○	○	○	○	○	○
3. Independence of decision making	○	○	○	○	○	○
4. Appropriate hours	○	○	○	○	○	○
5. Appropriate workload	○	○	○	○	○	○
6. Appropriate level of clerical/paper work	○	○	○	○	○	○
7. Fairness of rosters	○	○	○	○	○	○

8. Comments:

Office Use Only

G. Overall Rating

	Very Poor	Poor	Satisfactory	Good	Excellent
1. How would you rate this term overall?	○	○	○	○	○

2. Would you recommend this term to your colleagues? ○ Yes ○ No

3. Comments and suggestions:

Office Use Only

THANK YOU FOR YOUR CO-OPERATION

Have you completed your ID Number, PAC Code and Hospital Code at the start of this form?

Resource 17: Junior Medical Officers Progress Review
(Postgraduate Medical Council of New South Wales, Standards for Medical Officer Education and Supervision, Fourth Edition, 2002, Appendix L)

Note: Original copy in the file. This will need to be scanned.

Junior Medical Officer Progress Review

The information on this form contributes to decisions on registration and is a mechanism for providing JMOs with feedback each term for their professional development.

INSTRUCTIONS:

- Use a blue/black biro or 2B pencil
- Do not use red pen or felt tip pen

Please MARK LIKE THIS ONLY: ○ ● ○ ○

Example: Please write in boxes here, → then mark oval corresponding to the number in each column.

ID Number: 3 1 2 – 0 2

ID Number | PAC Code | Hospital Code

Hospital:

Term Name:

Term Number: (Please fill in appropriate oval) ① ② ③ ④ ⑤

Position: ○ PGY1 (Intern) ○ PGY2 (RMO1) ○ AMC Graduate (Overseas Trained Doctor)

Section A: Term Objectives & Training Goals

1 Were term objectives and training goals discussed during orientation to the term? ○ Yes ○ No

If "no", please comment: .....

Section B: Mid Term Assessment

Please assess your JMO's progress towards the satisfactory completion of this term in the following areas. It is expected that most JMOs will fall into the category "Consistent with level of experience".

	Requires substantial assistance	Requires further development	Consistent with level of experience	Performance better than expected	Not applicable/ Not observed
CLINICAL					
1.1 **Knowledge base** Adequate knowledge of basic and clinical sciences and application of this knowledge	○	○	○	○	○
1.2 **Clinical skills** Appropriate clinical skills including history taking and physical examination	○	○	○	○	○
1.3 **Clinical judgement/decision making skills** Ability to organise, synthesise and act on information	○	○	○	○	○
1.4 **Emergency skills** Ability to act effectively when urgent medical problems arise, including acknowledgement of own limitations and need to seek help when appropriate	○	○	○	○	○
1.5 **Procedural skills** Ability to perform simple procedures competently	○	○	○	○	○
COMMUNICATION					
2.1 **Communication** Ability to communicate effectively and sensitively with patients and their families	○	○	○	○	○
2.2 **Teamwork skills** Ability to work effectively within a team	○	○	○	○	○
PERSONAL AND PROFESSIONAL					
3.1 **Professional responsibility** Demonstrates professional responsibility through punctuality, reliability and honesty	○	○	○	○	○
3.2 **Teaching** Participates in the teaching of other health professionals	○	○	○	○	○
3.3 **Time management skills** Organises and prioritises tasks to be undertaken	○	○	○	○	○
3.4 **Medical records** Maintains clear, comprehensive and accurate records	○	○	○	○	○

4 Please provide a written comment about the JMO's performance during this term to date:

.....

.....

To be signed at mid term assessment:

.... / /

JMO Signature Term Supervisor's Signature Date

Section C: End of Term Assessment

Please assess the performance of your JMO throughout the term in the following areas.
It is expected that most JMOs will fall into the category "Consistent with level of experience".

	Requires substantial assistance	Requires further development	Consistent with level of experience	Performance better than expected	Not applicable/ Not observed
CLINICAL					
1.1 **Knowledge base** Adequate knowledge of basic and clinical sciences and application of this knowledge	○	○	○	○	○
1.2 **Clinical skills** Appropriate clinical skills, including history taking and physical examination	○	○	○	○	○
1.3 **Clinical judgement/decision making skills** Ability to organise, synthesise and act on information	○	○	○	○	○
1.4 **Emergency skills** Ability to act effectively when urgent medical problems arise, including acknowledgement of own limitations and need to seek help when appropriate	○	○	○	○	○
1.5 **Procedural skills** Ability to perform simple procedures competently	○	○	○	○	○
COMMUNICATION					
2.1 **Communication** Ability to communicate effectively and sensitively with patients and their families	○	○	○	○	○
2.2 **Teamwork skills** Ability to work effectively within a team	○	○	○	○	○
PERSONAL AND PROFESSIONAL					
3.1 **Professional responsibility** Demonstrates professional responsibility through punctuality, reliability and honesty	○	○	○	○	○
3.2 **Teaching** Participates in the teaching of other health professionals	○	○	○	○	○
3.3 **Time management skills** Organises and prioritises tasks to be undertaken	○	○	○	○	○
3.4 **Medical records** Maintains clear, comprehensive and accurate records	○	○	○	○	○
OVERALL ASSESSMENT					
4 **Overall rating** Overall performance during term	○	○	○	○	○

5 Please provide a written comment on the JMO's performance throughout the term:

.....

.....

.....

.....

.....

.....

.....

6 Did you consult with other medical/nursing/allied health professionals in completing this assessment?

○ Yes ○ No

To be signed at end of term assessment:

JMO: .... / /
Name (please print) Signature Date

Term Supervisor: .... / /
Name (please print) Signature Date

Thank you for your cooperation

POSTGRADUATE MEDICAL

OFFICE OF HEALTH PRACTITIONER

REGISTRATION BOARDS

Submission To: Medical Board of Queensland

Prepared and Submitted by: Jim O'Dempsey, Executive Officer

Subject: **Referral from Physiotherapists Board**

Recommendation

It is recommended that the Board:

(a) Defer initiation of summary proceedings against Ms Tyack until such time as the Chiropractors Board and Osteopaths Board have advised the Board on their strategy to address use of the title "Dr" by their registrants.

(b) Advise the Chiropractors Board and Osteopaths Board of its decision in this regard.

(c) Advise the Physiotherapists Board of its decision.

Purpose

1. To brief the Board on the attached (1) referral from the Physiotherapists Board of Queensland.

Background

2. The Physiotherapists Board has recently investigated a matter concerning advertising by Bayside Physical Health Centre and Julie Tyack. The Board found that Ms Tyack was:

   (a) in breach of the title restriction provisions of the *Physiotherapists Registration Act 2001*; and

   (b) potentially in breach of the title restriction provisions in the *Medical Practitioners Registration Act 2001* through her use of the title "Dr"'.

3. Ms Tyack is currently registered as a chiropractor. Prior to the establishment of the current Chiropractors Board, the previous Chiropractors and Osteopaths Board notified all their registrants that the use of the title "Dr" was permissible but only in conjunction with the descriptor "chiropractor" or "osteopath". For example, Dr J Smith (Chiropractor). In addition, the Boards included the title "Dr" on the register.

4. The previous Board apparently made this decision on the basis that those registrants qualified in the United States of America were awarded a qualification entitled "Doctor of Chiropractic" and it would be uncompetitive if Australian qualified registrants could not also use the title "Dr".

5. Prior to this issue being raised by the Physiotherapists Board I had advised both the Chiropractors Board and the Osteopaths Board that use of the title "Dr" in the absence of a provision similar to s.160 *Medical Practitioners Registration Act 2001* may mean that:

   (a) both Boards, by including the title "Dr" on their registers, are in breach of the *Medical Practitioners Registration Act 2001*, the *Dental Practitioners Registration Act 2001* and the *Higher Education (General Provisions) Act 1993*; and

   (b) any individual registered by either Board, by using the title "Dr" are in breach of the Acts detailed under paragraph 5(a).

6. I am currently, on behalf of the Chiropractors Board, seeking advice from Crown Law to inform a strategy to rectify the previous Boards' decision. In this regard, it may be premature for the Board to initiate summary proceedings against Ms Tyack given that all current registrants of both the Chiropractors Board and the Osteopaths Board may similarly be in breach of the title restriction provisions of the Acts detailed in paragraph 5(a).

Jim O'Dempsey
EXECUTIVE OFFICER

29 January 2003

Physiotherapists Board of Queensland

Please address all correspondence to: -
REGISTRAR
PHYSIOTHERAPISTS BOARD OF QUEENSLAND
GPO BOX 2438
BRISBANE QLD 4001
E-Mail: physiotherapy@healthregboards.qld.gov.au
Website Address: www.physioboard.qld.gov.au

19TH FLOOR
FORESTRY HOUSE
160 MARY STREET
BRISBANE Q 4000
Ph: + 61 7 3234 1164
Fax: + 61 7 3225 2527

ABN: 37 853 703 315

IN REPLY, PLEASE QUOTE
NO. T17.22

24 January 2003

Mr J O'Dempsey
Executive Officer
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4001

Dear Mr O'Dempsey

Holding out as a "Doctor"

The Physiotherapists Board of Queensland has investigated a matter concerning advertising by Bayside Physical Health Centre and Julie Tyack (refer attached advertisement).

At the Board's recent meeting, the Board resolved that the matter of Julie Tyack holding herself out as a "Dr" be referred to the Medical Board for attention.

For your information, although Julia Tyack is advertising in the Yellow Pages under the heading "Physiotherapists", Julia Tyack is not registered as a Physiotherapist.

Yours sincerely

Pauline Portier
Assistant Registrar

Enc

LOCALITY GUIDE CONTINUED

PHYSIOTHERAPISTS

Kallangur

MARK TURNER
Neck & Back Pain
Sports & Dance Injuries
Pilates Studio
1420 Anzac Ave
Kallangur 3204 6388

Kangaroo Point

Acuphysio West End Physiotherapy
Centre 109 Vulture West Ed.... 3844 0636

DOCKSIDE PHYSIOTHERAPY
Sports & Spinal Injuries
Manual Therapy, Video Gait Analysis
Town Square, Dockside
Kangaroo Point 3391 3780

Karalee

Ipswich Physiotherapy Centre
Karalee Shopping Village Junction Rd
Karalee 3812 3024

Karana Downs

Chong Anna
10 College Rd Krna Dwns 3201 1022

MT CROSBY ROAD PHYSIOTHERAPY & SPORTS INJURY CENTRE
Fran Pennay
1075 Mt Crosby Rd
Karana Downs 3202 1131
FAX 3201 1291

Kedron

Bourke Cindy
3 Norman Drv Cherm 3350 5455

DAY SANDRA
205 Stafford Rd Stffd 3857 5815

OPTIMA GROUP THE
Cnr Brookfield Rd & Gympie Rd 3857 5344

Kelvin Grove

Body Mechanics
15 Bowen Bridge Rd Herst 3252 4000

LIFECARE PHYSIOTHERAPY
See Our Main Display Advert Under "Physiotherapists"
QUT Fitness Centre, Kelvin Grove
Campus Kel Gr 3864 3711

RED HILL PHYSIOTHERAPY & SPORTS INJURY CENTRE
See Our Main Advert under Red Hill this Classification
AMA Place 88 L'Estrange Tce
Kel Gr 3856 5566

Long after the shops have closed, the Yellow Pages® directory offers a convenient source of information about business, services and location.

Kenmore

ALLSPORTS PHYSIOTHERAPY
Cnr Moggill & Station Rds
Indooroopilly 3878 9011
Christies Homebase Cntr
Jindalee 3279 3752

KENMORE PHYSIOTHERAPY
KENMORE
General Physiotherapy
Sports Injuries
DAMIAN A. GRIFFIN
B.Phty. M.A.P.A
MELINDA COBURN
B.Sc.B.Phty. M.A.P.A.
IN PAIN? - SEE US
– Back / Neck / Sciatica
– Shoulder / Hip / Knee
– Headaches / Arthritis
– Work / Motor Vehicle Injuries
– Veterans Affairs
SATURDAYS & EXTENDED HOURS
EASY PARKING
Suite 4, Kenmore Medical Centr
2081 Moggill Rd
Kenmore 3378 5712

METRO PHYSIOTHERAPY
900 Moggill Rd Kenmore 3878 8911
FAX 3878 4555

PHYSIOTHERAPY CENTRE
RONALD MOO
B. Phty., B.H.M.S., M.A.P.A.
- Back Pain
- Neck Pain
- Sports Injuries
GOLF INJURY & REHABILITATION AUST.
- Golf Injuries
3378 2672
8 Marshall La Kenmore 3378 2672

Keperra

ALLSPORTS PHYSIOTHERAPY
Cnr Waterworks & Payne Rds
The Gap 3300 6011

IN-LINE PHYSIO
Great Western Super Centre Kpra
Phone/Fax 3351 8808

KEPERRA PHYSIOTHERAPY & SPORTS INJURY CLINIC
Chris Cameron
18 Dallas Pde Kpra 3855 1367

LifeCare Physiotherapy
See Our Main Display Advert Under "Physiotherapists"
6 Patricks Rd Arana Hls 3351 5639

Kingston

KINGSTON PHYSIOTHERAPY CENTRE
Ron Jansen M.A.P.A.
170 Jacaranda Ave Kngstn ... 3209 2163

LOGAN CENTRAL PHYSIOTHERAPY CLINIC
Cnr Wembley Rd & Margarette St
Wdrdge 3808 3070

Kippa-Ring

PENINSULA PHYSIOTHERAPY
Member Falconer Physio Group
Refer Advert Under "Physiotherapists"
Next to Peninsula Private Hospital
Cnr George & Florence Sts
Kippa-Ring 3284 6383

Lawnton

ARROW LEANNE
Medical Centre Sparkes Rd
Bray Pk 3889 6233

Loganholme

ELITECARE PHYSIOTHERAPY SERVICE
AFTER HOURS & WEEKENDS
For Appointments Call Brendan
Shailer Park 3209 8614

HYPERDOME PHYSIOTHERAPY CENTRE
Deborah Hogg
– Neck & Back Pain
– Work/Sports Injuries
– Headaches
– Womens Health
Hicaps – H/Fund Claims
3209 8444
Hyperdome Medical Centre
42 Bryants Rd Lgnhlme 3209 8444

LOGANHOLME PHYSIOTHERAPY CENTRE PHYSIOWORKS
David Rieck – Sports Physiotherapist
Stewart Rieck – Physiotherapist
Sandi Hughes – Physiotherapist
Heather Fletcher – Physiotherapist
NECK & BACK CARE
SPORTS & WORK INJURIES
WOMEN'S HEALTH & PAEDIATRICS
70 Bryants RdLoganholme 3801 3417

SYNERGY MEADOWBROOK PHYSIOTHERAPY
Cnr Loganlea Rd & Edenlea Dr
Mdobrk 3805 6811

Lutwyche

Junction Rd Physiotherapy
312 Junction Rd Clay 3857 4810

OPTIMA GROUP THE
461-473 Lutwyche Rd Lut 3857 0727

MacGregor

MAXIMIZE PHYSIO
568 Kessels Rd McGrgr 3343 5494

Sportscare Physiotherapy
Sunnybank
Suite 12 309 Mains Rd 3344 7200
Calamvale
Shop 5b Cnr Kameruka St & Beaudesert Rd 3272 5230
Bulimba Suite 2 204 Oxford 3899 8177

Manly West

BAYSIDE PHYSICAL HEALTH CENTRE
Dr Julia Tyack's
Physiotherapy Rehab Team
Personal Injuries, Sporting Accidents, Stability, Work
148 Radford Rd
Manly West 3249 5333

My Physio Is at Bayside Physical Therapies
180 Hargreaves Rd Mly W 3396 3761

Mansfield

Mansfield Physio Works
John Perrier & Associates
Cnr Newnham & Wishart Rds
Mnsfld 3849 3099

Mansfield (Cont'd)

PHYSIO PLUS
Open 7 Days & After Hours
Shop 5, Metropol, Cnr Pine Mtn & Creek Rd Crndle 3219 3700

McDowall

ACTIVE CARE PHYSIOTHERAPY
Dirk Harm & Stuart Cox
Cnr Beckett & Hamilton Rds
McDwl 3872 5444

Bourke Cindy
3 Norman Drv Cherm 3350 5455

NORTH WEST PHYSIOTHERAPY & SPORTS INJURY CLINIC
ROGER McINTOSH
North West Medical Centre
125 Flockton St
Everton Park 3353 4111

Meadowbrook

SYNERGY MEADOWBROOK PHYSIOTHERAPY
Cnr Loganlea Rd & Edenlea Dr
Mdobrk 3805 6811

Middle Park

MIDDLE PARK PHYSIOTHERAPY
MIDDLE PARK
LAI PENG CHAN
B.Phty, M.A.P.A.
GENERAL PHYSIOTHERAPY with a focus on HANDS-ON THERAPY
SPECIAL INTERESTS:
– Neck & Back Problems
– Sports & Work Injuries
– Headaches; Arthritis
– Therapeutic Massage
HICAPS Available
Park Village Shopping Centre
Cnr Horizon Drv & Riverhills Rd
Middle Park 3279 3839

Milton

A PARK ROAD PHYSIOTHERAPY & MASSAGE CENTRE
Personalized Attention
Extended Consultation
Marie White
Milton 3368 1105

BAROONA ROAD PHYSIOTHERAPY & SPORTS INJURY CLINIC

Est. 1991
- Tracey O'Brien - B. Phty, M. Phty (Sports)
- Anne Morgan B. Phty, M. Phty (Sports)
- Michael Ridgway - B. Phty, M. Phty (Musculoskeletal)

Milton Shopping Village
Baroona Rd Milton 3368 4029

LOUISE SWANSON PHYSIOTHERAPY
General Physiotherapy Practice
Hospital & Rooms,
Sports Injuries,
Neck & Back Care.
L3 Sandford Jackson Building
72/30 Chasely St Auch 3871 0716

This Guide Continued Next Page

Office of
Health Practitioner Registration Boards
Queensland Government

MEMORANDUM

TO: Dr Toft

FROM: Jim O'Dempsey

DATE: 29 January 2003

SUBJECT: Delegation to appoint inspectors and investigators

Background

Mr Phil Watts was previously appointed by the Board as Inspector and Investigator on 28 May 2002. Mr Watts was appointed to investigate a number of complaints concerning the use of restricted titles in reliance upon the inspectorial powers under the *Medical Practitioners Registration Act 2001*.

Mr Watts has subsequently ceased employment with the Office of Health Practitioner Registration Boards and Ms Todd has been temporarily appointed to act in Mr Watts' position. Ms Todd has not been appointed as an inspector for the purposes of the *Medical Practitioners Registration Act 2001* or the *Health Practitioners (Professional Standards) Act 1999*. Ms Todd has however been appointed as an investigator for the purpose of the *Health Practitioners (Professional Standards) Act 1999*.

Issues

In order to conduct investigations planned for tomorrow in relation to the complaints concerning the use of restricted titles, Ms Todd must be urgently appointed as an inspector under the *Medical Practitioners Registration Act 2001*.

In order to prevent the need to seek such urgent Board appointments in the future, a delegation of the Board's power to appoint inspectors and investigators under the *Health Practitioners (Professional Standards) Act 1999* and the *Medical Practitioners Registration Act 2001*, to the position of Executive Officer will allow the person in that position to make the appropriate appointments and minimise the administrative tasks of the Board.

Recommendation

In light of the urgent need to appoint Ms Todd as an inspector prior to tomorrows planned investigative steps, I recommend that you delegate to the position of Executive Officer the power to appoint investigators and inspectors for the purpose of the *Health Practitioners (Professional Standards) Act 1999* and the *Medical Practitioners Registration Act 2001*. Such delegation to be later ratified by the full Board.

Jim O'Dempsey
Executive Officer

29/1/03 @ 4.30 pm.
P/w Dr Toft.
who has approved this delegation.
Please refer to board for

6 703461 9

DISTRICT COURT
OF QUEENSLAND
23 DEC 2002
FILED
BRISBANE

Health Practitioners Tribunal

Health Practitioners (Professional Standards) Act 1999

REGISTRY: Brisbane District Court
NUMBER: 2332/02

Registrant: **MICHAEL HARVEY GOLDEN**

Registrant's Board: **THE MEDICAL BOARD OF QUEENSLAND**

DECISION OF THE TRIBUNAL

Before: **Judge O'Brien DCJ**

Date: **20 December 2002**

Initiating document: Referral Notice from the Medical Board of Queensland filed on 12 June 2002

IT IS THE DECISION OF THE TRIBUNAL THAT:

The Registrant is required to give the Tribunal an undertaking in terms which are set out in reasons which are published.

THE TRIBUNAL DIRECTS THAT:

Details of the undertaking must be recorded in the Board's Register for a period for which the undertaking is in force.

IT IS ORDERED THAT:

The parties will be at liberty to apply to vary certain terms of the undertaking after the expiration of 14 days following receipt by the Board of any of Dr New's 12 monthly reports referred to in the undertaking on the giving of 21 days' written notice to the other party.

DISTRICT COURT REGISTRY BRISBANE

IT IS ORDERED THAT:

The Registrant should pay the Board's costs of and incidental to these proceedings fixed, in accordance with the Act according to the District Court scale in such amount as may be agreed or in the absence of agreement to be assessed.

REASONS FOR THE DECISION are contained in the attached Judgment

A party may appeal only on a question of law to the Court of Appeal about the decision.

HOW TO APPEAL

*"**How to start an appeal***
*s.**349.(1)** An appeal is started by-*
*(a) filing a notice in the approved form (a **"notice of appeal"**) with the registrar of the Court of Appeal; and*
(b) complying with the rules of court applicable to the appeal.
***(2)** The notice of appeal must require the appellant to state fully the grounds for the appeal and the facts relied on.*
***(3)** The notice of appeal must be filed within 28 days after the day the appellant receives notice of the appealable decision.*
***(4)** The court may, at any time, extend the period for filing a notice of appeal.*
Appellant to give notice of appeal to particular persons
*s.**350.(1)** Within 14 days after filing the notice of appeal, the appellant must give a copy of the notice-*
(a) if the appellant is the registrant - to the registrant's board and commissioner; or
(b) if the appellant is the registrant's board – to the registrant and the commissioner.
***(2)** If the registrant or a board is given a copy of the notice of appeal under subsection(1), the registrant or board is the respondent for the appeal."*

DISTRICT COURT REGISTRY BRISBANE

Place: Brisbane
Date: 23 December 2005

Deputy Registrar
Health Practitioners Tribunal
District Court
Ph: 3247 4416
Fax: 3247 5387

DISTRICT COURT REGISTRY BRISBANE

ADDRESSES FOR SERVICE

Registrant:	Dr Michael Harvey Golden 62 Habitat Place BRIDGEMAN DOWNS QLD 4035
Board:	Medical Board of Queensland C/- Gilshenan & Luton Lawyers 95 North Quay BRISBANE QLD 4002
Commissioner:	Health Rights Commissioner Level 19 Jetset Centre 288 Edward Street GPO Box 3089 BRISBANE Q 4001

DISTRICT COURT OF QUEENSLAND

CITATION:	*Medical Board of Queensland v. Golden*
PARTIES:	**MEDICAL BOARD OF QUEENSLAND (REGISTERS BOARD)** **v.** **MICHAEL HARVEY GOLDEN (REGISTRANT)**
FILE NO/S:	D2332/02
DIVISION:	Health Practitioners Tribunal
PROCEEDING:	Disciplinary Action
ORIGINATING COURT:	Brisbane
DELIVERED ON:	20 December 2002
DELIVERED AT:	Brisbane
HEARING DATE:	9 December 2002
JUDGE:	O'Brien DCJ Assisted By Dr. John Comerford Dr. Ben Steinberg Ms. Susan Johnson
ORDER:	
CATCHWORDS:	
COUNSEL:	Mr. D. Tait instructed by Flower & Hart for the Registrant Mr. D.K. Boddice instructed by Gilshenan & Luton for the Registrants Board
SOLICITORS:	

[1] This is a hearing of a referral of a disciplinary matter by the Medical Board of Queensland pursuant to s.26(1)(b) of the *Health Practitioners (Professional Standards) Act* 1999. The ground for disciplinary action is founded in s.124(1)(i) of the Act in that the registrant has been convicted of an indictable offence. There is no issue that the registrant has been so convicted, and the only matter of concern to this Tribunal relates to the penalty that should now be imposed.

[2] On 2 April 2002 in the District Court at Beenleigh, the registrant was convicted of two offences of indecently dealing with a girl under the age of 14 years. He was sentenced to a term of 12 months imprisonment, such imprisonment being suspended after a period of two months for an operational period of three years. The offences the subject of the charges were committed during 1984 and the very early part of 1985. At the relevant time the complainant was four years of age.

[3] The aggravating features of the registrant's conduct are set out in the remarks of the learned sentencing judge. One such feature was the fact that the registrant was a close friend of the complainant's family, although it is not suggested that the offences occurred in a clinical setting or in the context of a doctor/patient consultation.

[4] As indicated above, the convictions were recorded in April 2002, some 17 years after the offences and in the intervening period the registrant has continued his work as a doctor in general practice. There is no evidence whatever to suggest that he has engaged in any similar conduct during that period. On the occasion of sentence in the Beenleigh District Court, the learned sentencing judge make the following comments:

> "On the evidence before the court, you are otherwise a person of good character. The references speak of your willingness to help others and of your participation in the life of community at Redcliffe where for most of your life you have been in practice as a general practitioner.
>
> You have also become involved in the church. You have been active in the Casilo movement and in the Teams of Our Lady groups holding positions in both movements.
>
> You also enjoy a good professional reputation within the community and with your peers.

> The offences on the complainant have not been repeated on any other child. The time since the offences allows us to see the offence as isolated and that you have led an exemplary life over the period of 17 years since the offences were committed."

[5] These observations are supported by the numerous references that have been placed before this Tribunal in support of the registrant. These references, some of which are unsolicited, come from members of the medical profession as well as the public and include testimonials from patients of the registrant.

[6] On 8 July 2002 this Tribunal ordered, with the registrant's consent, that he should undertake a health assessment by a specialist medical practitioner nominated by the Board. Such an assessment was subsequently undertaken by Dr. Andrew Leggett, a consultant psychiatrist. In his report, Dr. Leggett has expressed the view that the registrant is unlikely to re-offend, and that he is fit to practice medicine subject, of course, to any conditions that might be considered appropriate.

[7] Counsel for the Board has submitted that balancing all of the relevant factors, the appropriate course in this case is not to suspend the registrant's registration but to allow him to continue in practice subject to certain strict conditions. The registrant, through his counsel, has indicated a preparedness to accept and abide by those conditions.

[8] Although matters such as general deterrence can often be of importance in appropriate cases, the jurisdiction exercised by this Tribunal is essentially protective rather than punitive. The offences of which the registrant was convicted were undoubtedly serious, but the essential purpose of these proceedings is not to punish him for that conduct. That task fell to the court at Beenleigh following the

registrant's conviction. It is instructive to keep in mind the purposes of disciplinary proceedings under the Act as set out in s.123 as follows:

(a) to protect the public;

(b) to uphold standards of practice within the health profession;

(c) to maintain public confidence in the health profession.

[9] These matters are also reflected in the objects of the Act as set out in s.6.

[10] The overwhelming evidence before this Tribunal is that the registrant is unlikely to re-offend. It is now almost 18 years since the offences were committed and although his offending did not occur in the course of the registrant's practice of medicine, the Tribunal should nevertheless be satisfied that a regime exists which will not only provide safeguards to the public but which will also allow the Board and even this Tribunal, to assess his continued suitability for practice. I have taken the advice of my assessors, and in the circumstances of the present case I am satisfied that the undertakings proposed by the Board are sufficiently rigorous to achieve those ends.

[11] The conditions involve counselling and supervision from an experienced psychiatrist and the orders will include liberty for either party to reapply. Such a provision will not only protect the rights of the registrant but importantly, if Dr. New's reports indicate any particular cause for concern then the public is further protected through the Board's entitlement to bring the matter back before this Tribunal.

[12] In the result, the order of the Tribunal is that, pursuant to s.241(2)(d), the registrant is required to give the Tribunal an undertaking in the following terms:

1. For a period of 36 months from today:

(a) the registrant -

(i) will not consult/examine/treat any patient under the age of 14 years without a chaperone over the age of 18 years or an adult guardian present;

(ii) will in respect of patients referred to in (i) hereof, maintain a register for examination at any time upon demand by the Board or its authorised agent recording the date of consultation, name of patient and name of chaperone or adult guardian present.

(b) the registrant will provide the Board with authority to access his patient records and his prescribing records through the Health Insurance Commission;

(c) the registrant will provide a copy of the conditions of this undertaking forthwith to all practitioners with whom he practices, either in partnership, or in association, or as an employer, or as an employee and to all staff including any Health Professional Registrants employed by any practice wherein the registrant practices;

(d) the registrant will seek and receive counselling and supervision from Dr. Frank New at his own expense. Such counselling

(i) is to be at such times as Dr. New may direct provided that the frequency by no less than monthly for the first six months and thereafter not less than three monthly;

(ii) is to address the registrant's relationships with patients, his boundary management and his insight level and is to include his presenting cases and discussing material with Dr. New.

(e) the registrant –

(i) authorises and directs Dr. New to provide the Board with a report of the progress of the counselling and supervision at the expiration of each 12 month period for the duration of this undertaking;

(ii) consents to Dr. New reporting any matter of concern to the Board, and providing any written report of that matter of concern;

(iii) authorises and directs Dr. New to forthwith notify the Board of any breach of this undertaking or its conditions by the registrant;

(iv) authorises the Board to inquire of Dr. New at any time to ascertain the registrant's compliance with counselling and supervision.

(2) The registrant's fitness to practice medicine be addressed by the Board on an annual basis upon receipt of Dr. New's 12 monthly reports.

[13] Pursuant to s.242(1)(b) of the Act it is further ordered that details of the undertaking must be recorded in the Board's register for the period for which the undertaking is in force.

[14] The parties will be at liberty to apply to vary the terms of paras. 1(d) and 1(e) referred to above after the expiration of 14 days following receipt by the Board of any of Dr. New's 12 monthly reports, on the giving of 21 days written notice to the other party.

QUEENSLAND COURTS

REGISTRY
DISTRICT COURT
BRISBANE

4530 02

HEALTH PRACTITIONER BOARDS
19 NOV 2002
RECEIVED

10

Contact: Robyn Wegner
Telephone: (07) 3247 4416
Facsimile: (07) 3247 5387

18 November 2002

Medical Board of Queensland
Level 19 Forestry House
160 Mary Street
GPO Box 2438
BRISBANE QLD 4001

Dear Sirs

RE: MEDICAL BOARD OF QUEENSLAND –V- RICKARDS
FILE NO. D3028/02

I refer to the above matters and give you written notice pursuant to Section 245(1) and (2) *Health Practitioners (Professional Standards) Act* 1999 of the decision of the Health Practitioners Tribunal made on 31 October 2002 which is contained in the enclosed copy of the decision.

Yours faithfully

R.A. Wegner
Deputy Registrar

OFFICE:
Law Courts Complex
304 George Street
Brisbane
POSTAL:
PO Box 167
Brisbane Albert Street
4002
DX:
DX 40168
TELEPHONE:

Health Practitioners Tribunal

Health Practitioners (Professional Standards) Act 1999

REGISTRY: Brisbane District Court
NUMBER: 3028/02

Registrant: **PAUL JOSEPH RICKARDS**

Registrant's Board: **MEDICAL BOARD OF QUEENSLAND**

DECISION OF THE TRIBUNAL

Before: **McGill SC DCJ**

Date: **30 October 2002**

Initiating document: Referral Notice from the Medical Board of Queensland filed on 16 July 2002.

IT IS THE DECISION OF THE TRIBUNAL THAT:

1. The Registrant is impaired within the meaning of s.124(2) of the Health Practitioners (Professional Standards) Act 1999 "The Act).
2. The Registrant's registration be suspended until 31 July 2003.
3. In the period from the date of this order until 31 July 2003 the following conditions shall apply:-
   (a) The Registrant will submit to the medical supervision of an experienced general practitioner who shall prescribe and supervise all medications other than those prescribed by his treating psychiatrist or any other specialist to whom he is referred by his general practitioner. The Registrant is to keep the Board informed of the name of his treating general practitioner and will authorise that practitioner to notify the Board if there is a significant change in his health status.
   (b) The Registrant, at his own expense, will attend for treatment by a psychiatrist of his own choice, experienced in the treatment of drug and alcohol abuse, at a frequency to be determined by the treating psychiatrist. The Registrant must authorise the treating psychiatrist to inform the Board of the termination of treatment of if there is a significant change to his health status, such as non-compliance with medication or treatment, or relapse of his depressive illness, or relapse of drug or alcohol abuse.
   (c) The Registrant will attend for random urine drug screening in Group 1 in accordance with the Board's UDS protocol.
   (d) The Registrant shall attend for review by a medical practitioner and/or psychiatrist nominated by the Board on an occasion or

occasions reasonably nominated by the Board and at the Board's expense.

4. From 1 August 2003 and 31 July 2004 the following conditions shall apply to the Registrant's registration.
   (a) The conditions referred to in paragraphs 3 (a), 3 (b) and 3 (d) above,
   (b) The Registrant will attend for random urine drug screening. Commencing in Group 1, in accordance with the Board's UDS Protocol.
   (c) The Registrant will, within 24 hours of his suspension being lifted, surrender his authority to prescribed controlled drugs.
   (d) The Registrant will not, within the 12 month period to 31 July 2004 apply for reinstatement (either full or partial) of his authority to prescribe controlled drugs.
   (e) The Registrant will work only in a supervised position.
   (f) The Registrant will advise his immediate practice supervisor of these conditions and shall advise the Board of the identity of that person and shall consent to that person providing reports to the Board regarding his clinical and overall work performance.
   (g) The Registrant shall authorise the Board to release information regarding his progress on the health assessment and monitoring program to his treating psychiatrist and treating general practitioner, should those circumstances be of a concern for the Board.
   (h) The Registrant shall authorise Queensland Health and the Health Insurance Commission to release to the Board information relating to his own health care (e.g. the prescribing and obtaining of controlled drugs and referral history).
   (i) Pursuant to section 242 (1) (a) of the Act, these conditions must be recorded in the Board's register for a period of 1 year.
5. On a permanent basis the Registrant shall not, and shall undertake not to, prescribe for himself any medication and this condition shall be recorded in the Board's register pursuant to section 242 (1)(a) of the Act.
6. The Board shall be at liberty to re-list this matter before the tribunal in the event that it has any concerns regarding the Registrant's impairment, the random urine drug screening, and his compliance with these conditions and each party shall be at liberty to re-list this matter before the Tribunal in the event that there is any other difficulty with the implementation of these orders.

REASONS FOR THE DECISION are contained in the attached Judgment

A party may appeal only on a question of law to the Court of Appeal about the decision.

HOW TO APPEAL

*"**How to start an appeal***

*s.**349.(1)** An appeal is started by-*

*(a) filing a notice in the approved form (a **"notice of appeal")** with the registrar of the Court of Appeal; and*

(b) complying with the rules of court applicable to the appeal.

***(2)** The notice of appeal must require the appellant to state fully the grounds for the appeal and the facts relied on.*

***(3)** The notice of appeal must be filed within 28 days after the day the appellant receives notice of the appealable decision.*

***(4)** The court may, at any time, extend the period for filing a notice of appeal.*

Appellant to give notice of appeal to particular persons

*s.**350.(1)** Within 14 days after filing the notice of appeal, the appellant must give a copy of the notice-*

(a) if the appellant is the registrant - to the registrant's board and commissioner; or

(b) if the appellant is the registrant's board – to the registrant and the commissioner.

***(2)** If the registrant or a board is given a copy of the notice of appeal under subsection(1), the registrant or board is the respondent for the appeal."*

Place: Brisbane
Date: 18 November 2002

Deputy Registrar
Health Practitioners Tribunal
District Court
Ph: 3247 4416
Fax: 3247 5387

DISTRICT COURT REGISTRY

A party may appeal only on a question of law to the Court of Appeal about the decision.

HOW TO APPEAL

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Place: Brisbane
Date: 18 November 2002

Deputy Registrar
Health Practitioners Tribunal
District Court
Ph: 3247 4416
Fax: 3247 5387

DISTRICT COURT REGISTRY

ADDRESSES FOR SERVICE

Registrant:	Peter Joseph Rickards C/- Tress Cocks & Maddox PO Box 7909 Waterfront Place Brisbane Qld 4001
Board:	Medical Board of Queensland Level 19 Forestry House 160 Mary Street GPO Box 2438 BRISBANE Q 4001 Medical Board of Queensland C/- Phillips Fox Lawyers Level 29 1 Eagle Street Brisbane Qld 4000 DX 289
Commissioner:	Health Rights Commissioner Level 19 Jetset Centre 288 Edward Street GPO Box 3089 BRISBANE Q 4001

Transcript of Proceedings

HEALTH PRACTITIONERS TRIBUNAL

JUDGE McGILL SC

DR J COMERFORD
DR B STEINBERG
MS K BROWN

No D3028 of 2002

MEDICAL BOARD OF QUEENSLAND — Applicant

v.

PAUL JOSEPH RICKARDS — Registrant

BRISBANE

..DATE 30/10/2002

JUDGMENT

The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

HIS HONOUR: This is a reference to the Tribunal pursuant to section 124(2) of the Health Practitioners Professional Standards Act 1999 on the ground that the registrant is impaired. The particular matters relied on are that he suffers from substance abuse and dependence together with major depression since approximately 1997 and that he has a history of relapsing into substance abuse since October 1999.

The registration of the registrant has been suspended for about two and a-half years and the Medical Board is now seeking the registration be cancelled and that conditions be imposed on the circumstances under which the registrant may re-apply for registration under the Medical Practitioners and Registration Act 2001. The registrant qualified in October 1992 and has practised principally in hospitals in Australia and New Zealand since then.

There has been a history of depression dating from not all that long after he commenced in practice and there were significant aspects to that depression in 1997 and subsequently he did not receive psychiatric treatment for that condition for a time. He was instead self prescribing and this led to the abuse initially of sleeping tablets and subsequently various benzodiazepines. There is also abuse of codeine from about 1998. There were - that extended to the abuse of pethidine in May 1999. There were on occasions instances of his appearing intoxicated at work and apparent interference with his ability to perform work duties although it does not appear that anything very significant happened or

that this was wide spread. He does appear to have been quite concerned about the situation and left some positions because of this.

In late 1999 he began to receive psychiatric care and was for a time hospitalised in Brisbane. There have been subsequent periods of hospitalisation in 2000. There were also other consequences of his depression and as a result of that condition he was regulated on, I think, two occasions in 2000 and 2001.

He has subsequently undergone early extensive periods of psychotherapy and reports that there have been no symptoms of depression for the last three months although he remains on a fairly mild dosage of an anti-depressant.

It appears that the last instance of abuse of a drug other than alcohol was in March 2001, although there have been examples of abuse of alcohol since then - sorry - in March 2002 there was some further - what was described as a cocktail of medications and it is not quite clear what that involved.

There was abuse of alcohol in June 2002 at a time when he was becoming depressed about the prospects of not being re-registered or not being able to get his suspension lifted and being able to practise medicine again. There have been in place for some time now a regime requiring testing for drug and alcohol - of alcohol and other drugs and that regime has, on two occasions since June 2002, detected some significant alcohol in the blood on the 25th of August and on the 7th of October. Both of those were explained by the registrant on the basis that there was some significant social occasion at which he was drinking alcohol socially but not on an occasion when he would be working or driving a motor vehicle, and that he did not appreciate that during this period he was expected to abstain totally from consuming alcohol.

He has been seeing, apart from the treating psychiatrist, two psychiatrists at the instance of the Medical Board. One of those, Dr Reddan, has produced a number of reports and, in her report in July, she indicated that there ought to be a significant period of abstinence in order to demonstrate that this problem was in remission. It is disconcerting that the registrant might have thought that that was consistent with social drinking and one would hope that he has now clearly

understood that abstinence means total abstinence; there is not to be any drinking at all.

The problem in his case is not social drinking but what it may lead to when there has been a history of alcohol abuse. Then, in order to demonstrate that that condition has been adequately controlled, it is necessary for there to be an extended period of total abstinence.

Dr Reddan, in her report, expressed the view that the psychiatric state of the registrant was such that there were prospects of his being able to be returned to practice provided that he could demonstrate a significant period of at least six months when there was an absence of further abuse of alcohol or other drugs.

That time has not yet arisen given the abuse of alcohol in the latter part of June 2002 which seems to be the last clear occasion when there was abuse of alcohol or drugs. On that occasion, it is quite clear that there was significant abuse. The registrant, on the 25th of May, presented at the Wesley Emergency Centre complaining of a five-day alcoholic binge. He subsequently tested to a significant extent on the screening program on the 4th of June, the 29th of June and 30th of June 2002. He has explained that relapse essentially as a consequence of his becoming depressed about the prospects of his regaining his registration as a medical practitioner.

He has, since July 2002, commenced full-time work with a pathology practice but in a non-medical capacity. He has deliberately kept quiet about his medical qualifications and experience and he is performing a strictly non-medical function. His employer is aware, at least in terms of the immediate supervisors and people responsible for him, of his history and background but has provided a reference which speaks highly of him and of his work.

It certainly appears that during that period of employment which involves working a 38-hour week, although on a casual basis doing shift work on a rotating 24-hour roster including some weekend work, that his work has been entirely satisfactory and there has been no indication that there has been any relapse into alcohol abuse or other substance abuse which has impinged on his ability to perform the functions of that position. And that is of some significance because, if there had been any significant relapse during that period, it is unlikely that it would have escaped the notice of that employer. It may well be that obtaining that employment has provided him with helpful support in resisting any propensity to relapse.

He has provided a number of other references which indicate that, apart from the problem of substance abuse and depression, he is a useful and competent and compassionate and thoroughly satisfactory medical practitioner.

It is not disputed that the registrant is impaired in the relevant sense and that he has a history of substance abuse and depression. That is a factor which makes it possible for the Tribunal to exercise the various powers under section 241 of the Act.

The issue facing the Tribunal has been essentially whether it - the appropriate way to deal with this situation in the light of the history of the lapses that have occurred over the years and such improvement as has been demonstrated in the history - and I should say that, given the constraints, I have put forward a very concise summary of a factual matter which occupies many pages of chronology - the appropriate course is to cancel the registration and impose conditions restricting any re-application.

In effect, the registrant should have his registration cancelled and it should be necessary for him to demonstrate that there has been a significant period of complete remission prior to any further registration.

The alternative position is that the suspension should be allowed to continue to a particular date which would be sufficient - or which would give the registrant the opportunity of demonstrating that there has been a sufficient period of remission to justify the lifting of the suspension

and to enable him to practice medicine again although it is recognised that that could well be subject to further conditions. The Tribunal has power under section 241 to impose conditions on the practice of medicine after a suspension has been lifted or has expired.

There are a number of features of the matter of this case which are disconcerting but there are also a number of positive features in the registrant's favour and it does appear that he has been now making significant efforts to overcome these difficulties.

On the whole, the Tribunal considers that it would be appropriate as a means of protection of the public interest and also appropriate in terms of, hopefully, the ultimate cure of the registrant to put in place a regime where the suspension continues for a fixed but significant period during which it will be necessary for the registrant to demonstrate that his remission is continuing but that the suspension then be lifted and that the registrant be permitted to practice subject to a number of conditions which would operate in most cases for a fixed period.

In formulating this regime the Tribunal is conscious of the fact that if there are further breaches of the conditions or the requirements during the period of the suspension further

steps would be taken by the Medical Board and in those circumstances the Tribunal may well take the view that there will be no alternative to cancellation of registration.

Further that in imposing conditions on the practice after the suspension is lifted would provide some continuing protection to the public interest and also permit some continuing supervision by the Medical Board so that, again, if necessary, further proceedings could be taken. Mechanisms are in place under the legislation whereby registration can be suspended at quite short notice if the situation deteriorates even after the current suspension comes to an end so that if there is some significant relapse in the future the public interest can be protected.

It is not necessary, at this stage, for the Tribunal to formulate an order which will do all the work which might ever need to be done to achieve an end. All the Tribunal has to do at the moment is formulate an order which provides appropriate protection of the public interest in the light of the particular history of this particular registrant up until now.

The Tribunal is of the opinion that that can adequately be done by continuing the suspension to a point where, in effect, it is been clearly demonstrated there has been an absence of relapse for a period of 12 months and, in the circumstances,

the date of the 31st of July 2003 is appropriate. That would give a clear period of 12 months after the last significant instance of substance abuse in June this year.

During that period the registrant should be subject to some continuing screening at the most intensive level for alcohol and other drugs and he should be required to continue an appropriate regime of psychiatric treatment.

Once the suspension has expired his practice should be subject to further conditions during the first 12 months. That he should practice only under the supervision of another medical practitioner or practitioners. That there should be some continuing regime for testing or screening for the taking of alcohol and other drugs and that he continue an appropriate regime of psychiatric treatment.

He should also be subject to the permanent condition that he not self prescribe in, I do not know that I mentioned it earlier, but one of the manifestations of the drug abuse earlier involved self prescribing. It was accepted by the registrant, on behalf of the registrant, that that should be a permanent restriction.

That would mean that at the end of the other conditions there would have been a period of two years during which there had been a demonstrated abstinence of relapse and the appropriate mechanism in place to cure the registrant's psychiatric problems in so far as they are said to have been cured. If, by that stage, he is still in remission, it would be reasonable to expect that that would continue. If there is a relapse prior to that time then some further appropriate steps could be taken by the Medical Board.

It has been suggested by counsel that the details of an order of a decision of the Tribunal to reflect what I have just formulated could be left to counsel to work out and I intend to agree with that course. So that the appropriate course, therefore, is simply to direct that an agreed form of decision to reflect what I have just outlined be settled by counsel. If counsel are unable to agree on any detail then the matter can be mentioned again before me and I will resolve that matter.

I think that is probably everything that I need to deal with.

...

HIS HONOUR: I think, in the circumstances, given the limited matter that was actually in dispute today and the nature of the particular problem that it is appropriate that there be no order as to costs of these proceedings.

Additional Agenda

THE MEDICAL BOARD OF QUEENSLAND

Additional Agenda Paper – Meeting – 11 February 2003

3. Business Arising From Minutes [No10A] FINANCE

Attached is a memorandum dated 7 February 2003 from the Executive Officer responding to the Board's questions relating to the Collection Account.

For information.

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4. Health Assessment and Monitoring * [No.11] DR L WARE (1030292)

Attached is a memorandum dated 5 February 2003 from the Acting Coordinator HAM regarding conditions of registration which the Health Assessment and Monitoring Committee recommended should be imposed should Dr Ware be granted registration.

For consideration.

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5. Complaints * [No.12] DR J DOUGLAS (704258)

Attached is report of the Complaints Investigation Committee regarding complaints made by Ms D Jones, Ds D Little, Mr A Ryder and Ms T Heal (nee Laverack).

For consideration.

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* [No.13] DR D GILLMAN (780326)

Attached is a briefing note from Investigator Elisa Petranich dated 7 February 2003 regarding Dr Gillman.

For consideration

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11. Removal through Death

981797 **BURMAN**, Nicole Mary – MB BS QLD 1999
25 January 2003

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12. Finance

(i) Accounts for Payment

Powell Jacinta	298.30
M2 Messagemate WA	220.00
Saud Ahsan	282.00
Dr Richard Astill	275.00
Bar Merlo	55.60

Blue Lemon	38.50
Alister Bevan McKinnon Cant	138.00
Gilshenan & Luton	1692.90
MD Mas-U-Dul Haque	282.00
Wendy Elizabeth Hoy	120.00
Dr Scott M Jenkins	495.00
Kingsley Ragnunathan Joseph	50.00
Tina Marie Mason	282.00
Dr Brad Matthews	495.00
Minter Ellison	8251.23
Michael John O'Keeffe	276.00
Danielle Emily Patterson	191.00
Prior Nigel	660.00
Neena Raizada	282.00
Reddan JG	2273.70
Dr Katrina Samios	440.00
Dr R P Taylor	1281.50
Lisa Anne Todd	71.83
Murray Tebbutt Webber	211.00
Christopher Hayden Wong	211.00
Australia Post	1072.73
Cabcharge	1445.80
Gilshenan & Luton	7670.71
Howard's Conference Catering	211.53
Toll Fast	59.13
Yanna's Gourmet Kitchen	199.70
International Detection Service	88.00
Johan Daniel Bence	25.00
Elsabe Dekker	25.00
Thomas Michael Alexander O'Rou	25.00
Oran Michael Rigby	282.00
Leanne Lei Du	120.00
Patrick Conner L Weinrauch	402.00
Matthew Robert Davies	138.00
Chidi Alisigwe Ejim	138.00
Toll Fast	256.28
TOTAL	31032.44

13. Correspondence [No.14] AUSTRALIAN COMPETITION & CONSUMER COMMISSION (M324) / ROYAL AUSTRALASIAN COLLEGE OF SURGEONS (M95)

Attached is correspondence dated 7 February 2003 from the Australian Competition & Consumer Commission (ACCC) regarding Application for Authorisation A90665 lodged by the Royal Australasian College of Surgeons.

The Board is required to advise the ACCC by 24 February 2003 if it wishes the Commission to hold a pre-determination conference in relation to the draft determination. A written submission to the Commission in response

to the draft determination can be made up to 7 March 2003.

Board members are requested to advise the Assistant Registrar by 17 February 2003 if they consider the Board should request a pre-determination conference to be held or that a submission to the commission should be made.

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14. Advertising

The report of the Advertising Sub-Committee has been circulated.

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15. Ordinary Business

M CORONEAS (804182)

The Registrar of the Health Practitioners Tribunal has advised verbally that the appeal lodged by Dr Coroneos is scheduled to be heard in the Appeals Court in June 2003.

For information.

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6. The 'Balance as per Bank Statement' refers to the balance of the Collection Account for individual Boards. Such individual Collection Accounts are not utilized given the service relationship between the Office and the Boards.

7. The Queensland Audit Office, when auditing the Collection Account, focuses its attention on the reconciliation made between the individual Boards' cheque accounts and the Office Collection Account.

8. The use of a single Collection Account in the Office Chart of Accounts is being reviewed and the outcomes of this review will be included in the proposal being developed for the new financial management infrastructure. I expect this proposal to be referred to each Board for consideration in March/April 2003.

Collection Account Costs

9. The 'Collection Account Costs' is the line item where the costs associated with payments by EFTPOS and credit card are recorded. When an applicant or registrant pays their fees by EFTPOS or credit card, the Commonwealth Bank of Australia charges a merchant fee of 1.5% (plus GST) of the total payment made. Therefore for every $100 payment received, a $1.50 (plus GST) service fee is incurred.

10. The Collection Account Costs were high for the month of December as this is a peak revenue period when medical graduates are paying their application and registration fees. I am advised that a high percentage of these applicants paid their fees either by EFTPOS or by credit card.

Change in Bank Rules

11. In December 2002, the Reserve Bank modified the rules associated with the service fee charged by all financial institutions for payments made by EFTPOS and credit card. This rule change enables the retailer to recoup the service fee from the consumer. In the case of the Boards, it may enable the Boards to levy a 1.5% (plus GST) service fee in addition to the fees detailed in the Regulation. In this way, it would be the applicant/registrant paying the fee, thus reducing the Board's expenses.

12. To date, there have been no reports of any retailer introducing this new service fee. I am currently seeking advice from Treasury as to the Government's position in relation to introducing this service fee. In this regard, it would be an inappropriate risk to introduce the service fee in the absence of Government support.

13. Further advice in regard to the Government's position will be used to inform the budget development process for 2003-2004. In addition, should the advice from Treasury be positive, a proposal for introduction of the service fee will be prepared for consideration by each Board.

Jim O'Dempsey
Executive Officer

7 February 2003

MEDICAL BOARD OF QUEENSLAND
MEMORANDUM

To: **Robyn Scholl, Assistant Registrar**

From: **Jackie Cunningham, Acting Co-ordinator HAM**

Subject: **Dr Leonard WARE**

Date: **5 February 2003**

I refer to your memorandum dated 22 January 2003 from Cecillia Conway requesting that the Health Assessment and Monitoring Committee consider reports and information from the Medical Board of NSW (including conditions imposed) pertaining to Dr Ware and make a recommendation to the Registration Advisory Committee.

The HAM Committee considered the matter at its meeting on 4 February 2003 and decided to recommend the following conditions be placed on Dr Ware's registration.

1) Dr Ware must only work in a supervised position approved by the Board.

2) Dr Ware must advise the Medical Superintendent (or equivalent) where he is employed or where he has been offered a position, of the conditions imposed on his registration by the Medical Board of Queensland.

3) Dr Ware must engage a senior workplace colleague who is approved by the Board to act as a supervisor. Dr Ware must meet with the supervisor initially on a fortnightly basis, to be reduced in frequency when determined by the Board.

4) Dr Ware must consent to the release of information from the supervisor to the Board, including the release of workplace performance reports at a frequency and in a format to be determined by the Board.

5) Dr Ware must submit to the medical supervision of an experienced general practitioner who should prescribe and supervise all medications other than those prescribed by treating specialists. Dr Ware must keep the Board informed of the name of his current treating GP.

RHONDA PENNY & ASSOCIATES
solicitors
principal
RHONDA PENNY
B.A. (psych) L.L.B. (hons).

Level 5
PADDINGTON CENTRAL
107 LATROBE TCE

P. O. BOX 385
PADDINGTON Q. 4064

tel : (07) 3369 3939
fax: (07) 3369 1020

DATE: 6/2/03

Dear Victoria,

Zoweeee

Chers
Rhonda

☐ *with compliments* ☐ *for your information* ☐ *as arranged*
☐ *for your comment* ☐ *please sign and return* ☐ *please telephone*
☐ *please acknowledge receipt*

FROM: _____

HEALTH PRACTITIONER BOARDS
07 FEB 2003
RECEIVED

COMPLAINTS INVESTIGATION COMMITTEE

REPORT TO THE MEDICAL BOARD OF QUEENSLAND

Practitioner Name:	Dr Jonathon Douglas
MBQ File No:	
Date of Appointment of Committee:	10 October 2000
Terms of Reference:	The Complaints Investigation Committee was constituted pursuant to section 37(3)(c) of the *Medical Act 1939* to investigate the complaints by Deborah Jones, Deborah Little, Anthony Ryder and Teresa Lavarack against Dr Jonathan Douglas and report to the Board.
Members of Committee:	Ms Rhonda Penny, (Chairperson) Dr John Waller Ms Peta Frampton The Committee was assisted by Mr Andrew Forbes from Phillips Fox.
Dates inquiry convened:	16.03.01 and 26.10.01
Appearances:	Dr Douglas accompanied by Dr David Pakchung of United Medical Protection, on 16.03.01
Witnesses:	Ms Deborah Jones; Ms Deborah Little; and Mr Anthony Ryder on 16.03.01; and Ms Teresa Heal (formerly Laverack) on 26.10.01
Secretary:	
Reporter/s:	Jessica Knight from Auscript on 16.03.01 and Lorraine Harton from Auscript on 26.10.01

FINDINGS OF COMMITTEE

- On the balance of the evidence presented, including the pre-hearing material, the Committee does consider that the available evidence establishes a prima facie case of misconduct in a professional respect.

RECOMMENDATIONS

In view of its findings, the Committee recommends to the Board that the Board

1. finds Dr Douglas guilty of misconduct in a professional respect with regard to the complaint that his manner with his patients was inappropriate; and
2. finds Dr Douglas not guilty of misconduct in a professional respect with regard to the complaint that he was biased.

Further, the Committee recommends the Board

1. counsels Dr Douglas regarding his manner with patients during medico-legal consultations; and
2. seeks an undertaking from Dr Douglas to attend one of the courses in medical professional communication, such as the one conducted by Dr Mark O'Brien.

1. Introduction

On 3 September 1999 the Health Rights Commission referred a complaint by Diane Little, Teresa Laverack (as she then was) and Deborah Jones regarding Dr Jonathan Douglas to the Medical Board for investigation.

On 10 October 2000 the Board resolved to refer the complaint to the Complaints Investigation Committee.

2. Legislative Provisions

2.1 The Complaints Investigation Committee was appointed by the Medical Board of Queensland pursuant to section 37(3)(c) of the *Medical Act 1939*.

> *37.(3) Upon a complaint made to it under subsection (2) the board shall investigate such complaint and, without limiting its powers to so investigate, may:*
>
> ... *(c) in respect of the complaint, appoint 2 or more of its members to constitute a complaints investigation Committee, 1 of whom shall be appointed by the board to be chairperson, and refer the complaint to it for investigation.*

2.2 Dr Douglas, Ms Jones, Ms Little, Mr Ryder and Ms Heal (formerly Laverack) were summoned to attend and give evidence before the Committee pursuant to its powers under section 37(3A)(b),(c).

> *37.(3A) Where the board appoints a complaints investigation Committee and refers a complaint to it under subsection (3)(c), the following provisions shall apply:*
>
> *(b) the complaints investigation Committee shall have the same powers as the board has to investigate the complaint as provided for in subsection (3)(a) and (b), and sections 12, 13(1), 13B, 13C, 37B and 40 shall apply as if references therein to the board were references to the complaints investigation Committee;*
>
> *(c) for the purpose of applying the provisions of the Commissions of Inquiry Act 1950, each member of the complaints investigation Committee shall be deemed to be a commissioner, and the chairperson of the complaints investigation Committee shall be deemed to be the*

chairperson, within the meaning of that Act;

2.3 The Committee was required to address its investigation and deliberations to section 35(1)

> *S 35(1) Without limiting the meaning of the expresson"misconduct in a profesional respect" a medical practitioner(including a specialist) shall be guilty of such misconduct who...*
>
> *(c) is guilty of infamous conduct in a professional respect, malpractice, or unprofessional conduct or practice; OR*
> *(d) signs or gives under his or her name and authority any ... report ... signed or given by him or her in his or her professional capacity for subsequent use in any court of law, or for administrative or governmental purposes, or for the pecuniary interest of himself ... where such ... report ... is untrue, misleading, or improper.*

2.3 The Committee delivers this report of its findings and recommendations to the Board pursuant to section 37(3A)(d).

37.(3A) (d) without limiting the effect of paragraph (a), the complaints inestigation Committee shall investigate the complaint and shall deliver its findings and recommendations to the board, which may act on the findings as if they were its own;

3. Material Before the Committee

The following written material was available to the Committee:

1. Summary of complaints about Dr Douglas prepared by Complaints Co-ordinator 5 April 2000

Dianne Little

2. Letter from Ms Little, Ms Laverack and Ms Jones dated 8 August 1999 enclosing:
   - Letter of complaint from Ms Jones dated 20 July 1999; and
   - Article "CFS the new negligence target"
3. Dr Douglas' response to the complaints of Little, Laverack and Jones dated 29 November 1999 enclosing Diagnosis and Management of Chronic Fatique Syndrome Discussion Paper (Fellowship Affairs Aug/Sept 1994) and RACP Draft Clinical Practice Guidelines
4. Letter from ACL enclosing their letter of instructions to Dr Douglas dated 7 April 1997
5. Letter from ACL enclosing Dr Douglas' medico-legal reports dated 22 May 1997 and 13 November 1996
6. Dr Douglas' medical records for Ms Little
7. Letter from Ms Little, Ms Laverack and Ms Jones dated 6 September 1999 enclosing:
   - Front page of draft clinical practice guidelines by RACP Working Group
   - Letter Senator Grant Tambling to Mrs May MP dated 29 July 1999
   - Speech to Parliament by Jim Pearce on 17 August 1999
8. Letter from Ms Little dated 15 October 1999 enclosing:
   - List of current symptoms as at 13 May 1997
   - Report Dr W Wilkie to Australian Casualty & Life (ACL) dated 25 March 1999
   - Report Dr J O'Regan to Maurice Blackburn & Co dated 26 May 1999
   - Report Dr S Moore to Maurice Blackburn & Co dated 20 April 1999
   - Report Dr J Ryan dated 25 November 1998
   - Report Dr J Ryan dated 8 June 1999
   - Report Dr J Ryan "To Whom It May Concern" dated 11 November 1998
   - Report Dr G Whiting to Dr J Ryan dated 20 February 1997
   - Report Dr G Deed dated 9 October 1999
   - Letter Senator Grant Tambling to Mrs May MP dated 29 July 1999
9. Letter from Ms Little to MBQ dated 14 February 2000
10. Letter from Ms Little to MBQ dated 3 July 2000
11. Letter Ms Little to MBQ dated 17 August 2000
12. Ms Little's submissions to CIC dated 14 January 2000

13. Speech by Mr Jim Pearce re Chronic Fatique Syndrome 30 November 1999

14. Letter Larry Anthony MP to ACL dated 18 January 2000

Teresa Heal (formerly Laverack)

- Letter from Teresa Heal (formerly Laverack) to MBQ dated 27 October 1999 enclosing:-

(d) letter ACL to Mrs Laverack dated 12 May 1998
- Letter "To Whom It May Concern" from Deborah Jones dated 20 July 1998
- Letter ACL to Ms Laverack dated 9 July 1998
- Front page of draft clinical practice guidelines by RACP Working Group
- Membership of RACP Working Group
- Definition of "Total Disability" from ACL Income Protection Policy
- Report "To Whom It May Concern" from Dr D Helliwell dated 25 August 1998
- Report Dr S Moore to ACL dated 22 April 1997
- Referral letter Dr D Helliwell to Dr S Moore dated 16 July 1998
- Report Dr S Moore to Dr D Helliwell dated 22 July 1998
- Referral letter Dr D Helliwell to Dr S Moore dated 22 October 1998
- Report Dr S Moore to Dr D Helliwell dated 2 November 1998
- Report Dr S Moore to Dr D Helliwell dated 11 June 1999

8. Report Dr S more to Dr D Helliwell dated 23 September 1999
- Report Dr R Loblay to Stone and Partners dated 15 September 1999
- Report Dr C Danesi to Stone & Partners dated 26 July 1999
- Speech to Parliament by Jim Pearce on 17 August 1999

16. ACL's letter of instructions to Dr Douglas dated 12 May 1998

17. Dr Douglas' medico-legal report to ACL dated 6 July 1998

18. Dr Douglas' further medico-legal to ACL dated 6 July 1998

19. Dr Douglas' medical records for Ms Laverack

20. Letter from Ms Laverack to MBQ dated 23 March 2000

21 Letter from Ms Laverack to MBQ dated 18 April 2000 enclosing:
- Dr Douglas' report to ACL dated 6 July 1998
- Ms Laverack's respone to Dr Douglas' report (completed 18 April 2000)
- Doc 1 – letter ACL to Ms Laverack dated 9 July 1998
- Doc 2 – letter "To Whom It May Concern" from Deborah Jones dated 20 July 1999
- Doc 3 – two letters from Mr Ryder to MBQ dated 3 March 2000
- Doc 4 – letter Ms Laverack to ACL dated 16 June 1998
- Doc 5 – report Dr S Moore to Dr D Helliwell dated 22 July 1998
- Doc 6 – front cover and p.17 from Dr Charles Shepherd, Myalgic Encephalomyelitis:
- Post-Viral Fatigue Syndrome – Guidelines for the Care of Patients (2nd ed)
- Doc 7 – letter Ms Laverack to ACL dated 12 July 1998
- Doc 9 – front page of draft clinical practice guidelines by RACP Working Group and membership of RACP Working Group

Deborah Jones

22. Letter Ms Jones to MBQ dated 8 November 1999 enclosing letter Hal Johnson to Royal Sun Alliance dated 10 September 1998

23 Letter from Royal & Sun Alliance dated 3 July 2000 enclosing copy of their letter of instructions to Dr Douglas dated 18 June 1998

24 Dr Douglas' medico-legal report to Royal & Sun Alliance dated 21 July 1998

25. Dr Douglas' medical records for Ms Jones

26. Letter Ms Jones to MBQ dated 30 August 2000

Anthony Ryder

27. Complaint by Mr Ryder dated 4 February 2000

28. Dr Douglas' response to Mr Ryder's complaint dated 16 May 1998

29. ACL's letter of instructions to Dr Douglas dated 29 may 1998

30. ACL's letter of instructions to Dr Douglas dated 16 June 1999

31. Dr Douglas' medico-legal report to ACL dated 19 July 1999

32. Letter Mr Ryder to MBQ dated 8 August 2000

33. Mr Ryder's submission to CIC dated 16 January 2001

Minutes

34. Medical Board minutes:
    - 14 September 1999
    - 22 February 2000
    - 10 October 2000

35. Complaints Committee minutes:
    - 21 September 1999
    - 21 December 1999
    - 15 February 2000
    - 15 August 2000
    - 19 September 2000

Legislation

36. *Medical Act 1939* extracts

37. Commission of Inquiry Act 1950

    This material was forwarded to Dr Douglas prior to the hearing.

38. After consultation with its legal advisor the Committee decided to seek from Dr Douglas some examples of medico-legal reports wherein he had diagnosed a patient with Chronic Fatigue Syndrome. Dr Douglas provided the following medico-legal reports in response to a Summons.

INFORMATION FROM DR DOUGLAS IN RESPONSE TO SUMMONS

Medico-legal Reports as follows:-

- Colin Harold Robertson
- Michelle Steinback
- Michael David Farrell
- Eileen Maria Nolan
- Thor Lambert
- Noel Charles Rubeck
- Caron Frappell
- Graeme Langsford
- Wayne Usmar
- Susan Dawes
- Sandra Orton
- Rosemary Hansen
- Anthony Law
- Sharyn Anne Martin
- Kenneth Burnes
- Angela Grant
- Janette Evans
- Darran Lyons
- Gordon Evans
- June Berry
- Miriam Battersby
- Gregory Painter
- Raymond Meusburger
- Glenda Sterling
- Michael Solomon
- Dr Julia Leeds

4. The Complaints

There were a number of complaints made by the witnesses against Dr Douglas. Of these the Committee chose to investigate the complaints under two (2) broad headings namely:-

4.1 Dr Douglas does not believe in Chronic Fatigue Syndrome (CFS) and therefore is biased and not in a position to form an objective opinion as to either the existence in a patient of CFS or any disability suffered by the patient, whole or partial, permanent or temporary consequent upon the CFS; and

4.2 Dr Douglas' inappropriate behaviour during medico-legal examination.

Regarding 4.1 it is not necessary for the Committee to examine in any detail the controversy existing within the Medical profession regarding the existence of Chronic Fatigue Syndrome, other than to comment that the syndrome describes a cluster of symptoms for which there appears to be no organic basis. The Complaints Investigation Committee (CIC) needed to determine only the issue as to whether on the evidence presented to it the Committee was reasonably satisfied that Dr Douglas was biased in the legal sense. Two of the complainants complained that Dr Douglas had verbally advised each of them at the beginning of their medico-legal examination that he did not believe in C.F.S. A third complainant had concluded, on the basis of discussions during her consultation that Dr Douglas did not believe in C.F.S. These complainants reasoned that, as he expressed no belief in the syndrome, he would not be in a position to diagnose its existence nor, indeed, any disability suffered by the Complainants consequent upon their suffering Chronic Fatigue Syndrome. There being no proper medical or psychiatric aetiology the patients disabilities could then properly be described as fabricated or fictitious and the patient could properly be described as "malingering". This being so an Insurance Company wishing to cease payment pursuant to an income protection policy might sever its payment obligation as the complainants incapacity to work would no longer fit within the relevant definition of incapacity.

Indeed, this exact sequence of events was manifest in the complaint histories of all the witnesses.

Regarding 4.2 the Committee viewed this complaint as somewhat more tangible consisting of the following allegations of Dr Douglas' inappropriate behaviour during medico-legal examinations:

- he was rude and /or brusque
- he appeared intentionally intimidating
- in a few instances he required patients to strip to their underpants, but did not offer either of them a gown
- in another instance Dr Douglas dwelt inappropriately on sexual matters.

5. EVIDENCE

On 16 March 2001, the Complaints Investigation Committee (C.I.C.) heard sworn evidence from Ms Deborah Jones, Ms Dianne Little, Mr Anthony Ryder and Dr Jonathan Douglas. At this time the witness the Committee believed would eventually constitute its principal witness, Ms Teresa Laverack was travelling overseas. The C.I.C. was reconvened on 10 October 2001 when it heard sworn evidence from Ms Teresa Laverack who then presented as Ms Teresa Heal.

On each occasion the C.I.C. was assisted by Mr Andrew Forbes of Phillips Fox. On 16 March 2001 Mr Forbes was accompanied by a student, Ms Christianne Kohler.
The Chair of the Committee directed that the proceedings be recorded. Each witness was introduced to the Committee and to the legal representatives assisting the Committee and permission was sought for the student to observe.

5.1 Deborah Lillian Jones

5.1.1 Ms Jones was accompanied by Mr Hal Johnson in a support role. Mr Johnson had accompanied Ms Jones to her medico-legal consultation with Dr Douglas.

5.1.2 Ms Jones stated "the first thing he (Dr Douglas) said when we sat down was that Chronic Fatigue Syndrome did not exist. They were his first words".

Mr Johnson confirmed Ms Little's recollection as above but indicated that Dr Douglas, in addition, said that what Ms Little suffered from was more like a depression.

Ms Jones went on to state Dr Douglas continually referred to her problems as being related to "burn out" and intimated that if she were to have a holiday she would be okay.

5.1.3 The witness stated she was initially asked to strip down to her sports bra and underpants and then Dr Douglas asked her to remove her sports bra. When she had removed her bra she lay on the examination couch as requested by Dr Douglas. She was not offered either a sheet or a gown to put over her now bare chest.

She stated at one point Dr Douglas bent over her and then moved towards her nipples with lips pursed as if he were about to kiss her nipple. She looked sternly at him and he unpursed his lips and moved away. After some questioning from the Committee Ms Jones asserted, supported by Mr Johnson that she remained bare chested and braless for 10 minutes. At one point she asked Dr Douglas' medical opinion as to her clinical condition. She was advised to go on a diet and /or a holiday.

5.2 Dianne Little

5.2.1 Ms Little was accompanied by Greg Rostron of Morgan Connelly, Solicitors.

5.2.2 The Committee specifically asked Ms Little why she thought Dr Douglas did not believe in C.F.S. She stated her basis was the Statutory Declaration provided by Deborah Jones. Ms Jones had shown Ms Little the Statutory Declaration which Ms Little had read. When asked if Dr Douglas had told her during her consultation with him that he did not believe in C.F.S. Ms Little replied "No". She therefore had no direct evidence to support her complaint that Dr Douglas did not believe in C.F.S.

5.2.3 The substance of Ms Little's complaint referred to Dr Douglas manner. In her letter to the Board of 14 February 2000, Ms Little had stated:-

> "Dr Douglas was rude, firing questions at me and not letting me finish my answers. I gave him a written list of my symptoms at the end of the consultation but he had not covered or allowed me to cover most of these items".

5.2.4 When asked to elaborate she stated:-

"Well he would ask a question and I'd start to give an answer and he's cut me off halfway - well not even half-way through. I'd make a summary and then explain more and he just wouldn't let me answer it, he'd go on with another question".

5.2.5 Further

"He was an exceptionally rude man. I didn't get to speak to him especially when I came up to Brisbane. I'm under stress. My speech gets affected and he doesn't - didn't let me finish".

She indicated she found him "intimidating" and the consultation was a "very traumatic and humiliating experience".

5.2.6 Ms Little, like Ms Jones indicated Dr Douglas did not provide a gown or sheet for her and she "was forced to parade in "my underpants... I felt like a victim not a patient. I believe this was intentional so that as a victim of his examination I would be so demoralised that I did not want to fight the insurance company any more".

Ms Little was required to submit to a physical examination solely in her underpants under the following circumstances-:

- whilst lying on a couch without a sheet to cover her;
- whilst walking up and down on tippy toes and then flat footed;
- whilst sitting on a chair and doing reflexes

As to why he needed to examine her chest Dr Douglas' only explanation to the Committee was that he needed to examine Ms Little's heart in particular as she had a small hole in the heart, and hence he needed to listen carefully to her chest.

She stated she had been examined by a number of doctors many times without the need to remove her bra. She stated he leant very close with his face and was almost breathing on her nipples.

Ms Little stressed that, in both positions, that is, while lying and while sitting Dr Douglas took a long time to perform the examination. He leant physically closer to her than any other doctors had previously, the result being she perceived his mode of examination to be more intrusive of her privacy than any other previous examination.

5.2.8 Ms Little was asked whether there was anything in Dr Douglas' report inconsistent with the history she had given him. As it was sometime since she had read the two reports the C.I.C. was adjourned for a short time to enable she and her legal adviser to read the report and consult in private.

When the enquiry resumed Ms Little advised that, in his report, Dr Douglas had stated she had a general lack of enthusiasm for continuing at work. She says he made no enquiries of her as to her enjoyment of her work as a Computer Systems Analyst. If asked, she would have advised him "she loved her job and found it fascinating. Further that, the loss of my career is quite devastating".

The second inconsistency related to Dr Douglas reporting "she tells me she is trying to have a walk every morning and she is now walking 40 - 45

minutes each morning. She can manage the walk without too many problems".

This is not so. She has a lot of problems managing that walk some days. "some days its a terrific struggle. Some days I can go along the flat okay and I have difficulty with the hills. All the time I have difficulty with the hills. Just some days are less bad than others".

The third instance was that in his report Dr Douglas says "she did not have any symptoms or clinical evidence to suggest she was significantly depressed".

On the contrary Ms Little, like Ms Jones asked Dr Douglas' opinion as to how she might improve her health. She states:

> "He said 'I don't think you've got Chronic Fatigue Syndrome. You - I think you're depressed and you should get a referral to a psychiatrist".

Further Dr Douglas states:-

> "She stayed with other friends in the month or so she had at Byron Bay. She felt generally well and was able to swim regularly".

Ms Little states there wasn't much swimming. It was more like salt water bathing and just sitting on the beach for a while. She states she was trying to improve her health.

5.2.9 In Ms Little's view Dr Douglas was looking only for physical disability. He did not enquire into the memory or concentration problems she experienced which impacted upon her work as a computer analyst. She states Dr Douglas failed to enquire into how she coped with doing complex mental tasks like programming, budgets or project management. He did not ask how she felt after two (2) hours of concentration.

She says "there was no - no questions about that kind of disabling symptoms".

5.2.10 The Committee enquired whether Ms Little had talked to Ms Jones about their consultations with Dr Douglas. The witness replied that she had talked to many people. In particular she had talked to Teresa Laverack because she was a Nurse. Ms Laverack told Ms Little what had occurred during the consultation should not have happened. She stated that that was when she decided to get a joint complaint together. She then stated she had talked to Tony (Ryder) and Deborah (Jones).

The Committee asked how Ms Little had found these complainants. She stated she found them through the New South Wales and Queensland societies and also in replies she had to an advertisement placed in a Queensland magazine. She was putting together a data base. She now had 16 people of which 8 were medico-legal patients of Dr Douglas. She claimed that in all these cases the patient had been on income protection benefits for between 6-24 months with a variety of insurance companies - Lumley Life, ACL, Royal & Sun Alliance. In all instances after consultation with Dr Douglas their benefits had been stopped.

5.3 Anthony Alan Ryder

5.3.1 Upon examination by the Committee Mr Ryder stated Dr Douglas had advised him right at the start of the consultation he did not believe in C.F.S. Mr Ryder stated:

> "...he was running late at the time and looked a bit flustered - he introduced himself and picked up the file and his opening comment to me was 'I don't believe in Chronic Fatigue. Now what's wrong with you?'"

5.3.2 Mr Ryder reported he found Dr Douglas' manner "rather gruff" during his first consultation. Mr Ryder saw Dr Douglas on 15 July 1998 and 14 July 1999. He stated he had been advised by others who know Dr Douglas that it was his nature to be short. When asked he agreed he found Dr Douglas manner "off- putting".

5.3.3 Mr Ryder had stated in his complaint that Dr Douglas had questioned him extensively with respect to his sexual activities. Asked to elaborate he stated Dr Douglas seemed interested in "the amount of times I was having sex and with how many different partners".

He stated his libido was not what it was once. In the past he had had no trouble with girls. He stated Dr Douglas dwelt on the comparative frequency of his having sex "more than any other doctor I had visited in the past."
He stated:-

> "I detected his eyes almost light up at - he just seemed overly interested. I just thought it was over and above the call."

5.3.4 Mr Ryder had stated that he thought Dr Douglas' physical examination was "pedestrian" in nature. He stated Dr Douglas performed almost a cursory examination of basic stretching, balance co-ordination whereas his complaints stemmed from joint soreness, swelling under the arms and in the jaws. He didn't recall him spending a lot of time on those areas.

He stated:-

> "I thought afterwards he didn't pay much attention to what I thought were the unusual aspects of my health".

And "yes just a straight forward examination, with no focus or additional attention to the areas where I said these are symptoms that seem to have appeared since my illness."

5.3.5 Upon further enquiry from the Committee Mr Ryder again confirmed his previous memory of Dr Douglas' opening remarks to him. Immediately after he had said "how are you?" Dr Douglas had said "Right, I don't believe in Chronic Fatigue. Now what is wrong with you?"

Further, despite Dr Douglas reporting Mr Ryder showed no signs of lethargy Mr Ryder stated he lacked concentration during the consultation and later. He went home and went to bed for the next 2 days.

5.4 Ms Teresa Heal (formerly Lavarack)

5.4.1 The committee noted that in Ms Heal's case her insurance benefits were reinstated on 29 February 2000. Ms Heal advised this was as a result of a civil action which she began. The insurance company re-instated her benefits and she continues to receive a monthly benefit. The payment of this benefit is conditional upon her being examined on a monthly basis by her General Practitioner Dr David Helliwell and upon him signing the claim form.

5.4.2 Ms Heal agreed there were three aspects to her complaint about Dr Douglas:-

- that he does not believe in Chronic Fatigue Syndrome and as a consequence he is not able to diagnose her as having the disease;
- that when she attended for examination he behaved in a rude and brusque manner towards her;
- there are significant inconsistencies between the history as provided by Dr Douglas and the facts as known by her.

5.4.3 The Chair explained to Ms Heal that the inquiry would concentrate on the following documents:

- her letter to the Board of 27 October;
- two reports of Dr Douglas both dated 6 July, 1998
- her response to Dr Douglas of 30 March 2000

5.4.4 The Committee dealt first with Dr Douglas' manner. Ms Heal wished to stress the fact that as a Registered Nurse and as a patient she had never before made a complaint about a doctor. This included another independent medical examination which she had experienced. She stated on examination by Dr Douglas she felt hostile and intimidated. She is usually not so easily intimidated. During the consultation she felt like "giving up" as he was not listening to her. He would not let her finish a sentence and he did not appear to be interested in what she had to say.

5.4.5 She stated he did not listen to her description of her symptomatology as other eminent specialists had. In her view, his obligation to listen to her went beyond simply affording her the courtesy of listening, it was closer to a professional responsibility. Further, she felt not only did he not listen to her but he went off on a tangent. He was insisting she quantify things. For example, he asked her how many shirts she could hang on a line before she became too tired to continue. Despite the fact that neither she nor her partner wear shirts she felt compelled to imagine how many shirts, she might be able to hang. He used the word "shirt" in the report despite the fact she had told him that she did not hang up shirts. It would have been more appropriate for him to ask her how she was able to look at dresses in a dress shop. She stated her arms ached as she tried to look at the dresses and move them around on their hangers.

When asked if this was similar to Dr Douglas' insistence that she state how

far she could walk on a good day and how far she could walk on a bad day she stated:-

"What I think they don't understand is, with that, is that its not to say I can't walk. It's that after that period of time I start to feel unwell. I start to feel weak. I start to feel I better not go any further, I start to feel insecure. I start to look for a seat. I start to look ...whether I can go back. It's not about that I can't do it. It's that I feel unwell and I know when I start to feel those symptoms that if I do push myself further I will only get worse and pay for it later on. But he - I don't believe, in his writing expresses that and understands it, whereas Dr Stephen Moore, my other physician does

Dr Moore in his report states:-

" She can function well for periods of time some days, but normally at a cost".

The witness stated the difficulty with Dr Douglas was that he was so insistent. He kept up a line of questioning designed to extract from her what it was that she did when she felt unwell as if he needed to have more and better evidence of her incapacity. Merely needing to take a seat when out for a walk was not enough. The witness seemed to be saying that Dr Douglas could not accept this alone as evidence of her incapacity when others did. He appeared to be searching for more detail than that.

She indicated she felt badgered by this line of questioning. At one point she was so flustered "I'm thinking 'what do I do?' I actually was going numb in my brain and not being able to think and I think the point too was - I - that I couldn't extrapolate to think it because I don't do it."

Ms Heal then gave the example of a day when she drove to the post office to post a letter, only two blocks from home. She drove the car, parked in the disabled car park out the front and got out of the car and just could not walk and it would be from here to here. (The witness indicated a short distance by foot.)

"There was something in me that was like a wobbly jelly thing and a guy went past and I said 'Excuse me, this may seem very strange to you but would you mind just popping this letter in that box for me' and that's the sort of thing on a bad day I can't walk, you know".

5.4.8 Ms Heal stated she was not given the opportunity to inform Dr Douglas she did not enjoy being unwell. She said she doesn't "wear a neck brace or fluffy slippers and look like a disabled person". She had bought, at some cost, a wheelchair, a walking frame and a scooter to try to keep mobile. She didn't find using them fun. In fact she felt humiliated sometimes when in the wheelchair or on the scooter, because people have a way of treating you - they talk loudly and pat you on the head."

5.4.9 Ms Heal stated she had not used her scooter for 12 months. Despite, in the past two weeks, feeling a slide in her physical health, she did not want to use it for the reasons stated. The main strength of the scooter was that it gave her a sense of security. It took minimum effort to get down from the back of the van and then up from the road as she had made aluminium ramps to guide it down. It motored itself up. It gave her a sense of security having it and the van with her. She used it mostly for going to big

shopping centres like Pacific Fair or Supermarkets where she simply would not be able to go unless she had the scooter. She would not be able to walk the distance from the car park to the shopping centre leave alone through the aisles as just reaching for things in the supermarket aisles would exhaust her! She states" but(with the scooter) I could do the tasks whereas without it, I couldn't".

Initially when she got her wheel chair she was the happiest person in the world as until she bought the wheel chair she had not been out for 3-4 years. She went from the chair to the scooter as she didn't have the strength to wheel it and so needed someone to push it.

She couldn't withstand the attention and questioning she received from passers by who would not have even noticed her if she were walking - if she were "normal" as she put it.

People would say things like:-

"I notice you're moving your legs. Why are you in that wheelchair - in the scooter"?

Initially she had been gracious with the comments but the constant attention wore her down. She became annoyed and frustrated with people intruding into her private life. She did continue to use it when going to large shopping centres. Otherwise she would drive her car to the shops and try to park just outside the shop.

5.4.10 Heal stated her decreased use of the scooter 12 months ago coincided with three significant events in her life:-

- she met her new partner who was patient with her and did not mind helping her walk. She gained in strength and confidence
- her unpleasant divorce finished
- her two year battle with the insurance company was over.

The witness indicated she suffered balance problems, so much so she sometimes entwined her legs around the four feet of her chair. On two occasions in 1992 and 1993 she suffered "true vertigo". One time the world spun around, the other time the world stood still and she felt her body was spinning around. It's not that I fell over - I've never fallen over - that was another inaccurate thing Dr Douglas wrote.

Ms Heal stated she understood it was part of the insurance company's policy to undertake a re-assessment of her illness and its disabling consequences from time to time. For this reason in 1997 she was sent to Dr Stephen Moore.

As she was being bombarded by questions from Dr Douglas, she felt like a victim. He did not facilitate conversation until towards the end of the consultation, when she asked him if he knew of any developments in the area of C.F.S. He gave a dismissive answer to that - there were a lot of illnesses which cause fatigue.

She states:- "As soon as he said that I knew because I have heard other doctors who don't believe in C.F.S. go along those lines of 'if we can't find a cause, therefore it does not exist".

5.4.14 Ms Heal said Dr Douglas did not at any time state that he did not believe in Chronic Fatigue Syndrome as he had with the other two people. His manner, his intimidation and hostile questioning, together with his failure to answer her questions about recent developments, in her view all pointed to the proposition that he doesn't believe in Chronic Fatigue Syndrome.

5.4.15 Ms Heal was devastated when the insurance company ceased paying her benefits because she knew she could not work and she would not be able to support herself financially. The fact she couldn't and can't work as a Director of Nursing is very important to her. She is well aware the definition of incapacity in her insurance policy is central to her maintaining her benefits. As the obligation to pay arises if she can't work as a Director of Nursing, the insurance company cannot make her lick stamps. The policy specifically says she must be able to perform each and every duty. "I have to be able to manage the budget, to evacuate the facility if there is a fire. I have to be fully competent at all my jobs".

5.4.16 Ms Heal stated she would not be able to take on "lighter" duties as even then she could not guarantee she would be able to go to work on a regular daily basis at the same time say, each day. She has "fluctuations which are beyond her control".

5.4.17 The witness stated she regretted deeply the loss of her career. She had not been able to have children and had decided having a career would give her a feeling of worth. Without her career she finds it quite hard and is presently seeing a psychologist. Dr Douglas' report was like calling her a bludger. She felt this was more insulting than calling her fat and ugly. She has always worked and working is how she identified myself.

5.4.18 The Committee inquired whether Ms Heal would take up employment other than nursing if she improved substantially over the next 6-9 months. She said she is one of those silly girls who loves nursing. For example, she often worked another 20 hours a week extra to insure the same quality she would expect for her mother in a nursing home. She is contemplating different employment. Self-employment at home is preferable and she may be able to do some sewing which she is good at. Working for someone else is difficult as she could not always be dependable and reliable to turn up every day.

5.4.19 There is no support for rehabilitation from the insurance company. They simply pay her a cheque each month. They will offer something when her doctors feel she is able to return to work, but to date none of her doctors have indicated she is ready.

The Committee took a short adjournment to consider whether it had any further questions before closing the hearing. On resuming:-

5.4.20 The Committee inquired as to what aspect of Dr Douglas' consultation and report Ms Heal found most difficult. The options were either

- Dr Douglas found she was not totally disabled; or
- Dr Douglas did not believe in Chronic Fatigue Syndrome; or
- his manner.

Ms Heal stated the issue of most concern to her was that she experienced the profoundest of symptoms but nobody believed her symptoms were due

to Chronic Fatigue Syndrome. Further, it was a very disabling disease. She states:-

> "at times I have wished I was a paraplegic because they play basketball and tennis and still get around in their wheelchairs and are fit and healthy. My lawyer is a paraplegic. They still have lives, they're still able to work. The most important thing with this horrible illness is that - is being believed, first of all."

She indicated that Dr Douglas' prejudice was "horrible because that means that no one is going to be believed. But at least if he had given me the opportunity to listen (explain). That is, maybe he would have learnt.

5.4.21 The witness indicated that she felt one of the things underlying her credibility was she wrote and complained about his behaviour before her insurance benefits were ceased. I complained to them about his behaviour and about having to go to Brisbane which was exhausting and costly. She stated the reason she was here was that his behaviour was unprofessional. She stated that after her benefits were re-instated she could have withdrawn her complaint, but she chose not to and the reason was that Dr Douglas had not made only one mistake. His mistake was not only a single error. She says "everyone in the world makes errors of judgment, but when you start to make a series of errors, then its serious..... This thing about not being believed is so undermining of your integrity".

5.4.22 The witness then gave a series of examples where she could have used her knowledge as a Nurse to exaggerate the amount of medication she was taking to control her symptoms and amongst other things she could have faked her balance problems. She did none of them.

5.4.23 The witness indicated to the Committee that she was seriously distressed by the Video Surveillance undertaken by the insurance company.

EVIDENCE (CONT)

5.5 DR JONATHAN DOUGLAS

5.5.1 The Chair welcomed Dr Douglas and noted he had provided full and frank disclosure. It was made clear to Dr Douglas that his competence was not in question. Dr Douglas was advised the reason the Committee had been appointed was the Board had received a total of 8 complaints over a period of 15 months from November, 1998 until February, 2000. Of these the Committee would be investigating four.

5.5.2 Dr Douglas was advised that on 16 March, 2001 when he attended for examination, the C.I.C. was examining Dianne Little, Deborah Jones and Anthony Ryder. Another complainant Ms Teresa Laverack, now known as Teresa Heal, was not available for examination on 16 March, 2001.

5.5.3 The Chair canvassed the nature of the complaints against Dr Douglas. There were two (2) distinct and separate complaints. The first concerned Dr Douglas manner with his patients which the complainants had described as brusque.

Secondly there was concern that Dr Douglas does not believe in Chronic

Fatigue Syndrome, and as a consequence of this disbelief, would not be able to diagnose the clinical entity or the consequent disability.

5.5.4. The Chair put to the witness that he had stated at the beginning of his examination with at least one of the complainants interviewed that day, by the C.I.C, that he did not believe in Chronic Fatigue Syndrome. Specifically Dr Douglas had started his consultation by indicating he did not believe in Chronic Fatigue Syndrome and had then said to the complainant "so what's wrong with you"?

5.5.5 Dr Douglas denied he had ever said anything like that. He indicated he usually starts by advising the claimants that they have been sent to him by an insurance company for an independent report.

> "What the insurance company is asking me is what is your diagnosis, are there any other factors in the case that impact on that diagnosis, and what is your degree of disability"?
>
> "Further I say well this is what I'm setting out to do; we're going to take a history along those sort of lines, then we're going to do a physical examination and then I shall write a report"

5.5.6 Dr Douglas indicated that he tried to avoid discussing in detail the nature of their complaints with the patients. He said the patients often questioned him and he understood the reason was they were seeking answers in a controversial medical area wherein they may have had multiple different opinions.

He stressed he tried not to get involved in debates with his claimants. He denied strongly he would say to them that he did not believe in Chronic Fatigue Syndrome because he stressed that he did believe in Chronic Fatigue Syndrome.

5.5.7 The Chair then referred Dr Douglas to the sample of medico-legal reports provided by him to the C.I.C. She stated after perusing the reports the C.I.C. had begun to query whether it was indeed difficult for Dr Douglas to make a diagnosis of Chronic Fatigue Syndrome.

For example in the first 12 reports on the list in which Dr Douglas had diagnosed a disability the disability was never made consequent on the patient having Chronic Fatigue Syndrome.

- In case one - the disability was related to multiple factors;
- In case two - there was some chronic fatigue syndrome, but in the presence of a significant element of depression;
- In cases three, four and five - the patient was depressed;
- In case seven - there was total disability, but this disability may have been the aftermath of infection;
- In case eight - it was a depression;
- In case nine - obesity, diabetes and hypertension;

- In case ten - fatigue following upper respiratory infection;
- In case eleven - psychological factors with an adjustment disorder; and
- In case 12 total disability with a long list of diagnoses and Chronic Fatigue Syndrome was number 3.

5.5.8 The Chair indicated to Dr Douglas that the Committee believed that Dr Douglas could link the fatigue state with Ross River Fever. However, although Dr Douglas had stated he believed in Chronic Fatigue Syndrome, from reading his reports, it appeared where possible, Dr Douglas had preferred to "hang his hat on something else".

5.5.9 Dr Douglas replied "it's hard because it's very rare to get somebody who is, if you like, pure Chronic Fatigue. Just about all these patients have got an element of another condition present. Often it's either primary depression, pre-existing their Chronic Fatigue state, or it's depression which has arisen as a secondary component of a Chronic Fatigue state. Because after all, if you get fatigued and you lose your job and you're out of work and you lose your social supports, it's not uncommon to get secondarily depressed, and so it's sometimes very difficult to tease out which is the dominant factor in these multiple causation situations. And so that's, I guess, part of the reason why sometimes there is this sort of mixed message at the end of the report, that there's a mixture of fatigue and there's a mixture of something else".

"I must say, I tend to regard post viral fatigue and Chronic Fatigue Syndrome as being essentially the same diagnosis. I think one is a variant, if you like, of the other. So these are Chronic Fatigue states, some of which have got an obvious antecedent basis as in someone who's had a viral illness like Ross River Virus or Glandular Fever who's then got fatigued and stayed fatigued out of all proportion to what the average, if you like, patient does. So that's how I conceptualise what is a very difficult area".

"I think it's fair to say these are among the most complex and difficult patients one ever sees in medicine because there's such a lot of mixed messages coming through. They themselves have often had all sorts of advice from all sorts of different people, and I see only the difficult ones. I only see the ones that are - that have been usually long-standing and are problems to themselves and perhaps the insurers".

5.5.10 Questioned further by Dr Waller, Dr Douglas confirmed he would not have said he didn't believe in Chronic Fatigue Syndrome. He then provided a history of the disease to illustrate his knowledge :-

"..... I'm aware of the history of Chronic Fatigue. It was first described in 1869 when it used to be called neurasthenia. It's been in the literature literally for that length of time, and of course, in 1980 - in the early 1980s I was a member of a working party for the College of Physicians on the

Chronic Fatigue Syndrome, and I think in eighteen - in 1989 I put together a document on our deliberations of that working party. It was subsequently published in Fellowship Affairs in 1990, and started the ball rolling, if you like, on the working party that was - then produced the other document in 1993 - no, 1994".

Dr Douglas also indicated he was invited to speak at the College of General Practitioners Annual Scientific Meeting at the Gold Coast in 1997 to run a workshop on Chronic Fatigue.

5.5.11 Ms Frampton put to Dr Douglas that Mr Ryder said that when he went for his appointment Dr Douglas was running late, didn't explain to Mr Ryder basically, he was not to be considered as a treating doctor but was there to do an independent report. Mr Ryder had said Dr Douglas' opening comments were "... that he (Dr Douglas)was running late, he was irritated, he looked at my file and it had me on the front, and Dr Douglas said "well I don't believe in Chronic Fatigue Syndrome . Now what's the matter with you."

5.5.12 Dr Douglas indicated he had been in practice for 30 years and he always used the same strict appointment system - one hour for a new patient, half an hour for follow-up and one and one half hours for all medico-legal consultations. If he was late to an appointment he always apologized to the patient. He was late usually because he was coming from the hospital. Sometimes he was late because he was reading the voluminous material which accompanied the file. In any event it was not his usual style and he could not recall saying those types of things.

5.5.13 Dr Douglas noted the medico-legal examinations conducted on behalf of an insurance company were difficult. The patients were often defensive and also antagonistic towards what they perceived to be mainstream doctors. He indicated he did try to modify the conduct of the examination to overcome these inherent difficulties.

5.5.14 The witness stated of all the medico-legal examinations he undertook, only a small percentage were of patients diagnosed by other doctors as suffering from Chronic Fatigue Syndrome. He indicated that in the past 30 years he had conducted 1,229 medico-legal examinations. Of the medico-legal examinations he had conducted since 1995, he thought about 10 percent (10%) would have been cases of Chronic Fatigue Syndrome, but he would need to confirm this assessment.

5.5.15 Ms Frampton, as the non-medical member of the Board advised Dr Douglas, after having read the sample of 26 reports provided to the Committee, in her view, when Dr Douglas could identify an underlying illness in a patient then it was relatively simple for him to find a disability for them.

However, where Dr Douglas could not identify underlying illness but thought there was depression he advised the patient to go to a psychiatrist or to have further assessment.

The problem seemed to lie with cases where Dr Douglas could not find an underlying illness and could not diagnose depression. In these cases he did not diagnose Chronic Fatigue Syndrome, nor did he come to the conclusion

there was a disability. Thus, if there was no underlying illness and in the absence of depression, there was no disability.

5.5.16 When asked directly to indicate which of the reports Dr Douglas could point to which demonstrates the basic belief that Chronic Fatigue Syndrome can, by itself, lead to disability he cited case 26 - Dr Julia Leeds.

In this case, he stated, he was prepared to certify for 4 years that the patient was disabled on the basis of her post Ross River viral infection. He also cited case number two - Ms Michelle Steinback.

Dr Douglas went on to explain it's very uncommon to get these patients as a pure Chronic Fatigue Syndrome. Often they have mixtures of depression, anxiety and sometimes some other form of disorder, sometimes de-conditioning from prolonged rest. In addition, some of them have been subjected to unusual forms of treatment and abnormal illness behaviour promoting activities which have caused added confusion.

5.5.17 Ms Frampton asked Dr Douglas how much weight he gave to the patient's history compared with his clinical examination which she indicated, from the perspective of a member of the public, seemed limited. Dr Douglas indicated he gave virtually all the weight to the history, which usually occupied about one and one-quarter hours of a one and one-half hour examination. He stated he saw the history as paramount to solving most people's problems. In addition, histories needed to be weighted appropriately according to how it was presented.

5.5.18 The Chair put Ms Heal's circumstances to Dr Douglas. In particular that she was a Director of Nursing. She had no children and loved her job. She had tried every medical avenue to find a cure or a rehabilitation process. The Committee questioned whether it would be in her best interest to just "lounge about and do nothing. Dr Douglas was advised that, following legal intervention, Ms Heal had her disability benefits re-instated.

5.5.19 Dr Douglas stated he was not aware this had occurred, but that she had a lot of symptoms some of which he was not able to reconcile with the physical examination. For example, Ms Heal complained of a lot of balance problems and vertigo. She showered only every second or third day because "her balance was so terrible". On physical examination there was absolutely no evidence of any balance disturbance. The surveillance video had influenced his diagnosis. Dr Douglas stated on the surveillance video she was doing all sorts of things she claimed she couldn't do when he saw her and when, on examination she had told him she had not been able to do these things for a very long time.

His conclusion was that he had come to the view she was not disabled fairly on the evidence provided to him. However," I make no pretence that I can't get things wrong."

Dr Douglas then raised the importance of the particular definition of disability in the insurance policy noting often he was asked "do you consider this person totally disabled" and also "do you consider them to be permanently disabled".

5.5.20 Ms Frampton advised Dr Douglas that both Ms Little and Ms Jones had been unhappy with the consultation and the examinations. Ms Little, for example, had said "Dr Douglas was rude firing questions at me and not letting me finish answers. He appears to be intentionally intimidating.

I gave him a written list of my symptoms at the end of the consultation and he hadn't covered or allowed me to cover most of those items". Further Ms Little stated Dr Douglas was cutting her off, not letting her reply so that "she found it [the consultation] very intimidating". Ms Frampton asked Dr Douglas what was his normal manner and style of questioning was when taking a history from the patients.

5.5.21 Dr Douglas replied by re- emphasizing the amount of time he allocates his patients - one hour for a normal appointment and a half an hour for a follow up. By usual doctors standards, Dr Douglas advised, this allocation of time was generous. Medico-legals were allotted one and one-half hours and they often went for two hours. In his defence he noted in his career he had had 102,900 patient contacts and that these people - the ones who had complained to the Board were the only complaints made against him. He explained he was an examiner and "I'm used to listening to people's answers before the next question. So this is something I'm not unfamiliar with". Dr Douglas stated he could not recall his consultation with Ms Little. He could not say whether she was correct or otherwise in what she said. He was sorry if she thought he was brusque and indicated he certainly didn't try to be. Again he stated he was well aware that often at these examinations people were very unhappy and didn't want to be there. He believed that as often these patients had seen many doctors before they got to me, the patients while not exactly hostile about the situation - " I suppose they are looking for - for any nuance of disapproval they might receive".

5.5.22 He indicated this was why he tried to give them as much time as possible to ... "let them ventilate all the things that they wish to ventilate... and ... if they bring along their list of symptoms, I keep them and look at them".

5.5.23 Ms Frampton then asked the witness to comment on Ms Little's assertion she had to strip to her underpants and neither a gown nor a robe was offered to her. Dr Douglas advised he has a separate examination room where there is a couch and a sheet, at least the width of the examination couch which can cover patients completely. He begins the examination with the non touching things first and gradually tries to move onto the more embarrassing things. He advised he could not alter what he does for medico-legal examinations from what he would do when examining a patient ordinarily.

5.5.24 Dr Douglas advised he needed to have Ms Little remove her bra as he wanted to examine her heart. He explained this was essential to a thorough examination of the heart.

5.5.25 Ms Frampton noted Ms Little's evidence was that having examined her, Dr Douglas then required her to walk up and down the room for 10-12 minutes without her "bra". Dr Douglas advised "this was again part of a general review of the bodily systems looking for, particularly, muscle wasting or weakness, so that if - in terms of trying to assess someone's fatigue and how it may have affected them, to look at their musculature as part of that examination, and to look at all their musculature is part of a proper examination".

5.5.26 When pressed Dr Douglas did advise that at this stage of the examination, Ms Little could have put her bra on if she had wanted to but that "he does not routinely ask patients "would you like to put your bra on", because most people adapt and move on. He added "sometimes they get up and hold a sheet if they wish to".

5.5.27 If Dr Douglas perceived the patient was finding the examination an ordeal he would have suggested the patient put their bra back on.

5.5.28 When asked if he had advised Ms Little why she was required to undress he advised he always informs his patients of the need for a thorough

examination. The reason is that he often sees patients "who are sent along with a particular diagnosis but turn out to have something else". The only way this can be resolved is by a thorough examination.

5.5.29 Ms Frampton then asked the witness ."Now Ms Little and also Ms Jones were concerned about the way that you examined their chest and they felt sort of that you came too close to them, right, and leant across their breasts in a manner that other doctors who had examined them for similar things had not done".

5.5.30 Dr Douglas replied " One can't speculate on why those comments were made, but all one can say is that in a lifetime I've had probably as I said over 100,000 patient contacts and in virtually all of those situations I would have examined in that sort of way. This I would regard as standard practice".

5.5.31 Dr Douglas then outlined his examination procedure standard for all consultations including medico-legal examinations.

5.5.32 Ms Frampton then inquired as to whether Dr Douglas felt he was able to gauge a patient's reaction to the way he was examining them. "Do you feel you pick up on if they're having any problems?"

Dr Douglas replied " Yes, either they don't remove the clothing they've been asked to remove or they are constantly holding the sheet up and making it difficult to get at them".

Ms Frampton noted that in her evidence, Ms Jones had stated she asked Dr Douglas three times "Do I have to remove my bra". Dr Douglas indicated in this situation he "would normally have explained to her that this is part of the full and proper examination of your chest". Further, he couldn't guarantee someone's heart sounds if he hadn't listened in all the areas of the heart which is difficult to do with a bra on.

5.5.33 Ms Frampton again pressed the witness regarding the robe and the gown. Dr Douglas was clear and adamant in his reply that he has always had a separate examination room with a table with a sheet and another sheet folded at the end of the bed.

5.5.34 Ms Frampton advised Dr Douglas that two complainants had given evidence that Dr Douglas was present when they were undressing.

5.5.35 Dr Douglas vigorously denied this indicating this is the reason for his maintaining a separate examination room which he has done in all four locations in which he has practised. He noted this contrasted with the situation where some doctors simply have a curtain around the table where they sit whilst the patient undresses.

Dr Douglas stated he could not recall the consultation with Ms Heal in June 1998. There was nothing out of the ordinary that he could remember. Ms Frampton then put to the witness the contents of a written statementmade by Ms Heal to the insurance company four days after her consultation with Dr Douglas.

> "I did not like Dr Douglas. His manner was brusque; his questions were curt; and his listening skills poor as he repeatedly almost continuously interrupted me and asked another question while I was still answering his previous question. He seemed rushed,

disinterested, and impatient. I consider his manner intimidating."

5.5.37 Dr Douglas could not comment. He re-iterated he allows his medico-legal patients plenty of time. He said "if that's how she found me I guess I can't dispute that, but that was her opinion. It is not uncommon, though, for people who are sent by insurance companies to complain about the ...the messenger because they do not like the message for whatever reason. So its not uncommon for those sorts of complaints to be fired in".

Dr Douglas added it might not be uncommon especially where the patient perceives they may get an adverse report.

5.5.38 Ms Frampton then directed Dr Douglas to page 2 of his report dated 6 July 1998. She noted he used the word "apparently" eight times on that page and asked if he were trying to create an impression in the reader.

5.5.39 Dr Douglas replied he does try to write down every word of the patient's history. "She apparently", he said "was just a figure of speech". He didn't think he meant anything particularly by it. Ms Frampton advised Dr Douglas in her opinion the word "apparently" did not appear as frequently in any of the other medico-legal reports she had read from the sample.

5.5.40 After questioning by the Chair Dr Douglas advised he had written two reports on the same day about Ms Heal because he had written one report before he saw the surveillance video and then another after viewing it. He gave considerable weight to the video because there were some very specific statements made by the claimant in her history outlining things she couldn't do. Dr Douglas advised the video did not confirm the claimant's history. In particular Ms Heal had claimed she couldn't balance, couldn't have a shower without sitting down, couldn't dust, mop, whatever.

5.5.41 The Chair then questioned Dr Douglas regarding Professor Loblay from whom Ms Heal had also obtained a report. When commenting on Dr Douglas' report, Dr Loblay had said "the principal difficulty with Dr Douglas' report is that he has not offered any diagnosis. In particular, he has not addressed the question of whether she might have Chronic Fatigue Syndrome, nor has he given any reason why this diagnosis might be inappropriate".

In reply Dr Douglas said:-

"Well, again, it's - it's difficult to malign patients. You know, my impression was that she was, if anything, trying to fabricate signs for the purpose of - for whatever purpose. But I - you know, I was sort of not keen on trying to say those sorts of things because it does tend to damn the patient and it's very hard to do that on one consultation. So that's why I probably resiled from saying those sorts of things. But the implication that I drew was that there was an attempt to, at the very least, exaggerate the degree of disability which wasn't confirmed on a surveillance video or on physical examination".

5.5.42 When asked if Ms Heal's profession had any impact upon Dr Douglas conclusion that she was not disabled and in effect was malingering. Dr Douglas said no.

5.5.43 Dr Waller sought clarification as to whether the activities Dr Douglas mentioned took place inside the house or outside. Dr Douglas replied that it was both and that the investigators had videod Ms Heal doing housework

from outside the house. Dr Douglas indicated the video showed Ms Heal "moving up and down stairs" dusting, vacuuming and doing quite a few things which she allegedly said she could not do"

"It also showed her going to the shops, walking in and out of the shops, and on some occasions wheeling a scooter, other occasions walking quite normally around"

Dr Douglas advised the skills or strengths needed for Ms Heal to perform the household tasks were similar to those skills he had assessed in his rooms. For example on the video he could see she was turning her head without demonstrating any loss of balance. He advised if he had not had any other knowledge of this person, while he watched the video then, he would have concluded she was a "normal person going about normal activities in a totally normal fashion".

Dr Douglas advised the videos were taken over a number of days and in his opinion took account of the possibility that Ms Heal may have been able to perform certain tasks on one day and not on another.

Dr Douglas expressed the view that his report had been based upon the totality of the evidence and the reports of interviews by the insurance investigators, the video evidence, the clinical examination and the results of the various investigations. He states:-

> "I believe it is a reasonable conclusion to arrive at when presented with the totality of the evidence taking into her account her statements, the reports of interviews by the insurance investigators with Mrs Laverack, the evidence of the video, the clinical examination and the results of the various investigations."

His physical examination was very important as it revealed she was able to perform certain tasks which were incompatible with the history she gave of her disability. For example she was able to walk on the tips of her toes across the room backwards and forwards. She was able to walk on her heels. These tasks would not be easy if she were so disabled she could not have a shower without sitting down.

Questioned about the material he had been briefed with and, in particular, the report of Ms Heals' treating physician Dr Stephen Moore, Dr Douglas cautioned that treating doctors were, ipso facto, advocates for their patients. Dr Douglas did not recall Dr Moore's report nor did he recall if he was briefed with it. He felt he had provided his file to the Committee, but the Committee were able to verify only that he had been provided with the surveillance reports and a subpoena from the District Court in New South Wales. Dr Douglas advised he may have sent the material back.

5.5.45 Ms Frampton put to the witness that Mr Ryder felt Dr Douglas had dwelt heavily on his sexual activities. Dr Douglas emphasized that sexual activities are important in assessing both fatigue status and depression as "there are well documented problems with libido and with impotence in both states".

Dr Douglas advised questions such as "Has your sex life been affected in any way by your illness?" or "What is the frequency of sexual intercourse"? are standard questions that you'd expect to ask any patient where you're doing a full history and examination.

Dr Douglas was not able to explain the source of Mr Ryder's bewilderment regarding the doctor's line of questioning. The questions were needed " since a person who is markedly disabled would not be expecting to have intercourse 2-3 times per week". This then was one way of assessing the degree of disablement.

5.5.46 Mr Ryder had advised the Committee that during his consultation with Dr Douglas his concentration was quite poor and he was quite sleepy. Dr Douglas indicated he saw no evidence of this during the interview. "My recollection of him was that he was a very fast talker and he was a very dynamic man". He was " animated and showed no evidence of slowness of speech, movement, or any other sort of psycho-motor retardation".

5.5.47 Ms Frampton put to Dr Douglas that Ms Heal had noted quite a number of factual errors in the body of his report and this raised a concern that Dr Douglas did not listen carefully enough. Dr Douglas advised the report was based on his handwritten notes which he had checked and which correlated well with the facts in his report.

Dr Douglas expressed the view Ms Heal may have suffered from " recall bias ".
That is Ms Heal may have recalled thingswhen she left the rooms that she probably wished she had said or wanted to say which she didn't actually say.

5.5.48 The Chair questioned the adequacy of the one hour consultation to properly consider the years of disability suffered by the patient and the many other medical reports provided by other doctors.

Dr Douglas agreed that in a perfect world it would be better to have a number of interviews over a period of time, but logistically this was not possible. He said:

> "But I agree you know the length of time some people have been sick, and the complexities of their history make it very difficult to encompass absolutely every aspect of their whole medical and surgical and psychological career over a life time and often their work career as well".

Dr Douglas felt he had not been briefed with the treating doctors reports in Ms Heal's case. The briefing letter from the insurance company did indicate that he had been provided with copies of some medical reports.

Regarding the surveillance video, Dr Douglas pointed out that he does receive some videos where the video material is entirely in keeping with what the patient has told him and has helped to support the degree of disability that the claimant was claiming. There were cases amongst the sample of 26 provided to the committee where the clinical examination, the patient's complaints, the patient's degree of disability were all coincidental and then the claimants report would be appropriately worded on those line.

5.6 VIDEO SURVEILLANCE

The Committee was also assisted by viewing both videos which Dr Douglas had available to him when he prepared his report.

The Committee was not greatly assisted in its deliberations by viewing the video evidence. The photographs relating to Ms Heal moving about her house indicated a woman moving about her household tasks - sweeping, watering flowers, washing up. Her movements were slow which fitted with Ms Heal's description of her abilities. Whilst taken over a number of days again the Committee believes the material was inconclusive in supporting either Ms Heal's case or that of Dr Douglas.

The out door photographs were clearer and showed Ms Heal able to drive to a shopping centre, remove the scooter from the back of her van, close the van and manoeuvre the scooter through the shopping centre. They also showed her manoevering the scooter back into the van, up two ramps. Ms Heal's evidence was she used this scooter to get around large shopping centres. She found it easier. Again the scooter was lightweight and easy to move up and down the ramp. I did not find it surprising she preferred to perform this task, albeit, a bit arduous rather than walk around a large and busy and sometimes hazardous shopping centre.

Whether viewing the indoor or outdoor photographs it was difficult to identify the evidence
that had so convinced Dr Douglas that Ms Heal had been lying about her disabilities.

6. LEGAL ISSUES

The Committee was appointed to investigate two principal complaints. The most significant of these was that Dr Douglas did not believe in Chronic Fatigue Syndrome and so was biased and not in a position to comment. The second comprised allegations of inappropriate behaviour during the consultations, including some sexual issues.

Whilst it was not necessary for the committee to investigate or to make findings regarding the existence or non existence of the syndrome Chronic Fatigue Syndrome, what constitutes the necessary and sufficient pre-conditions to establish "bias" on Dr Douglas' part is not a simple matter.

The CIC was complex, therefore in both the medical and legal issues it sought to resolve.

Standard of Proof

The standard of proof in an inquiry of this kind is the standard which applies to all proceedings not strictly criminal in nature "the Briginshaw Test" see Bringinshaw v Bringinshaw (1938) 60 CLR 336 per Dixon CJ. More usually termed "the balance of probabilities" the test is more usefully phased as "reasonable satisfaction". The standard depends upon:-

- the seriousness of the allegations raised;
- the likely consequences for the defendant if the allegations are upheld; and
- the inherent probability or improbability of what is said to have occurred.

On the direct evidence it does not appear that allegations of bias can be made against Dr Douglas. Dr Douglas had been specifically requested to provide examples of reports where he had determined disability as a result of Chronic Fatigue Syndrome. However, when the Committee reviewed the 26 medico-legal reports provided upon subpoena by Dr Douglas, in only two (2) of these reports did Dr Douglas mention the syndrome Chronic Fatigue Syndrome. Even in these

two (2) he found Chronic Fatigue Syndrome existed in the presence of other organic or psychiatric conditions.

Bias

Unlike standard of proof "bias" is a more "slippery" legal concept. Many of the decided cases such as R v Watson; ex parte Armstrong (1976) 136 CLR 248 and Livesey v NSW Bar Association (1983) 151 CLR 288 concern bias in a person exercising judicial or quasi-judicial powers such as a judge, a magistrate or a member of a statutory tribunal.

While Dr Douglas is employed by insurers to exercise evaluative skills and make a judgment, his role is more as an expert witness. The decided law regarding "bias" in a witness, whether expert or not, simply means that the witness is likely to give factually incorrect or "coloured" evidence for some specific reason. While it covers deliberate and malicious lying it is certainly not confined to conduct of that kind. Many biased witnesses are more or less unaware of their predilection for one side of the case. For example, a child may be biased because he has been "schooled" by parents to give evidence against a defendant. A witness may be biased because he is terrified of a party of the defendant supporters. A witness may also be biased because he or she holds strong views about moral principles, social issues or perception of reality touching the case in hand.

If the complainants Jones and Ryder are believed then the first thing Dr Douglas said when he sat down was "he did not believe in Chronic Fatigue Syndrome". His evidence is he "certainly would not say to them that I don't believe in Chronic Fatigue Syndrome because I do believe in it".

Dr Douglas may indeed be biased in the legal sense in that he is not likely nor almost never likely to diagnose a case of Chronic Fatigue Syndrome. This being the case, there still remains the question as to whether this amounts to unsatisfactory professional conduct.

In analyzing the transcript of evidence and the sample of medico-legal reports provided one needs to search for direct evidence of bias, in statements made by the complainants or by Dr Douglas in their evidence or in statements made by Dr Douglas in the sample of medico-legal reports.

This evidence needs to "reasonably satisfy" the Committee that Dr Douglas is biased.

7. DELIBERATIONS

7.1 DEBORAH LILLIAN JONES

The Committee found the witness credible. She presented as a truthful and forthright person who answered the questions put by the Committee in a straight forward and non-evasive manner.

Ms Jones asserted the first words said to her by Dr Douglas were that "Chronic Fatigue Syndrome did not exist".

Mr Johnson who had accompanied Ms Jones to the interview confirmed Ms Jones' recollection. Ms Jones alleged at one point during the examination she lay on the examination couch in just her underpants without either a sheet or a gown to put over her now bare chest. Both Ms Jones and Mr Johnson agreed she remained in this state for 10 minutes.

The Committee found no reason to disbelieve Ms Jones' evidence either when she addressed the issue of bias or when she gave evidence of Dr Douglas' inappropriate behaviour during medico-legal examinations. This was all the more so since Ms Jones' evidence was corroborated by her companion Mr Hal Johnson. It should be noted that Mr Johnson, if sworn, could have given direct evidence of Dr Douglas' statement of bias.

7.2 DIANE LITTLE

Again the committee found Ms Little a credible witness. The basis of Ms Little's contention that Dr Douglas did not believe in Chronic Fatigue Syndrome was the Statutory Declaration provided by Deborah Jones. Ms Little therefore had no direct evidence that Dr Douglas did not believe in CFS.

Ms Little complained mainly of Dr Douglas' rudeness. She alleged he fired questions at her and would not let her finish her answers. She found him intimidating. The consultation was traumatic and humiliating.

Ms Little concurred with Ms Jones in that Dr Douglas did not provide a gown or a sheet and forced her to parade in her underpants.

Ms Little complained she was required to submit to physical examination solely in her underpants in at least three separate circumstances:–

- On the couch with no sheet
- Whilst walking
- When sitting and doing reflexes

She complained of his history taking. He was wrong in 3 instances.

- He said she had no enthusiasm for work when he had not questioned her about her work
- He said she had no problems walking 40-45 minutes each day when she does.
- Dr Douglas' report indicates Ms Little had no symptoms of depression but Ms Little says he told her she was depressed and should see a psychiatrist.

Ms Little was a computer analyst. She stated Dr Douglas did not enquire into the memory or concentration problems she experienced which impacted upon her work as a computer analyst even though he was required to give an expert opinion as to her fitness to perform this job. Rather he concentrated on exploring her physical disabilities, if any.

The Committee took note of the fact Ms Little had consulted with a number of people regarding her complaint –in particular, Ms Laverack who was a nurse but also Ms Jones and the next witness Mr Ryder. The Committee believed that this collaboration may have had some contaminating effect on the extent to which the whole of their evidence might be accepted but the extent to which the collaboration did impact upon their evidence was, however impossible to guage.

7.3 ANTHONY RYDER

Again the Committee found Mr Ryder to be a credible witness who responded in a forthright and straight forward manner.

Mr Ryder, like Ms Jones claimed Dr Douglas advised him at the start of the consultation he did not believe in Chronic Fatigue Syndrome. The Committee found no reason to disbelieve Mr Ryder in this respect.

Mr Ryder complained that Dr Douglas' manner was gruff and off putting. He complained that Dr Douglas seemed inordinately interested in his sexual activities. Mr Ryder said even though Dr Douglas had said in his report he had shown no signs of lethargy Mr Ryder had suffered a lack of concentration during the consultation. After the examination he went home and went to bed for the next 2 days.

7.4 TERESA HEAL

The Committee waited for Ms Heal to return from a trip overseas before examining her evidence. This meant a wait of some 7 months between March, 2001 and October, 2001.

Ms Heal again presented as a credible witness. At times during the presentation of her evidence she was very emotional. This did not detract from the quality of her evidence. Ms Heal was a registered nurse. She had not previously made a complaint about a doctor.

Ms Heal was of the view that Dr Douglas did not believe in Chronic Fatigue Syndrome but she did not assert Dr Douglas had stated directly to her that he did not believe in Chronic Fatigue Syndrome as he had to Mr Ryder and Ms Jones. On the contrary Dr Douglas' manner, his intimidating and hostile questioning and, in addition, his failure to answer her questions about recent developments with Chronic Fatigue Syndrome, in her view, all pointed to the proposition that he did not believe the syndrome.

Ms Heal's circumstances were compelling. She stated she regretted deeply the loss of her career. She was devastated when the Insurance Company ceased paying her benefits. The fact that she couldn't work as a Director of Nursing was very important to her. She was not able to have children and she felt she had defined herself in terms of her career.

As a result of civil action by her lawyers Ms Heal's insurance benefits had been re-instated. It should be noted that this witness had complained about Dr Douglas's behaviour before the insurance company ceased paying her benefits, so that it could not be construed that the basis of her complaint was to discredit Dr Douglas so as to assist her case to have her insurance benefits re-instated by the insurance company.

The Committee advised Dr Douglas that the insurance company had re-instated Ms Heal's benefits. Confronted by this fact Dr Douglas agreed he might have made an "error of judgment" in Ms Heal's case. When questioned about this Ms Heal advised that, in her view, her case was not the only mistake Dr Douglas had made. Rather he had made a series of mistakes. The Committee found that Ms Heal's evidence was substantial and quite detailed in particular, as to its effects upon her personally. Importantly she identified numbers of instances of inconsistencies between her history as outlined by Dr Douglas in his report and as presented orally to Dr Douglas during the medico legal examination.

Of all the complainants Ms Heal was the most articulate and explicit about the impact Dr Douglas' manner and mode of questioning had upon her. It was clear his manner had been quite damaging to her self confidence. The Committee felt that this was both regrettable and unnecessary. A serious question arose as to why medico legal examinations performed independently and on behalf of an insurance company needed to be any more hostile, badgering, intimidating or

deflating than those performed on behalf of the patient's solicitor or, indeed, by the patient's treating doctor. The Committee felt that one way of utilizing this investigation would be for the Medial Board to expand its guidelines as to medico legal reports to include specific recommendations to those doctors preparing independent reports on behalf of an insurance company.

At the conclusion of her evidence the Committee was left in no doubt that Ms Heal was genuinely disturbed by her experiences during examination by Dr Douglas. She had felt intimidated and humiliated The Committee accepted that in Ms Heal's opinion the worst aspect of Dr Douglas examination was that he had questioned her integrity and intimated she was a bludger.. For a person who had previously been hardworking and diligent, for someone who had been a high achiever working in a position demanding diverse work skills and grave responsibilities, the consultation had been damaging in the extreme. The Committee felt Dr Douglas should take note of the result of his inappropriate manner especially in this instance.

The Committee notes, in addition, that this witness was subjected to video surveillance over an extended period of time. The Committee notes further that this process was initiated by the insurance company not by Dr Douglas. The Committee viewed the video material in its entirety but found it entirely inconclusive. The Committee finds that Ms Heal's purchase and use of the scooter was a genuine attempt to maintain a level of independent functioning and mobility.

7.5 DR JONATHAN DOUGLAS

Dr Douglas was helpful and co-operative when he appeared before the Committee. In areas where he did not have a clear recollection of events he acknowledged that it was possible that his words or actions could have been perceived differently by the complainants and, indeed, that the complainants could have formed different opinions as to his words or actions from those which he had formed. Right at the beginning of the CIC the Chair put to Dr Douglas that he did not believe in Chronic Fatigue Syndrome and further, that he had begun his consultation with two complainants by asserting this disbelief. Dr Douglas denied he had made that statement. On further questioning by Dr Waller, Dr Douglas again asserted he had not made those statements. He usually began by advising the patient he had been briefed by the insurance company to provide an independent report. He continued to assert his belief in Chronic Fatigue Syndrome throughout the CIC examination.

Accordingly, there was a clear discord between Dr Douglas' evidence and that of the complainants Jones and Ryder. Without further evidence the Committee was unable to establish who amongst the three were telling the truth. The Committee found all the complainants to be professional previously hardworking high achievers. The Committee found it difficult to accept that persons with this background would suddenly and inexplicably become malingerers. It was not strictly necessary for the Committee to determine this issue of credibility as the most damning evidence as to Dr Douglas' disbelief in Chronic Fatigue Syndrome was provided by Dr Douglas himself.

Having been requested by the Committee to provide samples of medico legal reports wherein he had diagnosed Chronic Fatigue Syndrome Dr Douglas provided a sample of 24 reports. In most of the reports Dr Douglas diagnosed a physical or organic cause for the patients' illness and disability or a psychiatric one, and in that case more usually depression. Despite having been given adequate opportunity Dr Douglas was not able to convince the Committee of his belief in Chronic Fatigue Syndrome on the basis of these reports. On the contrary, he was

able only to diagnose a post viral state or a depression pre-existing their Chronic Fatigue Syndrome. His explanation was these were amongst the most complex and difficult patients one ever saw in medicine because there were so many mixed messages.

Certainly Dr Douglas was able to describe in detail the history of the emergence of Chronic Fatigue Syndrome in medical literature and also his involvement with a working party for the College of the Physicians in 1989. He had also run a workshop on Chronic Fatigue Syndrome in 1997 at the College of General Practitioners Annual Scientific meeting.

Despite this involvement the Committee felt that Dr Douglas was not able to point to an independent medico legal report wherein he had diagnosed Chronic Fatigue Syndrome as a single and independent cause of disability sufficient to sustain the continuation of disability insurance benefits. Given this inability, it was difficult, if not impossible, for the Committee to sustain the view that Dr Douglas did believe in Chronic Fatigue Syndrome.

Accordingly, the Committee is of the view that Dr Douglas did not believe in Chronic Fatigue Syndrome. The Committee does not conclude that Dr Douglas was untruthful in giving his evidence, and does not need to prefer the evidence of the complainants over that of Dr Douglas. Dr Douglas' own incapacity to rest his diagnosis of disability on Chronic Fatigue Syndrome alone is, in the view of the Committee, sufficient evidence by itself.

The Committee is of the view that it would be unlikely for Dr Douglas to diagnose Chronic Fatigue Syndrome. He is more likely to diagnose an organic or psychiatric cause.

As to the complaints concerning the inappropriateness of Dr Douglas' manner described variously as brusque, rude and intimidating, there was certainly ample direct evidence from the complainants. The evidence was credible and repeated and the Committee accepted it.

The Committee accepted the evidence of Ms Jones and Ms Little that Dr Douglas did not provide them with a sheet to cover them whilst lying on the couch, and, in addition the Committee accepted that Dr Douglas allowed Ms Jones and Ms Little to walk around the room in their underpants only. The Committee notes that these allegations were put to Dr Douglas who did not deny them. He did explain to the Committee that there was a sheet available but the Committee was of the view that it was not sufficient for Dr Douglas to merely have the sheet available for use, it would have been more appropriate for him to have actually offered it to the patient.

8. FINDINGS OF THE COMMITTEE

8.1 The Committee is reasonably satisfied that Dr Douglas was guilty of misconduct in a professional respect in that he:-

- Did not offer a sheet to Ms Little or Ms Heal.
- Allowed Ms Little and Ms Heal to walk around without a bra when it was not necessary.
- Did not adequately explain his reasons for asking the complainants to remove their bras.
- Was too focussed upon his tasks during the consultations to the

detriment of his complainants' sensibilities.

- was rude, abrupt and intimidating.
- fired questions to the complainants and curtailed their answers.

8.2 The Committee, whilst being reasonably satisfied that Dr Douglas was biased to the extent he was unable to diagnose Chronic Fatigue Syndrome as a sole cause of disability was not able to find Dr Douglas guilty of unprofessional misconduct on this count by reason of law.

8.3 Dr Douglas' role was as that of an expert witness and to some extent his report is his opinion only. In order to be guilty of unprofessional conduct Dr Douglas would need to have produced a report which was in substantial discord with the facts and evidence upon which he prepared his report. Alternatively, if Dr Douglas were aware of his bias yet accepted insurance work knowing his conclusion prior to examining the claimant then he could be said to be guilty of bias. The Committee found that whilst, in their view Dr Douglas was biased, he had an honest belief in his findings. To the extent he held an honest belief the Committee is of the view that he could not be said to be biased in the legal sense, and hence was not guilty of professional misconduct in this respect.

RECOMMENDATIONS

1.The Board finds Dr Douglas guilty of misconduct in a professional respect pursuant to *S35(1) Medical Act 1939* and counsels him regarding his manner with patients especially during medico-legal consultations.

2. The Board seek an undertaking from Dr Douglas to attend one of the courses in medical professional communication, such as the one conducted by Dr Mark O'Brien.

....
Ms Rhonda Penny (Chairperson) Date

....
Dr John Waller Date

....
Ms Peta Frampton Date

AGENDA ITEM BRIEFING NOTE

To: **Medical Board of Queensland**

From: **Elisa Petranich**

Subject: **Dr David Gillman (780326)**

Date: **7 February 2003**

Background:

The Medical Board of Queensland (the Board) issued Dr Gillman with a Notice of Intention to Impose Conditions on Registration dated 20 December 2002. Dr Gillman was requested to provide the Board with a written submission on or before 10 January 2003.

In response to the Notice, the Board received correspondence dated 8 January 2003 and 14 January 2003 from Robertson O'Gorman solicitors acting for Dr Gillman (see letters attached).

The Board considered the matter at its meeting on 14 January 2003. The Board resolved that Dr Gillman's solicitors be advised that in view of the complexity of the response to the Board's Notice of Intention to Impose Conditions, received on the day of the Board meeting, consideration of the matter would be deferred pending advice from the Board's Complaints Advisory Committee (CAC).

Developments:

On 28 January 2003 the Board received written advice from Dr Alun Richards of the Drugs of Dependence Unit (DDU) on the outcome of the legal proceedings against Dr Gillman in relation to 46 alleged breaches of the *Health (Drugs and Poisons) Regulation 1996* (the Regulation) (see letter attached). Dr Richards advised that on 21 January 2003 at the Proserpine Magistrates Court, Dr Gillman pleaded guilty to 40 breaches of the Regulation.

Dr Gillman was fined $2,500 and ordered to pay court costs and professional costs. The conviction was not recorded.

On 29 January 2003 I contacted Adam Sorby, Senior Environmental Health Officer at the DDU to obtain specific details of the court proceedings against Dr Gillman and any follow up action proposed by the DDU.

Mr Sorby confirmed that Dr Gillman pleaded guilty to 40 of the 46 alleged breaches of the Regulation. Six of the charges were dropped, these all relating to one patient (Nigel Stone). Dr Gillman argued in relation to this patient, that a letter he received from Dr Richards constituted authorisation for him to treat Mr Stone with flunitrezepam. This was accepted by the court.

Mr Sorby also advised that the DDU proposed cancelling Dr Gillman's rights to prescribe Schedule 8 drugs (controlled drugs), and that Dr Richards was in the process of preparing the relevant notice, pursuant to section 24 of the Regulation.

This matter was discussed at the CAC meeting on 4 February 2003. CAC members recommended that confirmation be obtained from the DDU as to whether it had served notice on Dr Gillman cancelling his endorsement for controlled drugs, and for this matter to be referred back to the Board for further consideration and resolution.

On 6 February 2003 I contacted Adam Sorby of the DDU. Mr Sorby advised that Dr Richards had prepared a draft Show Cause Notice, which was being checked by Queensland Health's legal unit. It was anticipated that the notice would be ready to be served on Dr Gillman early in the week commencing 10 February 2003. Dr Gillman would have 28 days to respond to the notice and then another 28 days to appeal against any decision taken by the DDU.

Recommendation:

That the Board decides between the following options:

i. To impose a condition on Dr Gillman's registration pursuant to section 59(2) of the *Health Practitioners (Professional Standards) Act 1999*, that Dr Gillman not administer, prescribe, supply or obtain controlled drugs for patients, pending the outcome of the Board's investigations; or

ii. To impose some other appropriate condition/s pursuant to section 59(2) of the *Health Practitioners (Professional Standards) Act 1999*; or

iii. To await the outcome of the DDU's processes before making a decision on whether to impose conditions on Dr Gillman's registration; or

iv. To take no action against Dr Gillman pending the outcome of the Board's investigations.

E Petranich

Elisa Petranich
Investigator

Robertson O'Gorman
SOLICITORS

TERENCE P. O'CORMAN, AM., B.A., LL.B.

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OUR REF: TOG:TW

YOUR REF:

14 January 2003

Mr G Connell
A/Executive Officer
Medical Board of Queensland
Forestry House
Mary Street
BRISBANE QLD 4000

Fax: 3225 2527 - 6 pages

Dear Mr Connell

RE: **DR D GILLMAN**

We refer to our facsimile of 8 January 2003 and to our telephone conversation with you on 9 January 2003 when you indicated that in respect of the Notice of Intention to Impose Conditions on Registration (hereinafter referred to as the Notice) that dot points 1 and 3 covered the same factual matters.

On further examination of the Notice this clearly cannot be so in that the first dot point in the Notice refers to legal proceedings which are to be heard in the Proserpine Magistrates Court on 21 January 2003. These relate to what might be described as historical matters.

Dot point 3 in the Notice asserts that Dr Gillman has continued to prescribe controlled drugs to patients in breach of the Health (Drugs & Poisons) Regulation 1996.

Therefore this dot point must as a matter of construction and logic refer to a different subject matter from the subject matter which is contained within dot point 1.

FINDINGS OF FACT AND LACK OF PROVISION OF MATERIALS

In the Notice it is indicated that "the Board will consider this matter by reason of the following findings of fact" ...

We have received no facts or particulars which would allow us to respond to dot points 3 or 4 in the Notice.

In this regard the following chronology in respect of this firm's dealings with the Medical Board are relevant:-

- On 23 July 2001 the Medical Board wrote to Robertson O'Gorman enclosing a copy of a report of Dr Robert Brown of the Boondall Medical Centre dealing with various patients of Dr Gillman.

- On 4 October 2001 Robertson O'Gorman wrote to the Medical Board indicating that Dr Gillman did not wish to respond to the issues raised by Dr Brown in light of the foreshadowed move by the Medical Board to obtain an expert's report covering issues raised by Dr Brown's report. This firm's letter to the Medical Board indicated that Dr Gillman wished to be given a full and timely opportunity to consider a response to the expert's report which the Medical Board indicated it was to obtain. There has been no provision of this expert's report by the Medical Board to this firm.

- On 22 November 2001 the Medical Board wrote to Dr Gillman concerning a complaint that Dr Gillman was improperly using his office as a Commonwealth Medical Officer, particularly in relation to a patient Zoran Lekic.

- On 30 April 2002 this firm provided a submission to the Medical Board in relation to a number of matters including the complaint concerning Zoran Lekic. Dr Joice was the complainant in respect of matters concerning Zoran Lekic and this firm has been provided with no further material from the Medical Board as to a response by Dr Joice to this firm's submission of 30 April 2002 to the Medical Board concerning Lekic.

- On 28 November 2001 this firm wrote to the Medical Board asking for a copy of the full and unedited complaints of Dr Joice and Dean Douglas and on 11 December 2001 the Medical Board wrote advising the legislation does not require that a copy of a complaint be provided. To date all copies of the various complaints made to the Medical Board or under investigation by the Medical Board have not been provided to this firm.

- On 14 March 2002 the Medical Board wrote to this firm concerning complaints against Dr Gillman by Doctors Hansen and Farlow. This correspondence noted that Ms Petranich of the Medical Board had been directed to continue the investigations into complaints by Doctors Hansen and Farlow of the Medical Board and this correspondence sought additional information as to Dr Gillman's relationships with Mary Bauer, Petra Swidler and Carmel Pritchard and requested clinical records for those

patients. This same Medical Board correspondence referred to Dr Gillman's dealings with surgeon Dr Pease and sought various information in this regard.

- On 30 April 2002 this firm wrote to the Medical Board concerning Messrs Bauer, Swidler and Pritchard and provided information in relation to the referral history by Dr Gillman to surgeon Dr Pease.

- On 21 June 2002 the Medical Board wrote to Dr Gillman re a complaint by Dr Farlow and the Medical Board sought details of patients referred by Dr Gillman to Dr Pease.

- On 9 August 2002 this firm wrote to Ms Petranich at the Medical Board noting that the Medical Board had the resources to ascertain the list of patients that Dr Gillman had referred to Dr Pease and the list of patients that Dr Gillman had referred to local specialists. No further facts or materials have been provided by the Medical Board to this firm in respect of Dr Gillman's referral of patients to Dr Pease.

It will be seen, therefore, that a substantial body of material appears to have been relied upon by the Board in its "findings of fact" referred to in the Notice and such facts and materials have not been made available to Dr Gillman or this firm for the purpose of properly replying to the Notice.

SECTION 59 IMMEDIATE SUSPENSION OR IMPOSITION OF CONDITIONS ON REGISTRATION

Particularly reference is made to the terms of Section 59 of the Health Practitioners (Professional Standards) Act 1999 which relevantly provides:-

(1) This Section applies if a registrant's board reasonably believes at any time ... that –

(a) the registrant poses an imminent threat to the wellbeing of vulnerable persons; and

(b) immediate action to impose conditions on the registrant's registration is necessary to protect the vulnerable persons.

(2) The board may decide to ... impose conditions on the registrant's registration.

(3) However, in making its decision under subsection (2), the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons.

IMMINENT THREAT

From the relevant parts of Section 59 as extracted above the issue of imminent threat is central to the Board's consideration.

No facts or materials have been made available to enable the issue of imminent threat to be addressed in respect of the Board's proposed meeting for Tuesday evening, 14 January 2003.

Dot point 1 in the Notice could not, in the absence of facts or materials in your possession which have not been supplied to us, be relevant to the question of imminent threat as the various charges that Dr Gillman is facing in the Proserpine Magistrates Court relate to the period May 2001 to January 2002.

The Proserpine Magistrates Court matters in 1993 could hardly be said to relate to the question of imminent threat having regard to the fact that these matters are now a decade old and apparently the Proserpine Magistrates Court took a lenient view of this matter in that Dr Gillman was fined $2,500 and no conviction was recorded.

In relation to dot point 3 if there are issues relating to some current matters as apprehended within the phrase "you have continued to prescribe controlled drugs to patients in breach ...", we again reiterate that we have not been provided with any facts or materials in relation to which we can obtain obstructions and place a submission before you in respect of the Board's scheduled meeting for 14 January 2003.

It is asserted that the Board is currently investigating complaints concerning prescribing practices. While there has been some correspondence between this firm and the Medical Board over the last 2 years in that regard, as a minimum we are entitled to facts and materials on which reliance is placed to ground the issue of imminent threat in order to enable a submission to be addressed to the Board prior to a decision being made about imposing conditions on Dr Gillman's registration.

LEAST ONEROUS ACTION

Section 59(3) as extracted above makes it clear that if the Board is to impose conditions on a registrant's registration it must take the action the Board considers is the least onerous necessary to protect the vulnerable persons.

It is fundamentally unfair in this regard for the Board to decide at its meeting on Tuesday, 14 January 2003 the possibility of the imposition of a very onerous condition on Dr Gillman's registration, namely that he cannot administer or supply controlled drugs for patients prior to a determination of the matter in the Proserpine Magistrates Court.

The Proserpine proceedings have been on foot since approximately July 2002 and it is curious indeed that the Board would propose to make a decision about Dr Gillman not prescribing or administering controlled drugs before the outcome of the Court's decision and the reasoning underlying that decision is known.

It can rationally be argued that if our client pleads or is found guilty in respect of the Proserpine Magistrates Court matter and that the Court finds the matters complained of represents a lack of attention to administrative detail rather than a fundamental lapse of medical judgment, such a finding would be centrally relevant to whether it would be unduly onerous (as opposed to the least onerous course of action) for the Medical Board to impose the foreshadowed condition on Dr Gillman's registration.

If dot point 3 asserts, as the context necessarily suggests, that Dr Gillman was continuing as at the date of the issue of the Notice, namely 20 December 2002, to prescribe controlled drugs in breach of the relevant Regulation this is centrally relevant on the issue of the degree of onerousness of the condition which may be imposed on Dr Gillman's registration.

However, we can only guess at the relevance of this dot point because of the failure of the Board to provide facts or materials in relation to dot point 3.

In relation to dot point 4 we are aware of correspondence sent by the former complainant Dr John Hansen to the President, Medical Board Queensland of 2 January 2003 wherein he indicates that he withdraws all comments that appear in his submission to the Board dated 1 May 2000.

It is acknowledged that Section 57 of the Health Practitioners (Professional Standards) Act 1999 provides that in respect of a complainant withdrawing a complaint the Board has the option of taking no further action about the complaint or, alternatively, may continue to investigate the complaint.

We are instructed that there is some material in existence which may place a different slant on the real reasons for Dr Hansen's withdrawal of his complaint. These instructions need further investigation by us but the point can properly be made that if Dr Hansen's complaint is motivated by factors other than his criticism of the alleged tardiness of the Medical Board's investigation such a matter could impact on the level of onerousness of the proposed condition on Dr Gillman's registration.

CONCLUSION

We complained in our faxed submission to Mr Connell of 8 January 2003 about the significantly inadequate time that has passed from the receipt by our client of the 20 December 2002 Notice, namely 30 December 2002, and the meeting of the Medical Board proposed for Tuesday, 14 January 2003.

I have indicated that this matter came to my attention on Tuesday, 7 January 2003 because of time that I had taken off over the Christmas break including subsequent to 30 December 2002.

In my telephone discussion with Mr Connell on 9 January 2003 Mr Connell indicated that 21 days notice has been given and even though that notice spanned the Christmas and New Year period sufficient notice has been given.

In relation to the 21 days notice referred to by Mr Connell my client first received notice of the Notice of 20 December 2002 when it was collected on 30 December 2002 by way of registered post. Clearly the 21 days notice adverted to by Mr Connell has not yet elapsed.

In conclusion it is observed that the imposition of the proposed condition in respect of Dr Gillman's practice will cause him very considerable hardship and disruption to his practice as he has spent a number of years concentrating on dealing with and treating patients who are in need of controlled drugs as being central to their medical management.

On the material known to us there is nothing which could be said to pose an imminent threat to patients and accordingly an adjournment of the proposed meeting of 14 January 2003 for a period of 28 days would be proper having regard to all the relevant considerations the Medical Board needs to address in a matter such as this.

Further, the transcript of the appearance in the Proserpine Magistrates Court in 1993 should similarly be made available as this firm did not represent Dr Gillman in that matter.

Finally, the facts and materials underlying the findings of fact as referred to in the 20 December 2002 Notice, particularly in relation to dot points 3 and 4, should be provided within 7 days to us so that we can obtain instructions from our client and prepare a considered submission.

Yours faithfully
ROBERTSON O'GORMAN

for **TERRY O'GORMAN**

Robertson O'Gorman

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OUR REF: TOG:TW

YOUR REF:

8 January 2003

Mr G Connell
A/Executive Officer
Medical Board of Queensland
Forestry House
Mary Street
BRISBANE QLD 4000

Fax: 3225 2527 – 2 pages

Dear Mr Connell

RE: **DR D GILLMAN**

I act for the abovenamed, Dr David Gillman.

I refer to my telephone conversation with your secretary at 4:35pm today.

A Notice dated 20 December 2002 signed by you directed to Dr Gillman giving Notice of Intention to Impose Conditions on Registration came to my attention on Tuesday, 7 January 2003 on my return to work after the Christmas break.

That Notice was sent direct to Dr Gillman and was received by his office by way of registered post on Monday, 30 December 2002.

The Notice refers to certain "findings of fact" and refers to a meeting of the Board scheduled for 14 January 2003 and this Friday, 10 January 2003 as a deadline for submissions.

The time frame involved is impossibly short having regard to the fact that the Notice was not received by my client until 30 December 2002 and did not come to my attention because of the holiday break until 7 January 2003.

I request an extension of time for 28 days in order to properly take instructions and place a submission before the Board.

Further, I need to be informed as to the factual basis underlying the "findings of fact" referred to in the Notice dated 20 December 2002 especially in relation to the last two dot points, namely:-

- You have continued to prescribe controlled drugs to patients in breach of the Health (Drugs & Poisons) Regulation 1996;

- The Board is currently investigating complaints concerning your prescribing practices.

It would be appreciated if I could hear from you urgently first thing on Thursday, 9 January 2003 in relation to this matter but particularly my request for further reasonable time to address the matter.

Yours faithfully
ROBERTSON O'GORMAN

TERRY O'GORMAN

LTR MEDICAL BOARD JAN 08 03 TOGTW.doc

I consulted with Drs Toft and Campbell on this today spoke with Terry O'Gorman & left a message that in the immediate term he can have an extension until next Tuesday 14 January, and that if he is unable to meet that he could send a fax to me seeking a further extension and that could be considered by the Board at its meeting on Tuesday 14 January 2003.

Geoff Howell
A/ Executive Officer
9.1.03

Queensland Government

CONFIDENTIAL MEDICAL REPORT

Queensland Health

Enquiries to: Drugs of Dependence Unit
Telephone: 3896 3900
Facsimilie: 3896 3933
E-mail: ddu@health.qld.gov.au
Our Ref: AR:AS

Mr J O'Dempsey
Registrar
Medical Board of Queensland
Floor 19
Forestry House
Mary Street
BRISBANE QLD 4000

Dear Mr O'Dempsey

Re: ***SECTION 18A NOTICE***
Dr David Gillman Whitsunday Medical Centre, Airlie Beach

I refer to previous advice of legal proceedings against Dr David Gillman in relation to forty-six (46) alleged breaches of the *Health (Drugs and Poisons) Regulation 1996.*

In accordance with section 18A *Health Act 1937* notice is hereby given that on 21 January, 2003 at Proserpine Magistrates Court, Dr Gillman pleaded guilty to forty (40) breaches of the *Health (Drugs & Poisons) Regulation 1996.*

The defendant was fined $2500 and ordered to pay court costs and professional costs. The conviction was not recorded.

This advice is provided for the Board's consideration.

Yours faithfully

Dr Alun Richards
Delegate of the Chief Executive and
Manager, Drugs of Dependence Unit
January 21, 2003

14

Australian Competition & Consumer Commission

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Fax (02) 6243 1199

Our Ref: C2000/1776

10 FEB 2003

7 February 2003

Dr Lloyd Toft
President
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4000

Dear Dr Toft

Trade Practices Act 1974 Application for Authorisation A90765 lodged by the Royal Australasian College of Surgeons (the College)

The Australian Competition and Consumer Commission (the Commission) is the Commonwealth agency responsible for administering the *Trade Practices Act 1974* (the Act). A key objective of the Act is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

The Act, however, recognises that competition may not always be in the public interest. It therefore allows the Commission to grant immunity from the Act for anti-competitive conduct in certain circumstances.

One way organisations may obtain immunity is to apply for what is known as an 'authorisation' from the Commission. Broadly, the Commission may 'authorise' organisations to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment. The Commission conducts a comprehensive public consultation process before making a decision to grant or deny authorisation.

for Board agenda

The Commission has considered application for authorisation (A90765) lodged by the Royal Australasian College of Surgeons (the College) in relation to its arrangements for:

- selecting, training and examining basic surgical trainees;
- selecting, training and examining advanced surgical trainees in each of the nine surgical sub-specialities in which it conducts training;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

The Commission has issued a draft determination proposing to authorise the arrangements, subject to conditions, thereby granting them immunity from legal action under the *Trade Practices Act 1974* (the Act). The executive summary of the Commission's draft determination is enclosed.

A full copy of the draft determination can be obtained from the Adjudication page on the Commission's website located at http://www.accc.gov.au.

In accordance with section 90A of the Act, you may notify the Commission in writing by close of business on **24 February 2003** if you wish the Commission to hold a pre-determination conference in relation to the draft determination. The Act does not allow the Commission to extend this deadline.

A pre-determination conference provides the opportunity for interested parties, particularly in the event they are dissatisfied with the Commission's draft determination, to make an oral submission in response to the Commission's draft determination. In the event of such a conference taking place it would be held as soon as possible. The Act requires that the conference be held no later than **26 March 2003**.

You may wish to lodge a written submission to the Commission in response to the draft determination. We request that any submission be provided to the Commission by Friday, 7 March 2003. However, if this is not possible, please contact the Commission. I would add that the Commission would like to expedite the remaining stages of its assessment of the College's application for authorisation before issuing its final determination.

If you require further information please contact Gavin Jones on (02) 6243 1107 or Jaime Norton on (02)6243 1208.

A copy of this letter will be placed on the Public Register kept by the Commission.

Yours sincerely

Paul Palisi
A/g General Manager
Adjudication Branch

Australian Competition & Consumer Commission

Draft Determination

Application for Authorisation

lodged by

The Royal Australasian College of Surgeons

in respect of

The selection, training and examining of surgeons in specialities in which the College conducts training

The College's role in accrediting hospitals for basic surgical training and hospital posts for advanced surgical training

and

The College's role in assessing overseas-trained doctors

Date: 6 February 2003

Authorisation No.: C2000/1776

Commissioners: Fels
Bhojani
Jones
Martin
McNeill

Executive Summary

On 28 November 2000, the Royal Australasian College of Surgeons (the College) lodged application for authorisation[1] A90765 with the Australian Competition and Consumer Commission (the Commission). The College lodged a submission in support of its application for authorisation with the Commission on 30 March 2001, at which time the Commission's assessment process commenced. This submission is outlined in Attachment A to this summary.

The College

The College is a private professional association established in 1927 and incorporated in 1930 in Melbourne, Victoria. Approximately ninety per cent of Australian surgeons are College Fellows.

Origins of the College's application

The College's application followed a two-year investigation by the Commission into allegations that the College's processes restrict entry to advanced medical training in breach of the Act. The Commission's investigation focused on the College's role in deciding how many trainees received advanced training in orthopaedic surgery and how it assesses overseas-trained surgeons.

In September 2000, the Commission informed the College that it considered that this conduct may breach the Act. In response, the College informed the Commission on 9 October 2000, that it intended to apply for authorisation for its training and assessment processes. On 19 October 2000, the Commission stated that it would suspend its investigation while the application was being genuinely pursued.

The College's application

The College has sought authorisation for its primary functions which are as follows:

- selecting, training and examining trainees in basic surgical training and in each of the nine surgical sub specialities in which advanced surgical training is offered;
- accrediting hospitals as being suitable for basic surgical training if they meet standards set by the College;
- accrediting individual hospital posts as being suitable for advanced surgical training if they meet standards set by the College; and

[1] The ACCC has the function, through the authorisation process, of adjudicating on certain anti-competitive practices that would otherwise breach the *Trade Practices Act 1974*. Authorisation provides immunity from court action, and is granted where the ACCC is satisfied that the practice delivers offsetting public benefits. Applications for authorisation are considered on a case by case basis and involve broad public consultation with interested parties. The onus is on the applicant to demonstrate that there is a public benefit arising from the conduct and that the public benefit outweighs any public detriment.

- assessing the qualifications, training and experience of overseas-trained practitioners who wish to work as surgeons in Australia to determine whether they are equivalent to Australian-trained surgeons.[2]

Surgical training and examination

Medical graduates wishing to become surgeons must complete two years of basic surgical training and between four and six years of advanced surgical training depending on the specialty. The College administers these training programs and College Fellows do the actual teaching.

Broadly, surgical trainees are apprenticed to College Fellows. Over the course of basic and advanced surgical training, the scale and complexity of the surgical tasks trainees perform is increased so that, by the time they have completed training, they are ready to undertake all the operations expected of a surgeon in a particular specialty without supervision.

In addition, trainees must pass a 'Part 1' exam at the end of basic surgical training and a 'Part 2' exam at the end of advanced surgical training. The College sets, administers and marks these exams.

Selection of trainees

Prospective trainees must apply to the College to obtain a position in basic surgical training and apply again (2-4 years later) for a place in advanced surgical training. The College determines the selection process (assessment based on curriculum vitae, interview performance and referees' reports), sets the selection criteria and ranks applicants against these criteria. It also determines the 'cut-off' standard below which applicants are not eligible to enter training.

Accrediting hospitals and hospital posts

Basic surgical training may only take place in hospital posts in *hospitals* accredited by the College. Advanced surgical training may only take place in *hospital posts* accredited by the College. The College sets the criteria for accrediting hospitals for basic training and hospital posts for advanced training. It also appoints teams of College Fellows to ascertain whether hospitals/hospital posts meet the relevant criteria and makes the final decision about whether to grant accreditation.

Assessing overseas-trained surgeons

Doctors, including overseas-trained surgeons, may only practise in Australia if they are registered by one of the state or territory medical boards. Commonwealth, state and territory governments have established a system under which the College assesses whether overseas-trained surgeons wishing to practise in Australia are equivalent to Australian-trained surgeons. The College appoints assessment teams of College Fellows to assess individual applicants. The College then forwards a recommendation to the relevant medical board, which is almost invariably accepted. The recommendation will usually be one of the following:

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[2] The College conducts advanced surgical training, and assesses overseas-trained surgeons, in the following specialities: cardiothoracic surgery (heart and chest), general surgery, neurosurgery (nervous system, including brain), orthopaedic surgery (skeletal system), paediatric surgery, plastic and reconstructive surgery, otolaryngology (ear, nose and throat), vascular surgery (blood vessels) and urology (urological tract).

- that the applicant be required to complete basic and/or advanced surgical training in Australia before being registered; or

- that the applicant be required to complete a period of supervised assessment in a hospital position before being registered.

Commission assessment process

The Commission conducted an extensive public consultation process to assist its consideration of the College's application. In particular, the Commission actively sought the views of state and territory government health ministers and agencies, which are the largest employers of surgeons in Australia.

Submissions were ultimately received from nearly all health ministers, largely in the second half of 2002. These are outlined in Attachment B to this summary. Broadly, governments support authorisation being granted provided concerns held by nearly all of them regarding transparency, accountability, fairness and consistency of the College's processes are addressed.

Other submissions were received from, among others, state and territory medical registration boards, specialist medical colleges, industry associations, consumer groups, private health insurance funds and university medical faculties.

In total, the Commission received over 80 substantive submissions in relation to the College's application. An overview of all public submissions is provided in Chapter 11 of this draft determination.

Commission evaluation

Public benefit

The Commission is satisfied that the College's training and assessment processes generate a significant public benefit by ensuring that surgical training is of a high quality. High surgical training standards are likely to generate significant benefits for the community by excluding unqualified surgeons from the market, thereby contributing to:

- a lower rate of adverse outcomes from surgery leading to longer and better lives for patients; and

- reduced time in and/or fewer visits to hospital, thereby reducing costs for the public hospital system, Medicare, private health insurers and ultimately consumers.

Clearly, a range of other factors will also contribute to achieving these outcomes. This fact is highlighted by the establishment by health ministers in January 2000 of the Australian Council for Safety and Quality in Health Care to lead national efforts to improve patient safety and the quality of health care in Australia.

The second major public benefit claimed by the College is that surgeons organise and provide training on a pro-bono basis. In particular, they claim that surgeons provide pro-bono work valued at more than $230 million per annum (not including $70 million in capital costs).

To the extent that surgical training is provided on a pro-bono basis, the Commission considers that this constitutes a clear public benefit.

Training provided by surgeons in hospital hours – that is, the surgical apprenticeship – comprises over 90 per cent of the value of surgeons' pro-bono work as claimed by the College. However, some state and territory governments have submitted that surgeons are paid for this training. Others agree with the College.

The Commission is unable to form a view on this important issue given the conflicting submissions it has received. The Commission has therefore invited interested parties to provide further information to assist in resolving the matter.

However, the Commission is satisfied that surgeons provide some services on a pro-bono basis. The value of these services is in the order of $20-25 million per annum.

Public detriment

The College possesses significant influence over the number of surgeons entering surgical practice. In particular, the number of trainee surgeons is limited by the number of training posts in hospitals which meet College standards. Overseas-trained surgeons entering practice in Australia are, in practice, limited by the College's assessment as to whether they are equivalent to an Australian trained surgeon.

The College maintains that its training and assessment processes are based on the need to ensure that appropriate standards are maintained and raise no competition concerns. However, significant concerns have emerged during the course of the Commission's assessment of the College's application that its processes have been used to restrict the number of surgeons. These include:

- The Australian Orthopaedic Association, which administers orthopaedic surgical training on behalf of the College, ignoring a target for the number of orthopaedic surgical trainees determined by the Australian Medical Workforce Advisory Committee (AMWAC);[3]

- the College erecting 'invisible barriers' to overseas-trained surgeons wishing to enter practice in Australia – for example, by information booklets not being sent when requested, interviews not being held, or multiple interviews being held imposing considerable costs on applicants;

- the College not following or inconsistently applying assessment processes, unnecessarily delaying and not providing reasons for, decision about whether to recognise overseas-trained surgeons;

- concerns raised by interested parties – and particularly by several health ministers – about the existence of hospital training posts that have been accredited as meeting the College's standards alongside posts which appear to be very similar, if not identical, but which have not been accredited;

- the College penally marking a key exam taken by second year basic surgical trainees. While the College has now abandoned this marking system, it appears this exam may have been used to restrict the number of basic surgical trainees able to graduate to advanced surgical training; and

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[3] The Australian Medical Workforce Advisory Committee was established by Commonwealth, state and territory governments to calculate the number of trainee medical specialists, including trainee surgeons, required to ensure that enough specialists exist to meet community needs.

- the string of complaints received by the Commission since it began investigating the College from, for example, surgical trainees, candidates for surgical training and overseas trained surgeons, who nearly universally are unwilling to make their complaint public for fear that the College learning of their complaint would end their chances of, for example, winning a place in the College training program. This almost universal requirement for confidentiality suggests that a widespread perception exists within the medical community that the College does not necessarily administer its training and assessment processes in an appropriate manner.

The control of entry restrictions has far-reaching consequences for the Australian community. Such restrictions affect the availability, regional distribution, quality and price of surgeons' services. The Commission considers that the supply of such an important professional service as surgery is too important a community issue for the selection, training and assessment of surgeons to be left solely in the hands of the profession through the College and its Fellows.

In particular, surgeons undertaking selection, assessment and accreditation activities possess a conflict of interest. Requiring that surgical training standards, hospital training posts and overseas-trained surgeons meet high standards generates clear community benefits. However, unreasonably high standards inappropriately limit the size of the surgical profession thereby producing higher incomes for surgeons. More generally, the College's expertise is in surgical practice and techniques. It is therefore not well-placed to take into account broader community considerations such as access, distribution and affordability.

Shortage of surgeons

The need for reform is particularly important given that evidence of a surgeon shortage is now emerging. The Commission engaged Professor Jeff Borland of the University of Melbourne to examine whether the current supply of surgeons is sufficient. He found likely shortages of surgeons in a majority of surgical sub-specialties including the two largest sub-specialties – general surgery and orthopaedic surgery. A copy of Professor Borland's report is at Attachment C to the draft determination.

In addition, a number of factors suggest that there could be a severe shortage of surgeons in the coming years.. These include:

- the ageing of the Australian population, which is likely to generally increase health care demands;
- the ageing of the Australian surgical profession;
- the possibility that many surgeons are considering retiring early. The Commission understands that the College recently published a survey indicating that a substantial number of surgeons were considering doing this;
- the possibility that the demand for Australian surgeons to work overseas will increase;
- the apparent reluctance of younger surgeons, and particularly female surgeons, to work the excessive hours many surgeons have traditionally worked; and
- the implementation of the Australian Medical Association's safe working hours policy.

Again, these factors make it particularly important that unwarranted entry restrictions on

surgeons are removed and that there is greater involvement of the broader health community in the relevant decisions.

Alternative models

The Commission recognises that other alternative models for surgical training and assessment exist. For example, dental specialists are trained either in universities or the Royal Australasian College of Dental Surgeons. This contrasts with surgeons whose training is controlled by the College and does not involve universities. However, governments, who would ultimately be responsible for funding any new system, support the College continuing to administer its training and assessment processes so long as their concerns are addressed. The Commission also recognises the difficulties that would be faced in establishing a new system. Moreover, the Commission recognises that the College's processes do contribute significantly to the high standards of surgery enjoyed in Australia.

Proposed reforms

The Commission is proposing a range of reforms to the College's processes aimed at helping address concerns raised by interested parties. The reforms are intended to find an appropriate balance between the need for the College to remain substantially involved in the setting of surgical training and assessment standards given its technical expertise, while concerns such as those identified above are addressed.

Broadly, the Commission is proposing the College be required to:

- establish a review, through an independently chaired committee, of the criteria for accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training and implement such changes (if any) to the accreditation criteria as are recommended by the review (see Attachment D to this draft determination);
- invite health ministers to nominate persons available to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training);
- invite health ministers to nominate any hospitals for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation;
- introduce more timely processes for assessing hospitals and hospital posts and advise health departments, area health services, applicants and the general public of the outcome of its decisions;
- establish an independently chaired committee to prepare public guidelines on how it determines whether an overseas-trained surgeon is equivalent to an Australian-trained surgeon (see Attachment E to this draft determination);
- invite health ministers to nominate a panel of persons available to participate in the assessment of overseas-trained surgeons;
- introduce more timely processes for assessing overseas-trained surgeons and publish annually details of the assessment process;
- to the extent that they are not already, ensure that the College's processes for selecting basic and advanced surgical trainees are consistent with the Brennan principles of trainee