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Initial submission to the Bundaberg Hospital Commission of Inquiry May 2005

AMA QUEENSLAND

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Contents

1.0 Terminology

1.1 For the purposes of this submission, the term Overseas Trained Doctors (OTDs) is interchangeable with International Medical Graduates (IMGs). Both terms refer to those medical practitioners with qualifications attained outside Australia. The latter is increasingly the accepted and preferred term amongst this group of medical practitioners, and will be used predominantly throughout.

2.0 Australian Medical Association Queensland

2.1 Australian Medical Association Queensland (AMA Queensland) is the State's peak medical body representing more than 5,700 medical practitioners across Queensland. Nationally, the Australian Medical Association (AMA) represents approximately 28,000 medical practitioners. The Association represents its members individually and collectively in professional, industrial, and political matters. The AMA also considers itself to be perhaps the strongest and most effective advocate for all Australian patients. Areas of the Association's activity most relevant to the Bundaberg Hospital Commission of Inquiry (the Inquiry) include:

2.1.1 The Association negotiates grievance applications or complaints with the Medical Board of Queensland (MBQ), the Health Insurance Commission, employers (both Government and private) and their representatives. Typically, such processes include advocacy for members within the bounds of the *Medical Board Registration Act (Qld)* and *Medical Practitioners Registration Regulation (Qld)*, the *Industrial Relations Act (Qld)*, and the *Health Insurance Act (Comm)*.

2.1.2 The Association is active in policy analysis, development and advocacy for the medical profession and patients in various committees and forums in relation to public hospitals, medical registration, IMGs, workforce and professional standards. For example, the Association convenes an Ethics Committee, Public Hospital Working Party, International Medical Graduate Stakeholder Forum, Overseas Trained Doctor Committee, Joint Queensland Overseas Trained Doctor Committee, and a Combined College Chairs Committee.

2.1.3 The Association is also an advocate for patients. It welcomes enquiries, complaints or requests from the public. Indeed it receives approximately 2000-3000 telephone calls, letters, or emails a year from the public. Every complaint, even if it is directed towards a member of the Association, is investigated

and responded to.

Documents:
Nil

Proposed witnesses:
- Dr David Molloy, President, AMA Queensland
- Mr Kerry Gallagher, Chief Executive Officer, AMA Queensland

3.0 The Queensland Medical Workforce: traditional aspects, recent environmental drivers, and the critical need for IMGs

3.1 Traditionally the Queensland medical workforce comprised of graduates from the MBBS program at the University of Queensland. These doctors largely stayed in Queensland after graduating to complete their intern and registrar years. It was not uncommon for registrars in their final years to complete their studies in the United Kingdom to gain greater experience, and most then came back to the public sector in Queensland for a number of years, before changing to a mixed private and public sector role as a Visiting Medical Officer (VMO).

3.2 More recently, this continuum has morphed as a result of the frustrations of salaried doctors within Queensland Health: fewer and fewer medical practitioners stay in the public hospital system much longer than required to complete their training, and the number of privately practising doctors contribute via sessional VMO work in the public hospital system has reduced from approximately 80 per cent of the private workforce to 40 per cent.

3.3 These gradual changes in the career pattern of medical practitioners, combined with a rising demand for public health services (read ageing population and changing morbidity profiles of the population) indicated that the traditional medical workforce that once graduated from the University of Queensland could not alone satisfy the clinical demands of the public hospital system.

3.4 In recent years, three additional medical schools have been established in Queensland. The first, at James Cook University, will not produce graduates in the intern year until 2006. The other two, Bond and Griffith Universities will not produce their first interns until 2010 and 2011 respectively.

3.5 These elements have in part contributed to what is now a severe short to mid term workforce crisis.

3.6 Provider number amendments to the *Health Insurance Act* introduced under federal Health Minister Dr Michael Wooldridge in December 1996 prohibited IMGs who entered Australia with a view to permanent residency from unrestricted billing under Medicare for 10 years after gaining registration, and this *Act* further prescribed that if an IMG was granted entry then they may only serve this time in a periodically approved District of Workforce Shortage (paragraph 3.6). Restrictions

were also introduced for Australian trained graduates, who were required to participate in specialist training (including General Practice) before being granted access to Medicare rebates.

3.7 Concurrently, the number of university medical student places available nation-wide was effectively reduced by Commonwealth government funding and the number of medical graduates fell nationally.

3.8 The policies were an attempt to constrain burgeoning health budgets, and a perceived maldistribution of medical practitioners in metropolitan areas.

3.9 The Wooldridge amendments, coupled with an internationally recognised shortage of doctors, only exacerbated an undesirable doctor shortage in Australia. The policies were 'successful' in curtailing the supply of medical services, but did nothing to limit demand, and have been fundamental in producing the short to mid term medical workforce crisis in Australia.

3.10 Queensland is recognised as the state with the most acute shortage of medical practitioners, and highest utilisations of IMGs. Data from the Australian Institute of Health and Welfare shows the lowest number of doctors per head of population in Queensland[1]. This is due (in the opinion of the Association) to lower remuneration, poorer facilities, wide geographical and population spread, and the lure of the major interstate metropolitan centres - and overseas locations, for highly sought after highly competent Australian doctors where competition for quality doctors is fierce.

3.11 AMA Queensland believes that additionally that there has been a deliberate change in local specialist recruitment and employment in the public sector by Queensland Health. A private/public mix has been discouraged in traditional career patterns, which provided a reliable medical workforce being discarded in favour of a policy of employing full time specialists, particularly IMGs. This has further exacerbated the problem relating to the supply of doctors.

3.12 More recently, the Federal Government has redressed the 1996 amendments in response to the doctor shortage by doubling the number of medical student places available in Australia as a long-term solution, and streamlined immigration arrangements for IMGs wishing to practise in Australia as a short-term measure.

3.13 The two classification systems that allow IMGs to practice in Australia outside the bounds of Provider Number legislation cover functional and geographic considerations. The Commonwealth classification system, 'District of Workforce Shortage' (DOWS) enables short-term access to Medicare rebates under the *Health Insurance Act*, and considers the doctor-patient ratio in the setting. The Queensland Ministerial policy on 'Area of Need' (AON) classification enables recruitment in a non-fee-for-service appointment for positions (not regions) unable to attract and retain doctors, or for other purposes such as to enable training. The interplay of two layers of government in assigning doctors to AON or

[1] Australian Institute of Health and Welfare, *Australia's Health 2004,* Canberra: AIHW.

DOWS is complex and its implementation is often inconsistent. Indeed at times there appears to have been some political manipulation of these provisions.

3.14 Historically, AON or DOWS were in rural and regional locations, such as those attracting a Rural Remote, Metropolitan Areas (RRMA) classification of four through to seven, however, increasingly positions are unfillable by Australian recognised medical practitioners in major metropolitan centres. RRMA is a classification system developed by the Department of Health and Ageing (DOHA) derived from Australian Bureau of Statistics that allocates regions to the following numerical categories:

1.Capital Cities
2. Other metropolitan centres (urban centre population > 100,000)
3. Large rural centres with population 25,000 - 99,000
4. Small rural centres with population 10,000 - 24,999
5. Other rural areas with population < 10,000
6. Remote centres with population > 5,000
7.Other remote areas with population < 5,000

3.15 The Medical Board of Queensland (MBQ) predicates approval for IMGs to practice under these AON (Section 135 of the *Medical Practitioners Registration Act*) classifications via dedicated and sometimes conditional registration.

3.16 In 2004, the Federal Government eased immigration arrangements through the Department of Immigration, Multiculturalism, and Indigenous Affairs (DIMIA) under the *Strengthening Medicare* policy to extend the temporary medical 422 visa period allowable for IMGs from two years to four years.

3.17 AMA Queensland takes the position that there is an immediate, acute, and ongoing need for IMG services in Australia: in fact, a resolution of AMA Queensland Council in 2001 declared IMGs *'a vital resource'*. However, the highest standards of medicine must be upheld within the community, and extend throughout the State. This standard must apply to all doctors whether Australian or overseas trained.

3.18 In considering appropriate outcomes from the Inquiry, the Association urges the Commission to consider the public expectations of the health system and the medical workforce implications across the state, particularly in rural and regional areas.

Documents:
Nil

Proposed witnesses:

- Dr David Molloy
- Dr Bill Glasson, President, AMA
- Dr Dana Wainwright, Physician (RBH) and Councillor, AMA
- Dr Ross Cartmill, VMO Urologist (PA) – subject to availability (Dr Cartmill

will be overseas for part of the Commission's duration), or Dr Russell Stitz, VMO Colorectal Surgeon (RBH) and Chair, Royal Australasian College of Surgeons
- Mr Kerry Gallagher

4.0 AMA Queensland Submission

4.1 In order to address the issues in the Terms of Reference, this submission gives a history of AMA Queensland's involvement in matters relating to IMGs (including positions on various matters) up to 20 May 2005. The Commission's staff may wish to use these issues to ascertain requirements for further information or evidence.

4.2 The submission identifies and includes for the Commission's consideration a number of relevant pieces of correspondence, reports, other documents, and nominates representatives that may be useful to the Commission. This submission in all probability may be the first of a number of submissions over the course of the Commission's investigations. It is expected more information will be supplied as it becomes available or is sought by the Commission.

4.3 This submission includes information on the relevant activities and realised concerns of the Association in the years leading up to the Bundaberg Hospital Commission of Inquiry. The information itself pertains to perceived inadequacies in the MBQ vetting procedures of IMGs, that the Association has constantly feared may precipitate a situation such as the one at hand. This submission shall present information on these procedural and systemic concerns – rather than any specific information regarding Dr Jayant Patel's registration with MBQ and appointment to Bundaberg Base Hospital.

4.4 Whilst it is plausible, and in fact probable, that individual members of the Association were aware of disruption or complaints at the Bundaberg Base Hospital, AMA Queensland was not alerted as to the emerging situation in any manner – either through complaint to the Association, or the seeking of industrial support, or political advocacy - until the press headlines began to surface. AMA Queensland was unable to make contact with Dr Patel when he was named in Queensland Parliament by Rob Messenger, and noted that Dr Jayant Patel was not a member of AMA Queensland.

4.5 As suggested in the Commission's letter of 3 May 2005 it would be appropriate, therefore, that the appearance of AMA Queensland members and officials before the Commission is constrained to the limitations of the Terms of Reference applicable, and to where the AMA can be relevant to a particular stagy of the Inquiry.

Documents:
Nil

Proposed witnesses:

- Dr David Molloy
- Mr Kerry Gallagher

5.0 IMG Advocacy

5.1 In November and December 2002, AMA Queensland actively sought input from authorities to develop plans to deal with the unfolding IMG crisis as described above. Both Queensland Health and MBQ, and DOHA agreed on the principles for forming the committee, the Joint Queensland OTD/TRD Committee (see attachments B through F).

5.2 The Joint Queensland OTD/TRD Committee came to points of agreement about failings in the system, but neither state of federal Government accepted accountability for the shortfalls identified.

5.3 In July 2003, Dr Denis Lennox of Queensland Health (Queensland Health representative on the Joint Queensland OTD/TRD Committee) wrote a proposal *"Management of International Medical Graduates"* to improve the management process for IMGs and presented it to the Committee. The paper gave AMA Queensland a perception that Queensland Health was serious in engaging in IMG reform, and it stimulated considerable discussion. Many principles in the paper were strongly supported by AMA Queensland. Queensland Health did not endorse the paper (see attachment G and H).

5.4 A key element of the Lennox Paper was a greater Government (Federal and State) investment in the services provided by the Centre for Overseas Trained Doctors to ameliorate concerns regarding ineffective IMG processing. In August 2003, when AMA Queensland learned that Government funding for the Centre was collapsing, the Association approached the Government to remedy this (see attachment I).

5.5 AMA Queensland expanded the involvement of the stakeholder group to lend more weight to its lobbying. This group became known as the IMG Stakeholder Forum. Over the course of time, this group continued to expand to include Queensland Health, Medical Board of Queensland, Royal Australian College of General Practitioners, Australian Medical Association, Department of Health and Ageing, Australian College of Rural and Remote Medicine, Queensland Divisions of General Practice, General Practice Education and Training, the University of Queensland, Centre for Overseas Trained Doctors, and the Rural Doctors Association of Queensland (for minutes refer to attachments T and U under section 8) .

5.6 Recommendations from this group were forwarded to the Federal Overseas Trained Doctors Reference Group. Summaries of these meetings can be obtained on the DOHA website www.health.gov.au.

5.7 The non-government medical practitioner parties in the group adopted a revised AMA Queensland position paper, as it's own position paper on IMGs in July 2004. Both government representatives refrained from endorsing the paper because of the commitment implications it

contained. The position statement received media attention (see attachments J and K).

5.8 AMA recognised problems in the Australian recruitment of IMGs and adopted their own position on the issue during 2004. This is available on the AMA website at www.ama.com.au.

5.9 In addition to this collaborative work on finding solutions to the vetting and support of IMGs, AMA Queensland has lobbied both MBQ, Queensland Health, and the Premier to improve various aspects regarding IMGs in Queensland. AMA Queensland's initiatives have been met with little response other than a physical attendance at meetings by senior Governmental and MBQ figures. Subsequently AMA Queensland forwarded letters to both the Health Minister and Premier to reinforce the Association's claims, and warning of the potential political embarrassment ensuing (see attachments I and L).

5.10 Regardless, until the Patel case, both Governments have been unwilling to invest in a system that will vet, train, and support IMGs entering practise in Australia.

5.11 AMA Queensland has long recognised that the 'importation' of IMGs for short, medium, or long term has been flawed. Given ineffective and inefficient processes and lack of positive response by those agencies ultimately responsible for the health outcomes of Queenslanders, AMA Queensland considers that, whilst unfortunate, the Dr Patel situation was largely inevitable.

Documents:

A. Minutes, OTD/TRD Sub Committee (22 August 2002 and 18 December 2002)
B. Badly Trained GPs add to state health crisis (17 December 2002)
C. Correspondence, QH to AMA Queensland (6 December 2002)
D. Correspondence, MBQ to AMA Queensland (10 December 2002)
E. Minutes, Joint Qld OTD/TRD Committee (2 June 2003)
F. Minutes, Joint Qld OTD/TRD Committee (10 July 2003)
G. Queensland Health report, *Proposed Management of International Medical Graduates* (July, 2003)
H. Correspondence, AMA Queensland Rural Committee (9 September 2003)
I. Correspondence, AMA Queensland to Health Minister (11 September 2003)
J. Position Statement, IMGs, (July, 2004)
K. Imported Doctors Face Stiffer Rules, Courier Mail (19 August 2004)
L. Correspondence, AMA Queensland to Premier (27 October 2003)

Proposed witnesses:

- Dr David Molloy
- Dr Claire Jackson, Former RACGP Chair, and Co-Chair of IMG Stakeholder Forum
- Dr Steve Hambleton, President Elect and Chair of OTD Sub Committee, AMA Queensland
- Dr Bill Glasson
- Dr Ross Maxwell, President, Rural Doctors Association of Queensland and

Councillor, AMA Queensland
- Dr Yan Perumal, IMG (Mackay) and member, AMA Queensland OTD Sub Committee
- Mr Kerry Gallagher

6.0 Vetting, mentoring and support of IMGs

6.1 AMA Queensland maintains that there are a significant number of excellent IMG doctors working in Australia and the situation that has arisen surrounding Dr Patel's unfortunate and erroneous registration and recruitment by Queensland Health is not a reflection of the quality service provided by many hundreds of other IMGs. However, the Association concedes, and indeed promotes that there are a number of problems with the vetting, mentoring and support of IMGs that, in turn, lead to inconsistencies in the competence of IMGs practising in Australia.

6.2 In April 2005, the DOHA produced an informative background paper, titled, *Assessment of Temporary Resident Overseas Trained General Practitioners* that the Commission may find useful as an overview of the entry points to practice in Australia, registration requirements, and the current assessment processes and issues (see attachment M). The paper raises the issues that apply to the broader spectrum of IMGs (including non General Practitioner specialists) that are briefly outlined in the following paragraphs.

6.3 Historically, IMGs wishing to practice in Australia were from 'western' countries with similar medical training regimes e.g. England, Ireland, United States, Canada and New Zealand. More recently the IMG pool consists of a broader spectrum of candidates from over 70 countries where the original medical qualifications where obtained in places such as the African continent and the Pacific region, as well as from India, and eastern European countries.

6.4 Across jurisdictions, areas of specialisation, and geographical employment there are inconsistencies in the standards and support applied to IMGs practising medicine. In general terms in metropolitan areas both supervision and upskilling opportunities are reasonable, particularly now with the establishment of the Skills Centre on the Herston Campus. There are issues, however, with the Centre, particularly that of funding for trainees and low utilisation for training purposes and it may be worthwhile for the Commission to check utilisation rates. In any case, the potential for supervision and these opportunities quickly fall away in regional areas, while in rural and remote areas, they are virtually or entirely non-existent.

6.5 Currently there are many entry points for IMGs commencing practice in Queensland. Recruitment can occur through private or Government- funded recruitment agencies, or directly to Government and private health service employers. There is no uniform standard screening process applied across these entry points. The current but

unregulated methods that are used include simple Curriculum Vitae scrutiny, simple reference checks, and possibly telephone interviews. These methods are neither mandatory nor exhaustive. There needs to be a uniform national system introduced quickly that will ensure guarantees of qualification and competence to all IMGs entering Australia. Queensland Government and MBQ have moved to introduce interim standards that will provide protection to the public. Concurrently, the Federal Government is pursuing mechanisms to introduce offshore access to an online assessment tool equivalent to the Australian Medical Council's Multiple Choice Questionnaire, and to encourage the nationalisation of standards applied by each State's Medical Board.

6.6 As yet in Queensland (although there are now moves to tighten the requirements in this area) there is no specific obligation on the IMG during the length of their Visa period to achieve Australian recognition for qualifications (if the IMG has no view to permanent residency), no statutory assessment, induction, support, or mentoring scheme offered. That is to say that a number of immigration and registration anomalies exist which enable an IMG to enter and continue to practise in Australia for a number of years without entering into or providing proof of accomplishment in achieving Australian qualification or its equivalency.

6.7 Many IMGs are placed in positions under special purpose registration with no identified process or access to an Australian trained doctor, or one with Australian equivalent qualifications. Of course to overcome this aspect there will need to be, amongst other less important elements, financial support from government.

6.8 AMA Queensland has long maintained a consistent position on these aspects.

Documents:

M. *Assessment of Temporary Resident Overseas Trained General Practitioners*, Department of Health and Ageing (April, 2005)

Proposed witnesses:

- Dr David Molloy
- Dr Steve Hambleton
- Mr Kerry Gallagher

7.0 Language and cultural skills of IMGs

7.1 The ethnically diverse pool of IMGs entering Australia (see paragraph 6.3) has resulted in concerns over the communication skills of some IMGs working in Queensland as well as their understanding of local and national cultural issues.

7.2 Of particular and repeated note in all of the various IMG committees involving AMA Queensland, was concern over the poor language skills

of a number of IMGs practising in public hospitals.

7.3 In September 2003, these concerns and evidentiary examples were detailed to MBQ in a report authored by the then University of Queensland's Centre for Overseas Trained Doctors.[2]

7.4 Subsequently, MBQ introduced the requirement for applicants to have completed and passed the International English Language Testing System (IELTS), which will go some way to ameliorating concerns over the English language capabilities of IMGs. AMA Queensland understands that MBQ has or is about to raise the required score attained by IMGs in IELTS to bring Queensland into line with nationally consistent standards. Some concerns of the efficacy of the IELTS's ability to assess language competence in a medical context remain. These are also detailed in the COTD's report.

7.5 In addition to language skills there has been comment made through various AMA and telephone calls to the AMA that some IMGs show no understanding of cultural issues that may involve contraception or Indigenous practices.

Documents:
Nil

Proposed witnesses:
- Dr David Molloy
- Dr Steve Hambleton
- Dr Claire Jackson

8.0 Medical Board of Queensland

8.1 MBQ is held to be an independent statutory body funded by doctors registration fees and established under the *Medical Practitioners Registration Act 2001* to regulate medical practice, and medical practitioners in Queensland. Its functions are to:

- Keep a register of Medical Practitioners and Specialists.
- Determine applications for the registration of Medical Practitioners.
- Investigate complaints made about Medical Practitioners and to take disciplinary action where appropriate.
- Regulate the practice of Medical Practitioners in Queensland and exercise a general oversight over the standards of practice in Queensland.
- To publish and distribute information concerning the *Act* and its subordinate legislation to Medical Practitioners and other interested persons.[3]

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[2] Recommendations to the Medical Board of Queensland on the English Language Testing Requirements of Overseas Trained Doctors, Centre for International Medical Graduates (previously the Centre for Overseas Trained Doctors)

[3] Medical Board of Queensland, www.medicalboard.qld.gov.au

8.2 The current State Government, specifically the previous Health Minister, introduced the current legislation administered by MBQ.

8.3 MBQ is self-funded entirely from registrants' subscription fees, and as the largest Board within the Office of Health Practitioner Registration Boards (OHPRB) in Queensland, and could be considered to subsidise the costs of running the other 12 practitioner Boards via economies of scale. The fee for registration for doctors through the MBQ is the highest of all health practitioners registered through the OHPRB.

8.4 Theoretically, there is no jurisdictional link between Queensland Health and MBQ, which is purportedly an independent, statutory authority. However, in practice the Board is responsible to the Minister for Health, which certainly gives potential to the department to apply pressure to the Board to register special purpose registrants under the *Act*, and to secure and maintain controversial 'deeming' provisions. Allegations have been made that this pressure has resulted in a number of unusual and often inconsistent decisions, and preferential treatment in terms of the speed of application processing. However, AMA Queensland cannot offer any documentary evidence to verify these claims.

8.5 With regard to the deeming process the Medical Colleges have raised with AMA Queensland concern that the practice may give IMGs access to patients and procedures that would not be given to Australian graduates of the same skill level. The deeming process occurs under s143 of the *Medical Practitioners Registration Act,* which MBQ has interpreted to provide for a person to be registered to practice the profession in a specialist area and to be taken for a specialist for that purpose without actually being registered as a specialist. MBQ purportedly follows the pathway outlined in *The Users Guide: Assessment Process for Area of Need Specialists*[4] developed by the Australian Medical Council, which mandates that the Medical Colleges must make a recommendation regarding an IMG for AON placement based on documentary evidence supplied only. It would seem that this process is not adhered to in its intended fashion in Queensland, where the Colleges may return the documentation outlining that the applicant is suitable for appointment within the bounds of supervision and subject to collegial clinical assessment only. MBQ takes this conditional approval as sufficient to 'deem' the IMG a specialist, and the prescribed supervision and assessment is rarely provided. If deeming were used as intended (i.e. in full cooperation with the Colleges), it could be a satisfactory process.

8.6 As the largest, most inclusive, and truly independent medical organisation in Queensland, AMA believes it should have at least three direct appointees on the MBQ. This would ensure some direct opportunity for the concerns of the State's major medical association to be as least discussed by the MBQ. In practice AMA Queensland

[4] *The Users Guide: Assessment Process for Area of Need Specialists*, Australian Medical Council, http://www.amc.org.au/forms/AONUsersGuide.pdf

must nominate a panel of doctors to the Health Minister. In the past the Minister has been free to accept or reject these. Presently AMA Queensland has only two Association nominees on the Board despite the lack of a surgeon. The Minister has opted not to appoint a third AMA Queensland nominee.

8.7 Financial independence of the medical regulatory authority is paramount to clarify the separation of power between the MBQ and the State health department. Similarly, a separation of functional power should also be evident. In the opinion of the Association, it is the latter that is lacking in Queensland.

8.8 AMA Queensland has repeatedly raised with MBQ its concerns over the vetting, checking, mentoring, and supervision of IMGs. In the Association's submission to MBQ during the consultation period for the development of their *Strategic Plan 2003-2007*, AMA Queensland's initial comment was that resource allocation needed to be directed toward assessment of IMGs. Direct correspondence between Presidents of AMA Queensland and office bearers at MBQ has raised the Association's concerns since that submission. Additionally, at successive meetings and forums AMA Queensland has challenged the veracity of the registration process for IMGs registered with MBQ (refer to attachments N through U).

8.9 In 2001, AMA Queensland devised a survey to retrieve data from IMGs on their perceptions about failings in the system. AMA Queensland required the Board's assistance in the circulation of this document, but was unable to secure this.

8.10 When challenged on the thoroughness of verification of qualifications submitted with registration applications, MBQ indicated that whilst every care is taken no 'fool proof' method exists (Refer to attachment T, p6).

8.11 It is the Association's belief that undoubtedly Dr Patel sought to deceive the Board in his registration application, but that the circumstance highlights the not fully effective vetting, standards, mentoring, and supervision practises in the recruitment of IMGs. These practises are not quarantined to the public hospital system. The fact that there was no surgeon on the MBQ, while not guaranteeing a different outcome to Patel's registration, certainly made his registration process less likely to attract a full critical specialist examination.

8.12 It is the duty of an Administration Officer to complete checks on registration applications to MBQ and provide recommendation to the Registration Advisory Committee (RAC) of MBQ about each potential registration. With respect, it is unlikely that an A03 level employee is competent to critically analyse a proposed registrant's ability to practise in a certain clinical position.

8.13 MBQ has detailed to AMA Queensland that the interview conducted by a member of the Board as a final step in the credentialing assessment for registration is 'short and of a non-clinical nature'. (Refer to attachment T p7).

8.14 MBQ has detailed to AMA Queensland in meetings established to discuss IMG matters that special purpose registration provisions in the *Medical Practitioners Registration Act* are established to address workforce shortages and that registration efforts must not be 'contrary to the public need' (read public expectations of access to a local medical practitioner). In addition MBQ has advised AMA Queensland that MBQ does not have latitude to reject IMGs (refer to attachment U). It is the Association's opinion that the Ministerial abuse of AON authority could occur in the current environment when the State is unable or unwilling for whatever reason to recruit a suitably qualified Australian or equivalent trained medical practitioner. AON provides a mechanism that allows Queensland Health to remain a non-competitive local employer.

8.15 With respect, it may be that MBQ feel absolved of stringent clinical vetting as within MBQ's regulatory powers, special need or AON registrants may have conditions on their registration. However MBQ has no ongoing active interest in IMGs once registered in an area of need unless an official written complaint is raised. It is AMA Queensland's understanding that MBQ granted Dr Patel registration with the qualification that he be under the supervision of a specialist surgeon. At the time Bundaberg Base Hospital did not employ a specialist surgeon to undertake the supervision of Dr Patel, and (perhaps perversely) Dr Patel went on to train medical students throughout his employment at Queensland Health. It is the Association's opinion that when granting registration under those terms the Board must ensure the qualification as well as the conditions are complied with, otherwise MBQ is failing in its statutory obligation to the doctor and the public it serves to protect.

8.16 Prior to the Inquiry beginning AMA Queensland was provided with evidence that Queensland Health was alerted to Dr Patel's activities as early as July 2003 but may have failed to act. This evidence has been passed to the Inquiry for further investigation.

8.17 AMA Queensland continues to uphold the public position that the learned medical colleges are the appropriate standard-setters and assessors of medical competence in Australia and that all registration of IMGs where some doubt exists must be completed through a mutual MBQ/specialist college recognition process.

8.18 The proposed measures announced by Queensland Health to institute one to three months of supervision, software driven internet searches of applicants for registration, certification of qualifications, and clinical interviews of applicants via MBQ go some way towards meeting the long-term position of AMA Queensland. They are, unfortunately late. When AMA Queensland raised the suggestion to offer registration for IMGs conditional on supervision (at the OTD Stakeholder Forum on 21 April 2004) the meeting was advised by MBQ that this was not possible (refer attachment T, pp5-6) - yet these are now currently being proposed.

Documents:

N. Correspondence AMA Queensland to MBQ re IMGs (13 November 2002)
O. Submission to MBQ from AMA Queensland on MBQ Strategic Plan (November 2003)
P. Correspondence AMA Queensland to MBQ re IMGs (13 November 2002)
Q. Correspondence MBQ to AMA Queensland re IMGs (10 December 2002)
R. Correspondence AMA Queensland to MBQ re IMGs (17 December 2002)
S. Correspondence AMA Queensland to MBQ re IMGs (9 May 2003)
T. Minutes, OTD Stakeholder Forum (21 April 2004)
U. Minutes, IMG Stakeholder Forum (23 November 2004)

Proposed witnesses:

- Dr Steve Hambleton
- Dr Claire Jackson

9.0 Queensland Health

9.1 Within the terms of Inquiry, AMA Queensland provides the following information regarding Queensland Health as a preliminary comment only. The Association intends to provide further information and documentary evidence in relation to Queensland Health, as soon as is reasonably possible within resources available to AMA Queensland.

9.2 Queensland Health has declared all of Queensland as AON and that includes positions within Queensland Health. In AMA Queensland's opinion, Queensland Health cannot recruit nor retain medical staff because of:

- excessive workloads across all levels and specialist groups;
- systems inability to properly supervise junior doctors;
- district management that is unresponsive to the needs and concerns of medical staff;
- a bullying culture and a disrespect of medical staff regarding the delivery of clinical services; and
- an uncompetitive salary and conditions package compared to other States and countries.

In the opinion of the Association, Queensland Health has appropriated a mechanism whereby it can ignore its recruitment and retention problem. Thus, declaration of AON status allows Queensland Health to avoid its responsibility to provide the best possible health care it can. AON status has been the 'green light' to recruit IMGs to positions without appropriate clinical skills and experience.

9.3 On recruiting the IMGs, Queensland Health has then placed them in positions where there is little or no supervision. Comparative examples are available in rural DoWSs where GPs have been placed without support. Queensland Health has not provided the new medical officers with orientation or induction exercises. Furthermore, Queensland Health has not provided the medical officer with any cultural awareness that particularly applies to medical officers from

non-English speaking countries. Reciprocal cultural awareness is not provided to (local) doctors so they may be aware and understand the cultural background and values of the IMG.

9.4 Queensland Health's obligation, as the employer of Dr Patel, was to provide a specialist surgeon to supervise him, as prescribed in the conditions of his registration by the MBQ. Failure to acknowledge and fulfil this responsibility led to Dr Patel ultimately being appointed as the Director of Surgery while still retaining registration that required his supervision by a specialist. It is AMA Queensland's understanding that during his period of employment as the Director of Surgery, Bundaberg Hospital did not employ a specialist surgeon.

9.5 Waiting lists should be a process that is vital in the safe and effective management of patients and resources. Waiting lists in Queensland comprise three categories for treatment, from the highest priority, Category One (requiring immediate treatment), to the lowest category, Category Three. Unfortunately waiting lists have become merely a political tool and have been attempted to be used to indicate the efficiency and effectiveness of the public health system. Unfortunately, waiting lists now are almost meaningless as a measurement tool for any aspect of the public health system. Generally Category One is respected but the other categories are manipulated by managers. Managers have been reported to change the treating doctors original categorisation or the lists are further manipulated by restricting the patients' access to an initial consultation as an outpatient - 'the waiting list for the waiting list'.

9.6 In 2002, this manipulation of waiting list data became the subject of AMA Queensland's *Survey of Hospital Clinicians*, and precipitated AMA Queensland's request that both sides of politics commit to a full investigation of publicly presented waiting list data during the February 2004 State Election. The Beattie Government agreed to implement this audit as part of its election commitments, but as yet the audit is in the formative stages only.

9.7 AMA Queensland understands Dr Patel's workload and output created a very impressionable result for the Bundaberg area waiting list.

9.8 Complaints processes are a vital area for the Commission to consider. AMA Queensland has yet to compile input for the Commission on this area, and will submit information in a subsequent paper to the Inquiry.

Documents:

V. Report on Survey of Hospital Clinicians, AMA Queensland (2002)

Proposed witnesses:

- Dr David Molloy
- Dr Nicholas Buckmaster, Full time salaried Physician (Gold Coast) and President, Australian Salaried Medical Officers Federation Queensland (ASMOFQ)

- Dr Russell Stitz
- Dr David Hewett, Gastroenterology Registrar, RBH and Chair, AMA Queensland Council of Residents and Registrars
- Dr Les Nathanson, General Surgeon, VMO
- Dr Steve Hambleton

10.0 Visiting Medical Officers (VMOs)

10.1 Full time medical staff, whether they are senior medical officers or junior medical officers, provide the core of clinical services within the public hospital system. The third group vital to this medical workforce are VMOs. Queensland Health would not be able to provide the quality and variety of clinical services that it does, without VMOs.

10.2 VMOs play an integral role in Queensland's health system. VMOs comprise general practitioners, specialists and senior specialists who work principally in the private but do varying 'sessions' in the public sector. They are at the heart of what was once a vibrant public health system and high-class medical education and training forum. Queensland Health will be able to produce data for the Commission that shows a decline in the numbers of VMO sessions occurring in the system. There are approximately 850 VMOs engaged by Queensland Health who work on average three sessions per week. The greatest numbers of VMOs are in the combined fields of surgery where they balance their hectic private practice with their often lifelong commitment to the public health system and teaching of junior colleagues. VMOs provide vital world-class training for undergraduates and junior doctors. In addition, like their fulltime colleagues, they participate in important research projects which can effect significant improvements in health outcomes over the long term.

10.3 Without VMOs in the system, there is a real concern that the number of fulltime hospital doctors would not be able to service the health needs of the Queensland public. In addition, without VMOs junior doctor training will suffer and Queensland's ability to graduate doctors in the required numbers, and specialists in relevant categories, will be seriously impaired. Quality research projects, now essential budget supplements for many southeast Queensland hospitals, would also be endangered.

10.4 Over the last two decades the relationship between the AMA Queensland's VMO Committee (the representative body for VMOs across the state) and Queensland Health has been rocky with new lows being set at every three-year agreement negotiation. It is felt that the Queensland Government and Queensland Health does not value the input of VMOs and constantly attempts to make unreasonable comparisons with fulltime staff specialists. There is little recognition of the difficulty of managing the demands of both the private and public sector and unwillingness of VMOs to drop their

private commitments and return at short notice to the public hospital system or to be on call at what the public would consider ridiculous rates. The VMO Committee now views new approaches by Queensland Health suspiciously. The approach Queensland Health has displayed in recent times to all medical staff and towards VMOs in particular, has caused frustration among VMOs, and left them with the feeling they are not valued. This low morale has been reinforced by unnecessarily adversarial Industrial negotiations, which are both tedious and ultimately ineffective in terms of both addressing specific needs and improving morale. Some specific examples include:

10.4.1 In 2002, after 12 months of negotiations which were repetitive and unsatisfactory Queensland Health placed a 'Directive' on VMOs - the ultimate 'bullyboy tactic', as described by the VMO Chairman at the time in a letter to his colleagues.

10.4.2 In 2005 Queensland Health has not shown its commitment to VMOs through a revised negotiating process dealing with a range of terms and conditions. To date they have not negotiated with what the Association believes to be good faith and in an genuine attempt to deal with VMO issues. Indeed presently the Premier personally has the VMO offer and has had it for over a month and he has done nothing to resolve this vital issue. There is no current VMO agreement and yet the need for VMOs in Queensland has never been greater.

10.4.3 The VMO Liaison Committee, established under the 2001 VMO Agreement, has met on numerous occasions and senior and middle management of Queensland Health attend. It appears that the process merely pays lip service to the requirement for real consultation and action to prevent isolated 'problems' turning into major, statewide, issues. Many of the Agenda items remain the same - because Queensland Health has not satisfactorily completed the action items it committed to. The minutes are repetitive - AMA Queensland raises the same issues again and again, because Queensland Health isn't attempting to rectify them.

10.4.4 VMOs constantly have their clinical decisions impacted upon by middle and senior level managers who are not concerned with public health outcomes, but with budget bottom-lines. Simple examples of this include: rearrangement of Intensive Care Unit priority (decision made by an administrator) leading to a cancellation of surgery; refusal to pay hours as required for patient care on a clinical basis, in deference to an award condition requiring a minimum and ultimately cheaper 'block' of time requirement, and more examples of unprofessional behaviour including 'leaning on' VMOs to reduce sessions to reduce annual surgical costs, or forcing VMOs to take leave during an enforced closedown time (e.g. Christmas).

10.4.5 The current focus on upskilling nurse practitioners, which completely ignores the large population of GPs, particularly in

regional and rural Queensland, whose re/involvement in the public sector would bring immeasurable rewards.

10.4.6 Sourcing specialist medical and surgical practitioners from the private sector in Queensland would appear to AMA Queensland to be a simpler option than recruiting from overseas and the public/private interface would bring also many benefits to the public as well as to the medical community. VMOs are clearly required as supervisors and mentors for IMGs and should never be replaced by IMGs as has occurred in situations in Queensland.

10.4.7 The Queensland system clearly needs a reinvigoration of VMOs in all Districts and this will only happen once Queensland Health re establishes integrity and credibility of the role played by the medical workforce within its hospital system. Decisions on quality clinical care etc cannot be made without critical input in these decisions. Like full time medical staff, VMOs are an essential part of those process and should be part of the decision making process. This reinvigoration will only occur once District management realise that there are some clinical services that can only be provided in the public hospital system by VMOs.

10.4.8 In other circumstances VMOs complement the role of full time hospital specialists to provide a comprehensive array of clinical services. VMOs also are important in that they provide an on call service with their full time medical staff. In particular, rural VMO GPs provide valuable assistance and relief to the full time medical staff. VMOs also provide great stability in that they give and have their practices in the area of the hospital. This stability cannot be found to the same level from any other medical group.

10.4.9 The outcome for VMO Agreement negotiations has always been an offer (or imposition) of terms and conditions well below what VMOs can access in the private sector. Queensland Health know that VMOs have a traditional and principle based commitment to public hospitals and have continued to 'milk' that through successive negotiations. A review of the comprehensive submissions made by the VMO Committee and comparisons with 'negotiated' outcomes will reveal the vast differences in that reasonably claimed and that paid by Queensland Health.

10.4.10 In the mid 1980's, Mackay Base Hospital had a large compliment of VMOs. Anaesthetics, obstetrics and gynaecology and orthopaedic services were essentially sustained by VMOs. Since then the Hospital has alienated VMOs to extent that the VMOs in those specialties could no longer work at the Hospital. The VMOs have left citing a variety of reasons but the main issues were treatment by local management, inefficient theatre processes, lists being cancelled at short notice and poor

communication.

10.4.11 By poor management of VMOs and the resultant decline in VMO numbers Queensland Health has found itself more dependent than ever on IMGs to fill positions that could be serviced (on a sessional basis) by specialists from the local private sector. The role of the IMG should be supported and enhanced by local VMOs, and not be as a replacement for consultants deemed by Queensland Health to be too expensive. The situation of Dr Patel clearly evidences this.

Documents:

W. VMO minutes and log of claims (to be supplied to the Commission)

Proposed witnesses:

- Dr Ross Cartmill (presently overseas) or alternatively:
- Dr Russell Stitz
- Dr David Hewett
- Dr Chris Blenkin, VMO Orthopaedic Surgeon, and Chair of Orthopaedics Association of Australia.
- Dr Alex Markwell, Senior House Officer (RBH)

11.0 Other elements for disclosure to the Commission

There are a number of areas of AMA Queensland's related activities and business that should be noted when considering this submission.

11.1 Approximately 370 members of AMA Queensland are IMGs. This figure is a best estimate excluding medical practitioners who have been practising in Australia for a prolonged period with overseas qualifications from a western region that by all reasonable standards would not be considered an 'IMG' either by themselves, or by the public.

11.2 Whilst AMA Queensland maintains a cordial relationship with Queensland Health hierarchy in achieving mutual public health goals, AMA Queensland's charter to lobby and negotiate with government on public health, funding, and industrial issues means that at times the relationship can be adversarial. Recent examples of work in this genre include the Blackspot campaign (see attachment X), the 2004 Election Campaign, VMO agreement negotiations, salaried doctors Enterprise Bargaining negotiations, and a professional and cooperative relationship with ASMOFQ.

11.3 Conversely, Queensland Health also sponsors a number of AMA Queensland public health initiatives including Rural Health Week, the AMA Health and Lifestyle Expo, and Family Doctor Week.

11.4 AMA Queensland puts forth nominations for election to MBQ, and many of the medical practitioner members of the Board will also be members of AMA Queensland, by personal choice.

11.5 AMA Queensland represents individual members in registration matters with MBQ.

11.6 AMA Services Queensland is a wholly owned business subsidiary of AMA Queensland that provides fee for service recruitment of staff (including medical graduates from the international market), training, and practice management for the medical profession. It is necessary to highlight this fact to the Commission as a relevant commercial activity with an association with AMA Queensland, as a significant number of staff recruited for either General Practice or Hospital roles are IMGs.

11.7 Being associated with AMA Queensland, although it is a separate company with its own Board of Directors, has provided AMA Services Queensland with intimate knowledge of the shortfalls in some IMG recruitment, including the 'Laissez faire' approach to monitoring, assessment, and training afforded by both Queensland Health and MBQ. Subsequently, the company upholds the highest vigilance in the quality of candidates recruited. Only four to five per cent of IMG applicants to the company are accepted as potential candidates for positions in Queensland, and not all of these are eventually recruited.

11.8 However, in reading the MBQ's report and supplementary report on the registration of Dr Jayant Patel, it would appear that it was not necessarily the actions of a recruitment agency that resulted in the Bundaberg crisis, but rather the inattentive actions of MBQ staff, coupled with the deceptive intent of Dr Patel.

Documents:

X. *Blackspot Audit* Report, AMA Queensland. This document is too large to append via email transfer with this submission, but is available for electronic download from http://www.amaq.com.au/docs/Blackspot.pdf.

Proposed witnesses:

- Dr Bill Glasson
- Dr David Molloy
- Dr Steve Hambleton
- Mr Kerry Gallagher

12.0 AMA Queensland representation

12.1 In the first instance the Association would seek leave for the President and Chief Executive Officer of AMA Queensland to appear as amicus in the presence of Counsel before the Commission.
At the time of writing (and as requested) available dates in the suggested period, three weeks commencing Monday 23 May 2005 are as follows:

- Dr David Molloy: Tuesdays after 1pm, 24 and 31 May, and 7 June 2005.
- Mr Kerry Gallagher's availability is more flexible with notice. He

will be attending the AMA's National Conference in Darwin on 25 through to 29 May 2005.

12.2 Whilst the Association wholly supports the Inquiry and will take every means possible to accommodate the Commission, it is necessary to consider that Dr Molloy's availability (and indeed that of other medical practitioners nominated throughout this submission) outside the times advised above is limited, and will result in disruption to patient scheduling and treatment.

12.3 The Commission may wish to note that Dr Steve Hambleton will succeed to the position of President on 3 June 2005, after which time the Commission may wish to engage with him as the Principle Office Bearer. Dr Hambleton also serves in the role of Chair of the IMG Stakeholder Forum, and prior to becoming Chair earlier in 2005 attended as an ordinary member.

12.4 Throughout this submission, a number of other representatives have been nominated as appropriate witnesses for the Commission to more specifically detail accounts relevant to certain issues and positions, such as VMOs, rural and regional practice, collegial matters, Residents and Registrars etc.

13.0 Recommendations

As a result of AMA's involvement, as a significant medical group, and as a result of detailed close observation and consideration of the Queensland health system the Association submits these recommendations for consideration:

13.1 Regulatory structure

- IMGs should only be allowed to practice to their Australian medical specialist college assessed and demonstrated level of training and competence. This must be enforced and monitored;
- IMGs should be supervised and supported according to their level of demonstrated competence, by fully Australian qualified doctors;
- IMG registration 'concessions' should only occur for valid reasons allowable as part of their training and skills level and not because of a perceived demand;
- Regulatory system needs to be more responsive to clients;
- Regulatory system must be designed to be 100 per cent accurate;
- Irrespective of the requirements on the recruiting agencies the ultimate responsibility for verification of training, credentials, experience and disciplinary action is the Queensland regulatory authority, MBQ. The MBQ must be independent and must be resourced and staffed to appropriately and accurately meets the needs of the health system and Queensland public (keeping in mind seasonal variations in demand);
- Links between the state regulatory authorities must be mandated to ensure interstate issues do not arise;
- A more accurate and effective registration system for IMGs, must be implemented **before** July 2006, which is currently proposed by

MBQ as part of the outcomes of the Registration Review Project.

13.2 Supervision and support

- IMGs must be given an honest appraisal of the position applied for, including: Position Description, contract including hours of work and on call, hospital and community description, private sector activity level, training, supervision levels, available mentors etc;
- IMGs should be supervised and supported according to their level of demonstrated competence, by Australian qualified doctors;
- Recruitment of IMGs should be a centrally coordinated activity of Queensland Health with one single entry into the public health system;
- The single entry point should match IMGs skills to vacancies, should assess the clinical skills and experience of the IMG as well determining English language proficiency, and also provide for commensurate clinical, language, and cultural bridging training as required.
- A mandatory orientation on the Australian healthcare system (including the machinations of the Health Insurance Commission and State Departments) must also be provided.

13.3 Administrative Review /Bureaucratic/Systemic

- Remove multiple layers of management and re-medicalise the decision-making;
- Reduce administrative burdens in patient-care;
- Queensland Health ability to bully/control MBQ must be curtailed;
- Increase the reliability and consistency of decision making at the same time increasing the level of honesty, trust and confidence in these decisions;
- District management should be replaced with Hospital Boards comprised of active clinicians, senior nursing staff, lawyers, accountants, and community leaders. The three senior hospital management figures (Director of Nursing, Medical Superintendent, and hospital administrator) should be answerable to Board;
- Improve systems of recognising and rewarding work efforts of clinicians.

13.4 Workplace and workforce conditions

- A solid workforce is a long-term goal and steps must be taken immediately to address the resignation rates of clinicians at all levels of the public health system;
- Offering 'deals' regarding salary and other Industrial Relations conditions to IMGs that are not offered to Australian graduates is offensive, unethical and totally unacceptable;
- Better terms and conditions will encourage better skilled and experienced employees in all sectors of the health system.

Queensland Health to immediately initiate a set of salaries and conditions of employment that is competitive both interstate and overseas;
- All recruitment and incentive packages are transparent and open to all to see.

13.5 Workforce

- Queensland Health to invest immediately in a Human Resources/Payroll System that can provide timely and reliable data on all staff (by hospital and medical occupational category);
- Queensland Health to immediately commence the recruitment and establishment of a medical workforce that would continue to meet current and projected patient needs.
- Queensland Health to introduce recruitment and retention incentives for hospitals that consistently experience medical recruitment difficulties;
- Queensland Health to take immediate steps to restore the credibility of its medical service by raising the medical profile within the organisation by increasing doctor participation in decision making within the hospital e.g. inclusion on District Executives;
- That Queensland Health immediately re-instigates the training and educative role of Staff Specialist by introducing a 70:30 ratio between clinical and non-clinical duties (non patient contact);
- Queensland Health no longer employs, forces or a doctor to work in a position that is beyond their training and experience e.g. Interns being given higher duties at a Junior House Officer level etc.

13.6 VMOs

- IMGs in regional and rural Queensland should be required to be supervised by a senior colleague - most often a VMO.
- Encourage VMOs to stay or return to the workforce – as per section nine.

13.7 Political accountability in decision-making

- The overlaying and inconsistent approach of various levels of government and statutory authorities must be removed to streamline the administrative and regulatory processes relating to the delivery of health care services;
- The system must become more responsive to the needs of the community, and maintain a consistency of approach to decision-making;
- Basic honesty must be returned to the system;
- The independence of the registration and regulatory body must be maintained;
- The assessment of 'areas of need' and applicants for those positions must become more consistent, and the processes for

decision-making made transparent and accountable;

- Financial penalties for fraudulent registration activity by IMGs would appear to be ineffective as the applicants' most likely course is to flee overseas where the penalties, however large, are unenforceable;
- That a public debate commence regarding 'universal access' and the specifics of that in regional and rural areas (eg the preference for no doctors or unqualified doctors in 'areas of need');
- Any valid claims of 'workload pressures' made by MBQ be addressed immediately to ensure sufficient registration staff to meet needs and be appropriately skilled to review local and inter-state or international;
- Reassurance be offered to IMGs who are providing quality health services to Queenslanders that they are valued and that their input to the health outcomes of the Queensland public is recognised;
- Positive Public Relations be put into assuring Queenslanders of the excellence of doctors currently in the system, irrespective of the origin of their medical degree.

13.8 Clinical

- Mandatory supervision for IMGs for a defined period (not less than three months) with reports prepared at regular intervals and documentation to support;
- Mandatory participation by IMGs in training and education until College recognition is awarded – then follows on College requirements (e.g. Continuing Medical Education) would apply;
- Mentoring arrangements be applied that may include hospital specialists or VMOs or senior clinicians from the private sector;
- Reinstatement of the medical profession to being collaborative partners in the goals for the Queensland Health department.

14.0 List of attachments

A. Minutes, OTD/TRD Sub Committee (22 August 2002 and 18 December 2002)
B. Badly Trained GPs add to state health crisis (17 December 2002)
C. Correspondence, QH to AMA Queensland (6 December 2002)
D. Correspondence, MBQ to AMA Queensland (10 December 2002)
E. Minutes, Joint Qld OTD/TRD Committee (2 June 2003)
F. Minutes, Joint Qld OTD/TRD Committee (10 July 2003)
G. Queensland Health report, *Proposed Management of International Medical Graduates* (July, 2003)
H. Correspondence, AMA Queensland Rural Committee (9 September 2003)
I. Correspondence, AMA Queensland to Health Minister (11 September 2003)
J. Position Statement, IMGs, (July, 2004)
K. Imported Doctors Face Stiffer Rules, Courier Mail (19 August 2004)
L. Correspondence, AMA Queensland to Premier (27 October 2003)
M. *Assessment of Temporary Resident Overseas Trained General Practitioners*, Department of Health and Ageing (April, 2005)
N. Correspondence AMA Queensland to MBQ re IMGs (13 November 2002)
O. Submission to MBQ from AMA Queensland on MBQ Strategic Plan (November 2003)
P. Correspondence AMA Queensland to MBQ re IMGs (13 November 2002)
Q. Correspondence MBQ to AMA Queensland re IMGs (10 December 2002)
R. Correspondence AMA Queensland to MBQ re IMGs (17 December 2002)
S. Correspondence AMA Queensland to MBQ re IMGs (9 May 2003)
T. Minutes, OTD Stakeholder Forum (21 April 2004)
U. Minutes, IMG Stakeholder Forum (23 November 2004)
V. Report on Survey of Hospital Clinicians, AMA Queensland (2002)
W. VMO minutes and log of claims (yet to be supplied to the Commission)
X. *Blackspot Audit* Report, AMA Queensland. This document is too large to append via email transfer with this submission, but is available for electronic download from http://www.amaq.com.au/docs/Blackspot.pdf

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22 May 2005

Anthony Morris QC
Barrister at Law
Level 13, 239 George Street
BRISBANE QLD 4000

Dear Mr Morris

Re: Bundaberg Hospital Commission of Inquiry

Please find attached AMA Queensland's initial submission the Bundaberg Hospital Commission of Inquiry, as requested by the Commissioner on 3 May 2005. As Office Bearers of AMA Queensland, we are authorised to author this document on behalf of AMA Queensland.

The Association respectfully submits this document as an initial comment for the Commission to consider under the Terms of Reference. The Association remains committed to full participation in this review process and would be pleased to make a further submission addressing new issues raised by the Commission at a later time.

Please do not hesitate to contact either of us through the AMA Queensland Secretariat, Ms Debra Thompson (PA to President and CEO) on 3872 2254, or via our personal mobiles: Dr Molloy on 0417 700 429, or Mr Gallagher on 0418 720 395.

Yours sincerely

Dr David Molloy
President

Mr Kerry Gallagher
Chief Executive Officer

Enc

Denese Haynes

From: Colleen Smyth [c.smyth@amaq.com.au]
Sent: Sunday, 22 May 2005 7:54 PM
To: BHCI
Subject: AMA Attachments 2

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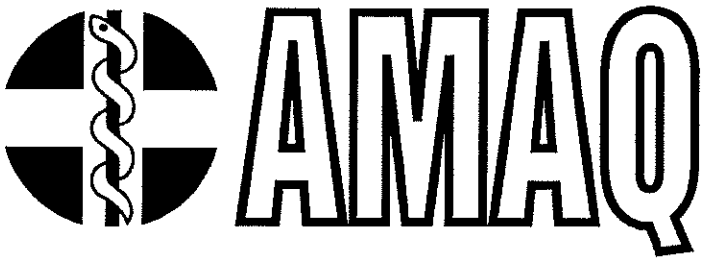


REPORT

Survey of Hospital Clinicians

Survey of Hospital Clinicians
DRAFT REPORT

Introduction

This report on the *AMAQ Survey of Hospital Clinicians*, as conducted by the Queensland Branch of the Australian Medical Association (AMAQ), explores details collected on the perceptions of 140 hospital clinicians across the state, regarding the status of public hospital services.

The survey and report follow on from the state-wide *AMAQ Public Hospital Report Card*, published in 2000, to more specifically address perceptions with regard to four issues impacting directly on patient accessibility to care:

- procedural waiting lists;
- out patient waiting lists;
- staffing levels; and
- removal of service due to budgetary constraints.

The Public Hospital Report Card was initiated in direct response to increasing concerns about perceived pressures on public hospitals, and an increasing inability by these facilities to service demand - to a point that patient care may be suffering.

To ensure the collection of geographically unbiased data the Report Card was circulated to hospital clinicians (both salaried and visiting medical officers) across the State. The Report Card presented doctors with a confidential forum within which to report on patient care in Queensland Public Hospitals.

Purpose of the Report

Public hospital funding and correlated levels of care have long been an issue of concern in Queensland. At this time disquiet with regard to waiting times and service cutbacks are becoming increasingly evident throughout the State. There is increasing concern amongst medical practitioners that the public hospital system does not have the capacity to ensure access to high quality patient oriented care.

As the peak representative medical body advocating for both the medical profession and the health of the community, AMAQ is ideally placed to provide the leadership necessary to convey information and work with the public and Government in identifying, developing and supporting strategies to address identified problems. It is the type of robust debate prompted by comments such as those contained in this report that may mobilise the necessary action to address burgeoning inaccessibility to public health care in Queensland.

In a day-to-day work setting, most hospital employees and contractors are unable to freely express any concerns they may have with regard to their employer, Queensland Health. Report Card respondents were invited to report freely their own experiences, in-line with the *AMA Guidelines of Public Comment by Hospital Doctors* (2002), that state:

"In general, the AMA takes the view that the public interest would be better served by ensuring that the public is well informed and that health and medical treatment issues are subject to open debate. Doctors are often well placed to inform the public on health and treatment matters on which others remain silent. They are encouraged to consider their professional obligation to be advocates for the health interests of their patients and the community.

The restrictions on public sector employees suggest that public comment involving criticism of hospital administration, the health system or government policy should be made, where practicable, through a professional association or union. Taking collective action to advance and protect the interests of members is a primary role of these organisations. The AMA

recommends that doctors make public comment through elected representatives of professional associations which have a legitimate role in weighing into the debate, such as the AMA, ASMOF, medical colleges or clinical and craft associations."

A significant amount of politically sensitive information is contained in the report. In keeping with AMAQ's privacy commitments to maintain confidentiality of respondents, the Association will not publicly release raw data obtained through the survey. It is information that is almost impossible to obtain through official channels and it will form an integral part of a campaign to achieve more appropriate funding for our public hospitals.

Survey response rate

The Public Hospital Report Card surveyed 541 hospital clinicians throughout Queensland, and received 140 valid responses. This represents a response strike rate of 26 per cent.

The relatively small number of respondents used as the basis of this report does not intend to represent stringent statistical validity, but rather confirms and identifies strong concepts in available literature with regard to the possible derogation of public health services by those directly providing care, who are well placed to provide such information.

Survey demographics

Respondents were asked to supply information such as their name, Health Service Districts (HSD) specialty, and employment position. However, many opted to supply none or only part of this identifying information.

Reasons for this trend are unclear, but may include a general culture of privacy awareness, and/or as a response to recent disciplinary action taken by Queensland Health against particular doctors in the Cairns region who chose to speak publicly regarding their concerns with the Cairns Base Hospital, against the public service *Code of Conduct* (Hansard, 2003).

Responses have been received from hospital clinicians working in the following HSDs: Bayside (2), Bundaberg (3), Cairns (4), Fraser Coast (1), Gold Coast (8), Mackay (1), Mater (3), Princess Alexandra Hospital (19), Prince Charles (8), QEII (5), Logan Beaudesert (5), Redcliffe -Caboolture (8), Rockhampton (2), Roma (1), Royal Children's Hospital (8), Royal Brisbane and Womens Hospital (16), Sunshine Coast (9), Toowoomba (5), Townsville (4), West Moreton (5), and not identified or indeterminate (23).

Medical practitioners identified themselves to be from the following specialties: Anaesthesia, pathology, surgery, cardiology, drug and alcohol, emergency, endocrinology Forensic, gastroentorology, general medicine, geriatric and rehabilitation, gynecological oncology, obstetrics and gynaecology, haemotology, intensive care, infectious diseases, neurology, neurosurgery, oncology, orthopaedic surgery, paediatrics, psychiatry, radiology, respiratory, trauma, and urology.

Procedural waiting lists

According to national figures, Queensland continues to fair well with regard to hospital waiting list statistics in the Australian Institute of Health and Welfare Report (AIHW 2002). This same data shows an improvement in Queensland waiting times over the past three years.

However, these statistics do not accrue times for patients transferred from one list to another (inter-hospital), nor those recategorised. Queensland is also the only State which

does not report the reason for removal of patients from elective waiting lists other than for procedural admission (AIHW 2002:82).

Queensland Health hospitals have a vested interest in keeping waiting lists within certain established limits, as financial penalties apply for those who do not.

Despite the "official" record of Queensland's performance, anecdotal evidence suggests alarming increased waiting times in Public Hospitals throughout the State. (Courier Mail 2003:7).

Finally, studies show that the type of information published by Queensland Health is subject to cross-jurisdictional data type differentiation and different levels of aggregation. These factors beg questions with regard to the accuracy of Queensland Health public hospital performance reports. (Cromwell et al, 2002).

As part of the Report Card questionnaire, hospital clinicians were asked to describe the length of procedure waiting lists in their specialty during the past three years (Appendix One:Q2.0)

Fifty five respondents (39.21 per cent) indicated that waiting lists had increased, while 22.9 per cent (32) said they were about the same, and eight medical practitioners (5.71 per cent) believed they had decreased.

Almost a third of respondents were not able to comment on the status of procedural waiting lists because the question was either non applicable (16.42 per cent), or unknown (11.43 per cent).

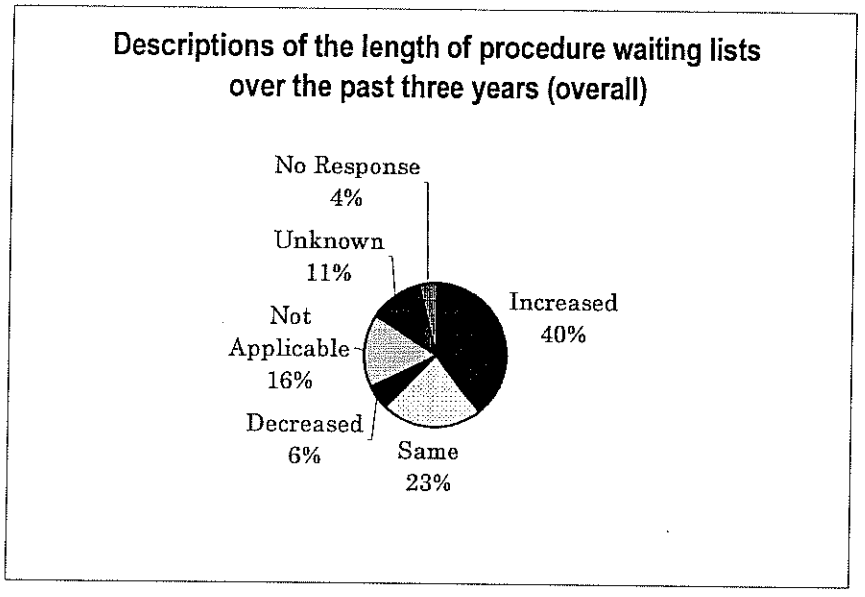


Figure 1.0: Length of procedure waiting lists over the past three years (overall)

Reasons given for these responses were predominantly that the clinicians worked in non-procedural situations (e.g. emergency and psychiatry). The remaining 4.28 per cent did not respond.

Of those who said procedure waiting lists had increased, 81.82 per cent said they had increased significantly, and 94 per cent of these (37 per cent of total respondents, or 52 doctors) claimed increases had been to an extent that patient care had been compromised.

Six respondents (4.29 per cent) indicated that patient care had not been compromised by the increased length in procedure waiting lists. Remaining respondents did not respond or sited "unknown", perhaps for the same reasons as identified above.

District Specific Comments

Examples of compromised patient care as at a result of increasing operating waiting lists were offered by clinicians from the following HSDs:

Cairns:

- Increased access block in the Emergency Department (ED) team hard to delay fracture reductions.
- Longer wait for colonoscopy - several late diagnosis of cancerous colon.
- Intensive Care Unit (ICU) patients receiving ED come for 24 hours.

Gold Coast:

- Unable to find beds on a regular basis - of 2-3 patients/week. They are transferred to Ipswich and to Northern Districts sometimes - leaving relatives, support groups etc.
- Patient waiting for an Out Patient Department session with (illegible). No size states a General Practice (GP) referral letter. Patient presented to Accident and Emergency (AE) with hear cardio equip (illegible) symptoms and needed urgent operation, but before charging outpatient and working on the long weights it ran 30-38 per cent. Although the waiting lists have now come under control it is because the full time staff specialists I have operated on the long weights from everyone's list. Plus the block is placed an OPD waiting list (now 9 months for a new case to be seen).

Logan:

- Keep on seeing patients who have waited over one year whose co-morbidities have become worse.

Princess Alexandra:

- Patient with gallstones and pancreatitis varicose veins - ulcers - inguinal hernia - bowel obstruction - la pancreas - jaundice - three weeks wait. Four weeks wait for vascular access for renal failure.
- Cancer of pancreas waiting six weeks. Same with cancer of liver.
- Bed block. Patients are treated in corridor routines.
- A large number of quality clinical indicators have significantly deteriorated (e.g. time to creation of dialysis access, graft of native fistulae, proportion of temporary catheters, nutritional indices, filtration in PD patients).

Prince Charles:

- Because of the cramped schedules I have to juggle urgent cases significant wait for elective device closure of ASD/PDQ.
- Patients dying on list - waiting for transfer for coronary angiogram.

QEII:

- Angiographing has now become standard of care for cardiac symptoms - patients wait too long for definitive diagnosis and procedures.

Royal Brisbane and Women's Hospital

- Vulval lesion increased markedly in size requiring radical surgery rather than local excision.
- Patient in chronic urinary retention developing bladder stones while waiting for treatment
- Three identified patients where cancer has progressed on waiting list. One has gone from operable to inoperable.

- Urgent and semi-urgent cases wait longer to be performed therefore increased risk of natural HR of disease process
- Some patients given chemotherapy for ovarian cancer instead of primary debulking because waiting list for surgery is over eight weeks. Some patients seek sub-optimal or sub-specialist care off public operating list because waiting time is so long.
- Documented radiological and clinical evidence of cancer progression while waiting for treatment.
- Category Three faecal incontinence keep returning to clinic. One patient developed major depression.
- Some patients go from operable to inoperable while waiting on a waiting list. Some patients need to undergo therapy for ovarian cancer because surgical waiting lists are so long.

Royal Childrens' Hospital:

- General anaesthetic MRI waiting time increase from three to six months over the last three years.
- MRI waiting times (especially for general anaesthetic) list, 6/12 stressful for patients and parents and staff trying to accommodate more urgent cases.
- The low availability of MRI at RCH results in children still being subjected to undesirable levels of radiation when CT (scan) is substituted for MRI.
- Length of time required for diagnostic testing.

Sunshine Coast:

- Patient care and outcomes are impacted daily due to excess waits and overcrowding in our emergency department. Huge stress on medical and nursing staff. Poor care, access block etc.
- Colonoscopy waiting lists - up to 1000 at least (at an average of 600/year this is a significant delay).
- Increasing delay to thrombolysis - known to increase mortality and morbidity in Acute Myocardial Infarction. Increasing delay to analgesia. Increased patients leaving not seen.
- Increased wait in emergency of critically ill patients, increase transfers from my hospital to Brisbane, early discharges from ICU, and unable to admit patients to ICU from Operating Theatre (OT) Medical Ward

Toowoomba

- Our patients have a nine-month plus wait for an Ear Nose and Throat (ENT) and some here too therefore have long-term antibiotics.
- Consulting time shorter.

Townsville

- Delays in admission for chemotherapy. Some patients have some interstate and allied treatment elsewhere.
- 1999 - no wait for treatment, now vast majority of patients wait with deaths on waiting lists for palliative RT. Category Two patients wait seven weeks - recommended under four wks. Category Three patients wait 15 weeks - recommended under 4 weeks.
- Gallstone pancreatitis while waiting for laproscopic cholesysectomy.

Category Two Waiting Lists

Respondents were then asked to estimate a current percentage of the Category Two (semi-urgent) patients seen within 90 days for their specialty.

However, only 26 respondents said they were able to provide a percentage, and the average was 37 per cent. The figures cited ranged to each end of the spectrum, with dual modes, zero per cent and 100 per cent, equal of a frequency of four.

Other responses included "unknown" (45.7 per cent), "not applicable" (20.7 per cent), and "no response" (15 per cent).

(compare to official data?)

Category Three Waiting Lists
When then queried about the percentage of Category Three (non urgent) patients having procedures within one and two years respectively, 25 hospital clinicians responded. On average they estimated that 42 per cent were seen within one year, and 21 per cent within two years.

"Surgeons should be allowed to advise the patients of relatives and general practitioners that at certain hospitals Category Three patients will never be allowed access to the public operating theatres. Administrators unconnected with surgical services or patient care are paid to obstruct these patients"

Outpatient waiting lists

What is not reported in official data from Queensland Health and the AIHW is the waiting time before a patient is added to a waiting list – that is, the length of time taken before being seen in the Out Patient Department (OPD).

Accurate data on these figures are not kept and therefore not able to be compared, and this simple data collection is particularly vulnerable to subjectivity and the emotional bias of respondents.

However, the 'pre-waiting' list has been identified as the major cause of waiting for treatment in public hospitals. One practitioner made the following comment:

"The biggest 'con' is not the length of waiting lists, but the delay in being seen in OPD. Such stats are not kept, but if you don't get to see the patient, they don't get to be on a waiting list. I suspect delay in initial consult has grown....patients are referred to OPD with abdominal pains months before they are seen in OPD. They either see someone privately in the interim or put up with it."

When asked to describe the length of outpatient waiting lists in their specialty over the past three years, almost half (47.14 per cent) of respondents indicated that outpatient waiting lists had increased, and 49 (35 per cent) believed they had increased significantly. All but one of these respondents said patient care had been compromised as a result of this change in waiting list times.

Twenty-four per cent of hospital clinicians said outpatient waiting lists were about the same, and 3.57 per cent said they had decreased. 8.57 per cent, 9.27 per cent and 8.57 per cent said this was not applicable, unknown or gave no response respectively.

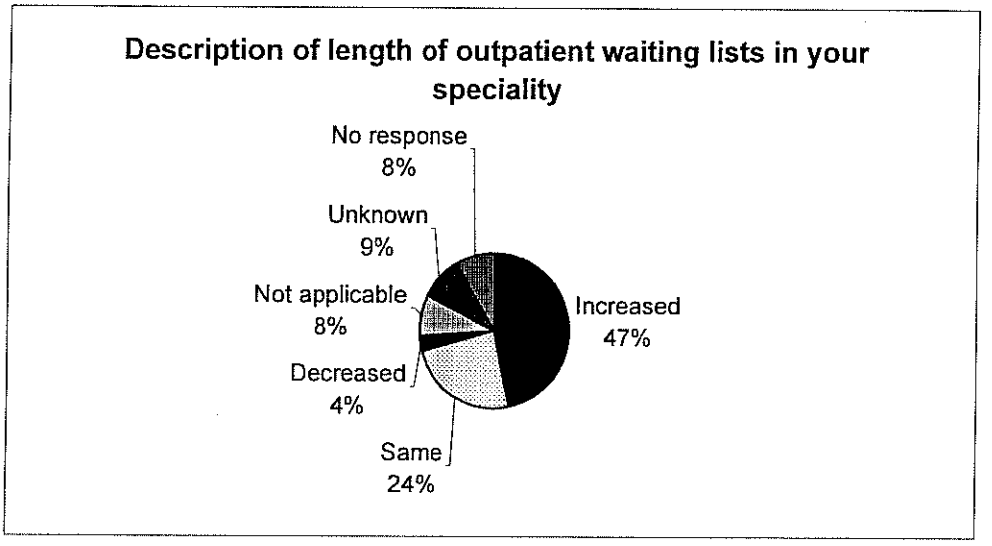


Figure 2.0 Hospital Clinicians descriptions of outpatient waiting lists.

Nine respondents (6.43 per cent) indicated that the increased length in procedure waiting lists had not compromised patient care. Remaining respondents did not respond or sited "unknown".

Examples that clinicians cited to explain compromising patient care compromised as a direct result of increasing outpatient waiting lists; included:

- *Unable to get an OPD appointment for ophthalmology, gastroenterology, orthopaedics, neurosurgery, neurology, urology, colonoscopy, gastroscopy, for over 12 months and often up to two years.*
- *Patients in palliative care often deteriorate while awaiting OPD appointments.*
- *Delayed diagnosis leading to date of medical and therapy intervention. Prolonged sufferings of patients waiting to be seen.*
- *This mean I only book in 1-2 cases per outpatient as opposed to 5-6 previously.*
- *Patients with stomas over 19 months when 6/52 is all medically indicated.*
- *Patients have been left with suspected genital cancer for 4 months.*
- *Children with acute problems having to wait 1-2 weeks. Non-urgent wait 3-4 months. Kids being expelled from schools or suspended while assessment being awaited.*
- *This means that incontinence problems etc have to wait a long time enduring great hardships.*
- *If too many patients waiting more than 90 days, often pressure is put onto surgeons to re-catergorise patients as category 3 instead of 2.*
- *One patient took 5 months to get a new case appointment and turns out to have an AN RCC. The proportion of patients requiring dialysis within the first 3 months following their first clinic visit is 25 per cent.*
- *Patients wait and then have to be admitted at emergency.*
- *Lack of bed space in ED. Have had up to 12 patients requiring monitoring in a 7-bed area sharing 7 monitors. AMI patients, intubated patients, patients on isotropic infusions.*
- *Patients with CAD or heart failure delayed in assessment and procedure.*
- *My public outpatient waiting list is 2-3 years! Some patients have passed away while waiting. I no longer can afford to offer category 3 patients surgery on a public list, due to severe pressures.*
- *Delayed treatment of dementia and often geriatric and rehabilitation issues.*
- *Patients with pelvic masses waiting list too long. AWC(?) patient seen very late after the 24-36/53 by consultant. Late GP referred.*
- *Patients have longer delays for initial assessment.*
- *Increasing suffering by delay to treatment.*
- *Commonly patients are waiting with non urgent triage categories (eg 4 and 5) for 5 - 7 hours. Urgent (triage category 3) for 3-4 hours to be seen in many days of the week.*
- *Too many to list!*
- *Patients that needed urgent assessment have been seen too late.*
- *Patients do not engage with MH focus - end up in hospital acute care.*

- *Unknown, but very likely.*
- *All patients rushed through despite working 55 hour weeks and now we are told not to claim overtime as a result outpatient clinics will be curtailed.*
- *Inadequate patient follow up. Late detection of progressed complications,.*
- *Urology OPD not taking new referrals. Direction not to dialyse any more patients (i.e. no new chronic dialysis patients).*
- *Rectal cancer waiting for over 6 months for appointment.*
- *Delayed diagnosis. Person with angina progressed to infarction before angiography (not performed here but had significant waiting time before even medical OPA). Delayed diagnosis of RA (evidence supports early intervention).*
- *Wait for new appointment increased from 3 months to 8 months. Considerable patients in pain.*

Staffing and service levels

This year, the AIHW identified Queensland as the State with the lowest State ratio of population to medical practitioner, at 232.9 to 100 000 (AIHW, 2003:1). This data signified a drop of 19.9 Full Time Equivalent (FTE) medical practitioners since 1995 figures (AIHW, 2003:27).

Hospital clinicians were asked about the status of staffing levels. Their responses indicated that they believed levels of all health professionals where insufficient in Queensland hospitals (see figure 3.0), but in particular, the levels of nursing staff were overwhelmingly inadequate to meet patient care demands.

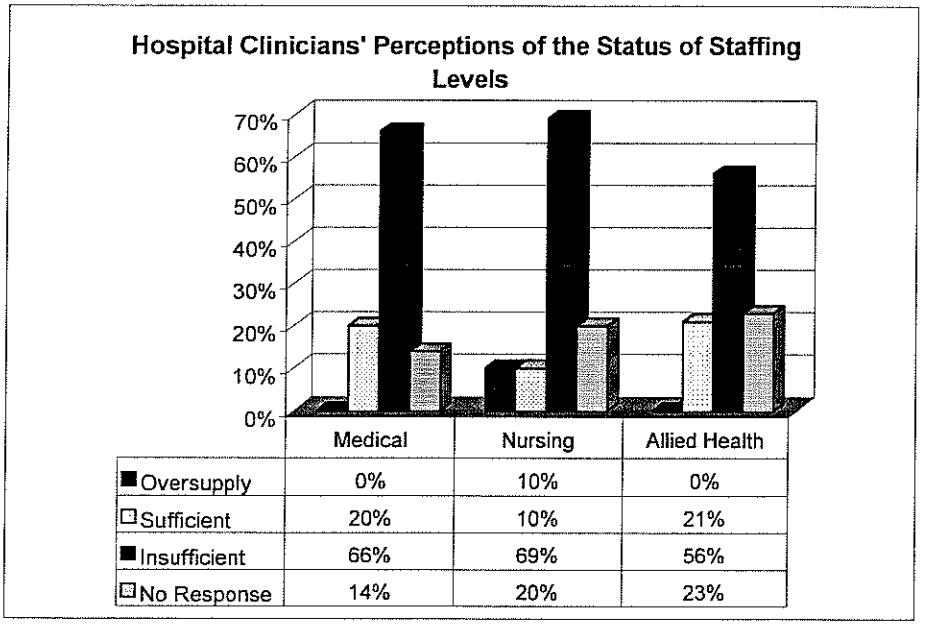


Figure 3.0 Hospital Clinicians Perceptions of hospital staffing levels, by profession.

When asked to provide justification for these responses, clinicians from the following HSD made the following comments:

Bayside

- Especially so in Bayside district where rapidly increasing OPD wait.

Caboolture

- Chronic understaffed of allied health at Caboolture. Nurses and rehabilitation too. Increases my workload causes Resident Medical Officer (illegible).
- No specific physiotherapy or Occupational Therapy time for palliative care unit. Services have to be supplied from other areas.
- Insufficient PMO/Registrars - 10 short in the district.

Cairns

- Medical inadequate staffing in ED, psychiatric, and no relievers.

Nursing

- The new method of calculating nursing homes allows no slack for busy days.

Ipswich

- Deteriorating emergency department staff for adequate patient care in ED and wards. Frequently closed ICU beds.

Logan

- A Visiting Medical Officer (VMO) who is keen to each rarely has the opportunity to teach registrars and residents.

Mater

- Mater recently employed a new full-time Respiratory Physician. Nursing Staff at OPD satisfactory. Allied Health waiting times/availability is poor.

Princess Alexandra Hospital

- Severe shortage of public hospital anaesthetists.
- Insufficient anaesthetists in public sector. Unattractive pay structures/ on call impinging of next day's private practice commitments (I have just resigned).
- Medical - outpatient activity triples since 1998 and dialysis numbers doubling yet no increase in staff since 1991. Many clinical indicators worsening. Insufficient access sessions. Nursing - insufficient staff to run dialysis shifts. Shifts are having to be juggled and dialysis sessions are sometimes postponed. Dietician - ability to meet clinical practice guidelines with respect to dietician review fallen from 86 per cent in 1998 to 41 per cent in 2001.
- Loss of specialist hours when staffs have departed of reduced their hours and staff are not replaced. Significant reduction in number of RNs available in inpatient service. Reduced availability of allied staff for input and outputs.
- Insufficient Medical staff to allow adequate turn around on cases such as Post Mortems. Insufficient scientific staff causing blow outs in time taken to turn around reports.
- Podiatry - only one and a half for the whole hospital - puts diabetic feet at risk.

Prince Charles

- The most recent review of cardiology from the UK suggest one paediatric cardiologist per 500,000 population. Current staffing in QLD is half of that
- Insufficient medical staff lead to increase workload and can potentially compromise work load.
- Insufficient nursing staff lead to inadequate care on wards.
- Only basic medical/nursing/therapy care can be provided with shorter staffing level. A lot of time wasted with meetings, paper works, bureaucratic policies and pathways rather than clinical care. Outcomes and success based only on financial considerations and Length Of Stay.
- Insufficient cardiologists for performing PTOA.
- All staff doing unpaid overtime, beds shutting because staff cannot be covered, staff appointments delayed, cannot get locums, not enough staff to run groups.
- At TPCH the current staffing of 2 full-time anatomical pathologists is just sufficient to deal with the caseload of approx 8000 surgical accessions and 3500 cytology cases per annum. However there is no or little provision for leave which results in stress when leave is taken and a lot of leave owing and not taken. Across QHPS as a whole there is a market shortage of medical staff as well as understaffing of some laboratories by scientists

QEII

- Nurses are continually "off-lined" and regarded as project officers on trivial projects which are really a front for research masters thesis.
- Chronic shortage of medical registar/PMO's requiring overseas recruiting to fill position

Rockhampton

- Even with "full staffing" there is not enough personal. There is no method to back fill when staff are absent. This causes interruptions to patient's programs.

Royal Brisbane

- Again the "coalface" staff are doing their best and the 'administrators' are at meetings in Town. Operating theatres unavailable due to decrease in staff. ICU beds unavailable due to decrease in staff
- Minimal locum support for consultants on leave, not enough allied health staff to look after our patients. Not enough nursing staff overnight and to improve the transition to community care. E.g. heart failure outreach/discharge programs.
- There is also insufficient clerical support such that this centre no longer reports to FIGO and has not produced an Annual Report since 2000.
- The definition of sufficient staff is rather difficult - it depends on the expected standard service.
- Combined medical staff shortage = cancellation of operating lists.
- Unable to staff beds because of no nurses.
- Combined medical staff shortage = cancellation of operating lists.
- Insufficient PMO/Registrars - 10 short in the district
- No experienced nursing support for GE procedures outside 0800-15-- Monday to Thursday.
- All staff doing unpaid overtime, beds shutting because staff cannot be covered, staff appointments delayed, cannot get locums, not enough staff to run groups.
- No medical oncologist employed since Oct '01. Fourteen Radiation Therapists, establishment 20, need 28 for 3 linear accelerators. Lose more radiation therapists - down to 1 treatment unit.
- Shortage of theatre nurses - inefficient use of time and multiple patient consultations. Loss of accreditation for training in peripheral hospitals.
- Operating time is the problem.

Royal Children's' Hospital

- Insufficient senior medical staff to cover paediatric ED 7 days per week. Lack of nursing staff in hospital directly responsible for bed restrictions.
- No experienced nursing support for GE procedures outside 0800-1500 Monday to Thursday.
- Insufficient medical staff to train registrars- so that future generations of children will suffer - 2) overbooking results in hurried and sub optimal investigations and harassed and frustrated staff.

Sunshine Coast

- Especially after hours when services most busy and most stressed.
- Medical - prolonged ED waits, prolonged waits for consultation inpatients units. Nursing - beds unable to be opened. Lack of RNS - all areas. Allied Health - no access to allied health for ED patients.
- Anaesthetic Department down 2 staff specialists so far.

Toowoomba

- This hospital has had a long term doctor shortage and while the nurse to patient ratio has increased over the last 10 years, the has been a decrease in some areas.

staff.

- *Lists cancelled.*
- *GP OPD.*
- *We have a HDU ward which we really need to use which is closed (actually used by office staff).*
- *Surveillance of theatre staff for infectious diseases eg kidney, hepatitis B, hepatitis C, now difficult to obtain from pathology.*
- *Chronic pain clinic 2) acute dialysis access (patients are refused admission to PAH if they have renal failure) 3) elective access to ICU for surgical patients and patients sent to Greenslopes for surgery.*
- *Gynaecology – PAH.*
- *Most surgical sub-specialties -ENT -Vascular - Plasters -Pain Service (acute) TPN Service.*
- *Interventional radiology not available.*
- *No service withdrawn but waiting times long. All varicose veins are category 3 so some people have been on the list for 5 years. So ensure we do not provide a service to these people.*
- *Redirection in acute medical care beds.*
- *Theatre lists cut - access to ICU Beds cut.*
- *Forbidden by management to perform reversal of sterilisations, even on private patients.*
- *Changing radiation treatment to try to treat more patients.*
- *Closure of gynaecology unit at PAH.*
- *Unable to perform any Cat 3 Gastro (?illegible).*
- *Certain clinical testing.*
- *Radiation oncology for gynecologic cancer patients in Townsville; Sub optimal medical oncology facilities resources in Townsville.*
- *Free access to Intergra (?) if as a VMO appropriate. Need to justify need. Too much documentation for the hands on worker.*
- *Pacemakers.*
- *Attempts at re-directing some core clinical pathology to Brisbane.*
- *The gastroentrology service is under threat. Teaching is under threat.*

Other findings

Emergency Departments

Although not addressed specifically in this survey, a significant number of doctors signaled emergency departments as a service within the hospital setting in need of great attention. Anecdotal comments from emergency practitioners cited increasing loads, access block, waiting times and lack of resources.

"Unfortunately this questionnaire doesn't really address the issues around Emergency Medicine – where we are seeing problems with worsening waiting times and access to inpatient services. We do see some indirect effects of OPD waiting lists – as the patients keep returning to us in the interim with worsening conditions (general surgery, orthopaedics, urology and medical). We also have many other issues such as deteriorating GP services which lead to increased Emergency Department work load and poor continuity of care for the patient"

Clinical indicators

Medical practitioners reported that emphasis was placed on length of stay as a clinical indictor by hospital management, rather than the quality of care provided by hospitals, and articulated this as a hindrance to medical practitioners' ability to provide care in a patient's best interest.

""Early discharge" presumes that a patient either has someone at home who can do some nursing, or they have the means to get a community nurse to visit. There will be someone to do the shopping and the housework and prepare meals. It's a bit hard if you are 85, widowed, your kids live in another city and you are recovering from a bout of pneumonia."

Staff marginalising
The ability for medical staff to be involved in decision making in Queensland Health hospitals has been flagged as an issue of great frustration within the administration sector of public health care. This and many other factors lead many doctors to site a general lack of morale within the system.

These issues may be subject to further investigation by the Association.

Recommendations

The responses of medical practitioners with regard to public hospital waiting lists reflect the probable inaccuracies of available data on hospital procedural waiting lists. The findings confirm that clinicians find elective surgery waiting list data a crude measurement of health access and outcomes, with the following measures being cited as tools for public manipulation of data:

- Bureaucratic pressure to re-classify patients into different categories;
- Having long waiting times for outpatient appointments so few people have any chance of getting on to the waiting list.

Therefore, AMAQ calls upon the State Government to implement the following recommendations:

1) Establish an independent taskforce to investigate the manipulation of waiting lists through re-booking and re-categorising patients. The same taskforce should be responsible for reporting on bureaucratic pressures placed on hospital clinicians to commit to reallocation of patient status.
2) Investigate and implement mechanisms to report on out patient waiting data and require governments at both State and Federal level to make this information known publically. It is proposed that the outcomes of any investigations will give Queenslanders a more transparent view of hospital waiting times.
3) Investigate and implement programs to ensure clinical staffing levels meet best practice guidelines, particularly with regard to theatre work, post-operative care, and staffing ratios that enable maximum bed capacity.
4) The above three recommendations will require commensurate funding. It is recommended that Queensland Health investigate the current allocation of funds to public hospitals in Queensland in order to ensure that focus is placed on clinical need.

Conclusion

AMAQ is confident that hospital clinicians prioritise treatment to ensure that patients are treated with the highest and most efficient level of care possible. However, AMAQ remains unconvinced that sufficient resources are allocated each budget to ensure that Queensland public patients are treated in-line with the emergency of their clinical diagnosis dictates, or that compassionate grounds would demand.

The *AMAQ Public Hospital Report Card* confirms that the Queensland public hospital system remains under-resourced to meet demands for access to quality care, equipment, and infrastructure replacement.

It is clear that Government must commit to reassessing its public hospital funding allocations and management style AMAQ calls upon Government to adopt the recommendations listed in this report and will continue to lobby in the interests of Queensland patients and doctors on these issues.

References

AIHW (2002), *Australian Hospital Statistics 2001-02*, Health Services Series, Canberra

AIHW (2003), *Medical Labour Force*, National Health Labour Force Series, Canberra

AMA (2002), *Guidelines on Public Comment by Hospital Doctors*, Workplace Policy, Canberra

Queensland Government, *Hansard Wednesday 30 April 2003*, Legislative Assembly, Brisbane, pp 1437 – 1438

Cromwell, D, Griffiths, D, and Kreis, I (2003), 'Surgery dot.com: the quality of information dissemated by Web-based waiting time information services', *MJA*, 177:253-255

Appendix One
Survey of Hospital Clinicians

Survey of Hospital Clinicians

AMAQ is conducting this survey to capture data that reflects the current direction of public hospital services, particularly with regard to patient care. It is in this vein that AMAQ asks you to take a few minutes to complete this survey honestly. Every attempt has been made to simplify its completion.

1. Name (optional): _____

1.1 Position: _____

1.2 Health District: _____

1.3 Specialty: _____

All personal information supplied will be treated confidentially. Specific information supplied will assist AMAQ to determine and issues to address.

2. How would you describe the length of **procedure** waiting lists in your specialty over the past 3 years?

☐ Increased → Significantly? ☐ Yes ☐ No
☐ About the Same (skip to question 3)
☐ Decreased (skip to question 3) → Significantly? ☐ Yes ☐ No
☐ Unknown (skip to question 3)

2.1 If the length of waiting lists have increased, has this negatively impacted on or compromised patient care?

☐ Yes
☐ No (skip to question 3)
☐ Unknown (skip to question 3)

2.2 If yes, please provide an example (optional):

_____

_____

_____

3. Are you able to provide a current percentage for long-wait category 2 patients (90 days) in your specialty?

☐ Yes - please provide details: _____ %
☐ Unknown

4. Are you able to provide a current percentage of category 3 patients having procedures within one and two years respectively?

☐ Yes – please provide details: _____% within one year

_____% within two years

☐ Unknown

5. How would you describe the length of **outpatient** waiting lists in your specialty over the past 3 years?

☐ Increased → Significantly? ☐ Yes ☐ No
☐ About the Same (skip to question 6)
☐ Decreased (skip to question 6) → Significantly? ☐ Yes ☐ No
☐ Unknown (skip to question 6)

5.1 If yes, has this compromised the standard of patient care?

☐ Yes
☐ No
☐ Unknown

5.2 If yes, please provide an example of where individual patient care has been compromised:

_____

_____

_____

6. Please indicate the status of staffing levels for the following disciplines at your hospital, and provide justification below (centered around patient care and outcomes):

Medical:	☐ Oversupply	☐ Sufficient	☐ Insufficient
Nursing:	☐ Oversupply	☐ Sufficient	☐ Insufficient
Allied Health:	☐ Oversupply	☐ Sufficient	☐ Insufficient

_____

_____

_____

7. Are you aware of any standard services being withdrawn from practice at the hospital, as a direct result of *financial constraints* (not evidence based)? Eg. Colonoscopic surveillance

☐ Yes – please provide details: _____
☐ No
☐ Unknown

8. Would you be prepared to?

☐ Discuss any of this information in person with the AMAQ President

☐ Become involved in a confidential, medical professionals only teleconference

☐ Become a regional spokesperson

9. If you have indicated yes to any of the above, please provide your contact details:

Name: _____

Phone number: _____

Email address: _____

10. Other Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this survey

Please fax or post back to AMAQ
using the enclosed pre-paid envelope:
Fax: (07) 3856 4727 OR Post: PO BOX 123, Red Hill, Qld, 4059

Appendix Two
Survey Cover Letter

Thursday 19 June 2003

«Title_» «Initial_» «Surname_»
«Address1»
«Address2» «Address3»
«State_» «Suburb» «Pcode»

Dear «Title_» «Initial_» «Surname_»

Re: Survey of public hospital clinicians

As a public hospital clinician, you would be aware of the mounting evidence indicating that public hospital standards of care have deteriorated because of under resourcing.

AMAQ is aware of a widespread perception among clinicians that senior administration in Queensland Health is not being adequately informed by middle management, of the real facts relating to this deterioration.

In addition, it has become clear that administration of Queensland's public hospitals is being increasingly driven by budgets, and not health outcomes or the immediate health needs of Queenslanders.

I am eager to gather data to support these arguments regarding deteriorating standards of care, and will use the information collected to present clinicians' concerns to Queensland Health and help rectify any gaps in standards of care.

I believe that clinicians are best placed to provide this information, and I know and recognise that the demands placed on your time are many. However, if we are to present a credible case to government, this information is vital from as wider array of hospitals in Queensland as possible.

Accordingly, I would be grateful if you could take the time to answer the questions that follow this letter, and provide us with the name and regional location of your hospital. Please be advised that it is optional to supply your name and the position you hold at your hospital.

Yours sincerely

Dr Ingrid Tall
President
Queensland Branch of Australian Medical Association

Background Paper:

ASSESSMENT OF TEMPORARY RESIDENT OVERSEAS TRAINED GENERAL PRACTITIONERS

April, 2005

DEPARTMENT OF HEALTH AND AGEING

CONTENTS

Note on Terminology

This paper uses the terminology "overseas trained doctor" (OTD) in referring to doctors whose undergraduate medical training was undertaken in a medical school in another country. Some jurisdictions prefer the use of an alternative term – "international medical graduates" (IMG).

It has been pointed out that the term OTD is used to describe a number of different and complex circumstances of doctors whose primarily medical training was overseas.

This paper continues the use of OTD, and TROTD for temporary resident OTDs, but recognises the alternative terminology of IMG.

Jurisdictions also vary in the term used to describe the type of registration granted to a TROTD which imposes practice conditions. Most states and territories use the term "conditional registration". Victoria uses the term "special registration" and Queensland uses the term "special purpose registration".

1 INTRODUCTION

This paper for the Forum on Developing National Consistency in the Assessment of Temporary Resident OTDs was written after a process of document review, telephone and face to face interviews with a range of people in the key stakeholder organizations. They included medical boards in each state and territory, departments of health, rural workforce agencies, the Australian Medical Association (AMA), the Australian Medical Council (AMC), the Australian College for Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA) and other practitioner organisations and some private recruiters.

1.1 BACKGROUND

Numbers and Trends

Overseas trained doctors (OTDs) are an increasing important component of the Australian medical workforce. They comprised over 21% of the total medical workforce in 1998[1]. OTDs have helped meet the increasing demand for general practitioners, hospital medical officers and specialists in the community. This is especially so in general practice in rural and remote communities and in other areas of workforce need. OTDs comprised 35% of all general practitioners billing Medicare in RRMA[2] 3-7 locations[3] during 2003/04.

In recent years, most OTDs enter Australia on temporary resident visas[4], referred to in this paper as TROTDs. In 1992-93 there were 692 TROTDs in the Australian medical workforce. This has risen steadily to over 4000 TROTDs[5] in 2002/03. These figures include all TROTDs whether specialists, non-specialists or other medical categories.

An indication of the number and type of TROTDs (and Permanent Resident Overseas Trained Doctors or PROTDs) by medical category and jurisdiction in Australia during 2003/04 is given in Table 1.1. Various visa categories are involved. Totals by medical category and jurisdiction have been adjusted to remove multiple exemptions where a doctor holds several exemptions[6].

The data in Table 1.1 shows that 783 full time equivalent (FTE) TROTDs in general practice positions had been granted Section 19AB or 3GA exemptions in 2003-04, consistent with working in an area of need. It also shows the relative numbers of TROTDs and PROTDs in each jurisdiction, with Queensland having the greatest reliance on OTDs to fill general practice positions.

While some TROTDS come to Australia for short term work experience and travel,

[1] Australian Institute of Health and Welfare data quoted in Medical Training Review Panel (MTRP), Overseas Trained Doctors Subcommittee Report, February, 2004, page 16
[2] RRMA is a seven category remoteness classification in which RRMAs 1 - 2 are city and urban areas
[3] Department of Health and Ageing data. The data includes OTDs who have been part of the Australian medical workforce for decades.
[4] Some OTDs enter Australia on permanent resident visas granted on the basis of family reunions, refugee status, etc...
[5] From data collated by Australian Institute of Health and Welfare data quoted in MTRP, Overseas Trained Doctors Subcommittee Report, February, 2004, page 16
[6] The figures for some jurisdictions therefore marginally overstate the number of doctors, as opposed to the number of exemptions granted, as some doctors work in two or more locations

before returning overseas, many intend to stay long term and settle[7]. There is no available data on this proportion, but it is likely to be at least 50% and possibly much higher for general practice positions. For many in this group, being a TROTD is seen as an interim step in becoming a permanent resident.

Table 1.1: OTDs Granted Provider Number Exemptions by Medical and Visa Category Current in 2003-04 since 1997*

Medical Category	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Adjusted TOTAL
Specialists:									
- TROTDs	2	74	7	79	19	12	103	23	**258**
- PROTDS	10	61	6	58	19	10	52	26	**221**
TOTAL	12	135	13	137	38	22	155	49	**479**
Assist at Ops									
TROTDS	1	36	0	26	39	4	77	15	**193**
- PROTDS	0	0	0	3	6	0	0	2	**10**
- TOTAL	1	36	0	29	45	4	77	17	**203**
GPs:									
TROTDs	2	69	26	407	56	20	103	118	**783**
- PROTDS	1	136	7	138	32	14	97	61	**471**
- TOTAL	3	205	33	545	88	34	200	179	**1254**
Total OTDS:									
- TROTDS	5	179	33	512	114	36	283	156	**1220**
- PROTDS	11	197	13	199	57	24	149	89	**675**
- TOTAL	16	376	46	711	171	60	432	245	
- **Adjusted TOTAL**	**16**	**367**	**45**	**698**	**166**	**59**	**374**	**241**	**1895**

Source: Summary of OTDs in Department of Health and Ageing's database for 2003/2004 based on Section 3GA and 19AB exemptions granted. There are also thousands of OTDs practicing medicine without provider number restrictions registered before 1997 who are not included in these data.

OTDs entering Australia have medical qualifications gained in a variety of medical schools around the world and have varying types and lengths of postgraduate experience as medical practitioners. In the period December 2003 to January 2005, 3184 temporary resident medical practitioner visas (Type 422) were granted to OTDs who came from over 70 countries[8]. Some of these OTDs were already in Australia under other visas or were renewing their existing 422 visas. It is not possible to identify from these data how many OTDs were first time 422 visa recipients.

Temporary medical 422 visas are granted for up to four years[9] on the basis that the OTD is sponsored by an employer for a full time position in an identified area of need for which the employer has been unable to recruit an Australian resident doctor. TROTDs with these visas work as specialists, as non-specialists in hospitals or as general practitioners. DIMIA expects to provide an alternative visa category (Visa 457) in 2006, for most OTDs seeking temporary resident status under employer sponsorship. The 457 visa process will be more streamlined and applications can be submitted electronically. Process changes include the removal of the need for OTDs to have police reports and increased sponsor responsibilities[10].

[7] There are exceptions to this. One Queensland Health officer estimated that less than 10% of hospital doctors (OTDs) working in QLD intend to stay.
[8] Data supplied by DIMIA for the period 19 December, 2003 to 28 January, 2005
[9] Recently extended from a maximum period of two years
[10] The 457 visa for medical practitioners is currently being trialed in a few countries. Further details can be accessed from DIMIA's web site – <www.immi.gov.au/allforms/books11.htm>

A sample indication of the distribution of these TROTDs and other OTDs is given in the following data for Queensland – Table 1.2. Within Queensland there were 965 medical practitioners working in RRMA 4 to 7 locations as at 30 November, 2004. Of these, 559 (58%) are Australian trained doctors and 406 (42%) are OTDs. 189 or 47% of the OTDs are temporary residents. So, 20% of the medical practitioners working in Queensland in RRMAs 4-7 are TROTDs. Other jurisdictions may not share the same pattern as that for Queensland.

Table 1.2 also shows the number of the medical practitioners in Queensland by type of employment and visa status. It indicates the spread of TROTDs throughout the medical workforce in rural and remote areas for one jurisdiction. Over 70% of the TROTDs are working as general practitioners, of whom 13% are TROTDs.

Table 1.2: Medical Practitioners in Queensland by Employment Type and Visa Status For RRMAs 4 to 7 - at 30 November, 2004*

Employment Type	Rural and Remote Classification					*Aust. Citizen*	*Perm. Visa*	*Temp. Visa*
	4	5	6	7	TOTAL			
Aboriginal Community Controlled Health Service	0	10	4	1	15 *1.5%*	*7*	*1*	*7*
General Practitioner**	273	337	50	26	686 *71.1%*	*489*	*110*	*87*
Hospital Positions with Rights of Private Practice	1	34	7	24	66 *6.9%*	*48*	*9*	*9*
Other Hospital Positions	70	50	40	20	180 *18.6%*	*86*	*10*	*84*
Royal Flying Doctor Service	0	0	5	13	18 *1.9%*	*12*	*4*	*2*
All Medical Practitioners	344	431	106	84	965 *100.0%*	*642*	*134*	*189*

* Adapted from Health Workforce Queensland Minimum Data Set Report as at 30 November, 2004 with additional analysis by Col White (Health Workforce Queensland)

** Include small numbers of academic or company doctors in RRMAs 5 and 6, and a number of TROTDs employed as Locums. For example, Health Workforce Queensland report they employed 18 bona fide Locums during 1-3-04 to 28-2-05, all were TROTDs mostly from USA, UK and Canada.

Registration Requirements

All OTDs must all be registered with the relevant medical registration board in the state or territory they plan to practice in before they can start medical practice. Apart from New Zealand trained doctors, all OTDs must have their qualifications, postgraduate experience, medical knowledge, clinical competence, English language proficiency and communications skills assessed before a decision on their medical registration can be made.

The assessment processes involved vary according to such factors as:

- Whether the doctor is a specialist or general practitioner;
- Which state or territory the doctor plans to practice in;
- The doctor's prior registration status and whether equivalency of status exists;
- The type of medical program or position the OTD intends to work in; and
- Whether the OTD seeks permanent or temporary resident visa status.

Assessment processes and procedures for permanent resident OTDs (PROTDs) and temporary resident (TROTDs) seeking general or full medical registration involve the Australian Medical Council (AMC), and others, through examinations, clinical assessments and other assessment processes. These pathways are not the subject of this paper. However, TROTDs may adopt one of these pathways in order to gain a

vocational accreditation and permanent residency.

Most OTDs seeking to work or study in Australia as TROTDs can only be granted conditional, special or special purpose medical registrations by the respective state or territory medical board. Under this type of registration, conditions are imposed such as supervision requirements, time limits (up to 12 months) and sometimes attendance at orientation, training or short term work experience programs.

A TROTD may be granted conditional medical registration to work in a particular certified area of need position in a particular location in a hospital or in a general practice position. They may re-apply for conditional registration when their conditional registration expires providing they remain in the original area of need position. They are also subject to satisfactory supervisors' reports.

To facilitate the placement of the TROTDs in area of need general practice positions, the assessment processes do not require the involvement of the RACGP or the AMC assessment processes directly. Instead, a set of assessment processes are used in each state and territory that provide the basis of each medical board's decision to register (or not) the TROTD applicant, and to determine the conditions that should apply.

The processes are not the same in each state of territory, but there is a generic set of steps each TROTD has to undertake in achieving temporary resident status and conditional registration as a general practitioner. They are:

- Connect with an 'employer' (or employer's agent) willing to sponsor them for an approved area of need position to which they can (potentially) be appointed – this involves some assessment of the OTD by the recruiter or employer from their perspective;

- Have DIMIA approve the proposed sponsorship and, subsequently, the temporary visa application in the appropriate category (ie a 422 visa) if registration is approved;

- Be assessed by the relevant state or territory medical board for registration and determination of conditions on registration (if granted); and

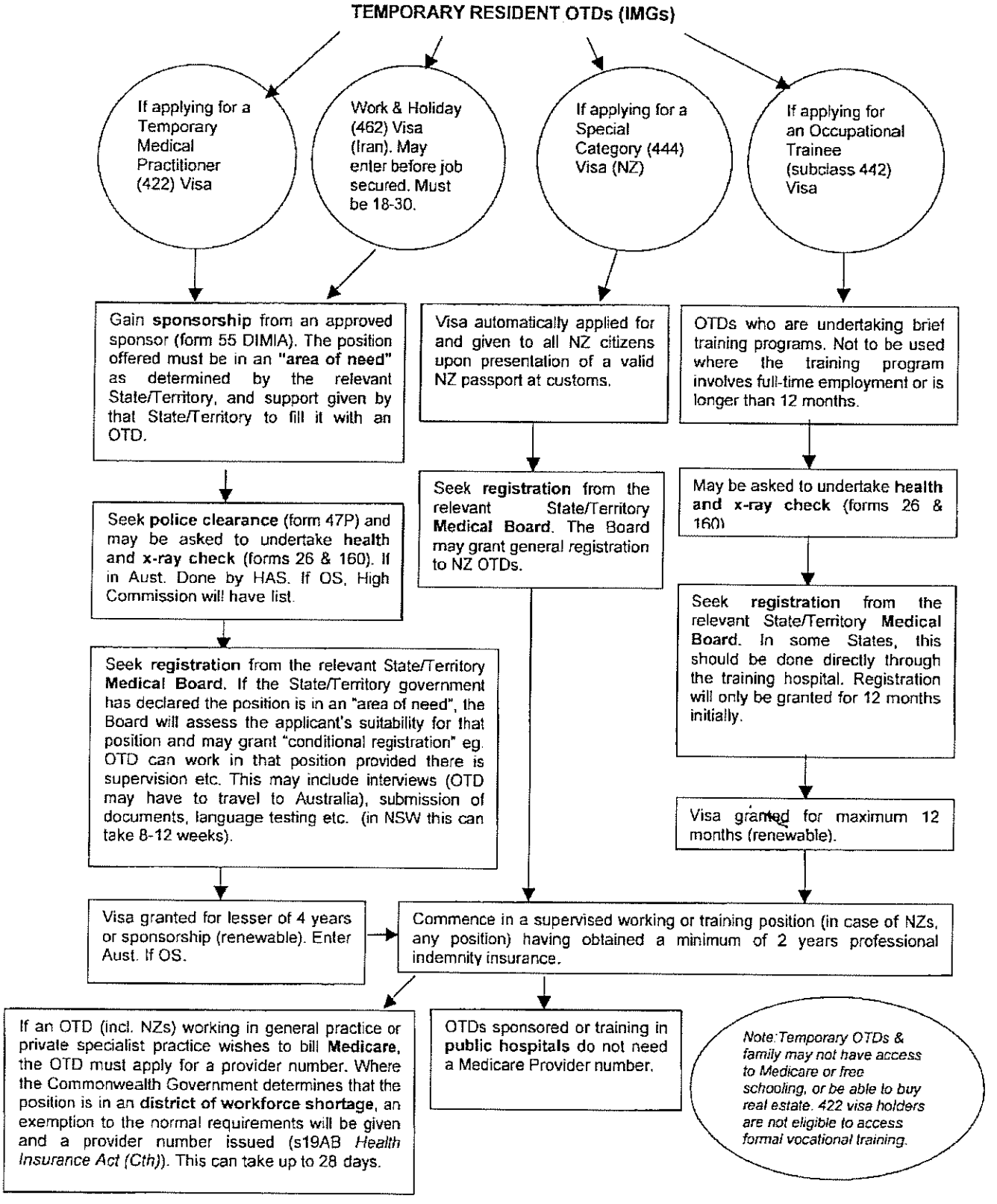
- Successfully comply with and meet all set conditions attached to the conditional registration in the position for the registration period.

The processes controlled by the Department of Immigration and Indigenous Affairs (DIMIA) are more or less the same across the country. It is the other processes that show variations in each state or territory. Figure 1.1 provides a generic map of these processes.

1.2 KEY STAKEHOLDERS

There are a complex range of stakeholders involved in, or with an interest in, the assessment and registration of OTDs working in general practice positions. Some bodies have a national focus, but most have roles focused within a particular state or territory. There are eight separate state or territory jurisdictions.

Figure 1.1: Interim Assessment Flowchart of Temporary Resident OTDs



Some of the key roles and objectives relevant to the various stakeholders include:

- Maintenance of public safety and standards in medical practice and healthcare;
- Medical education, training and professional development (CME/CPD);
- Recruitment, assessment and selection of OTDs for relevant medical vacancies;
- Workforce planning and management;
- Immigration and visa application and processing;
- Representation of general practitioner and medical practitioner interests;
- Representation of OTDs needs and that of their families; and
- Meeting community needs for adequate and appropriate medical services, particularly general practitioner services in rural and remote locations.

1.3 PROJECT AIMS AND OBJECTIVES

The National TROTD Assessment Project aims to ensure that current procedures used for the assessment of temporary resident OTDs entering general practice in Australia are appropriate to maintain the quality of doctors required by the Australian public. The project focus has been on the transparency, quality and national consistency of current processes. The specific objectives are to:

- Document the existing processes that apply to the assessment and registration of TROTDs entering Australia seeking to work as general practitioners or in non-specialist practitioner roles outside the hospital system;
- Clarify the roles and functions of key stakeholder organizations;
- Report on issues and needs in the assessment and registration processes in each state and territory, and nationally in relation to these TROTDs; and
- Identify options that will enhance and improve the national consistency of the assessment processes for each jurisdiction and nationally.

2. ASSESSMENT PROCESSES AND ISSUES

2.1 CURRENT ASSESSMENT PROCESSES

Assessment Processes and Variations

All jurisdictions select and assess TROTDs using information about an applicant's:

- Undergraduate and postgraduate qualifications;
- Medical knowledge and clinical competence;
- General practice experience equivalent to practice in Australia;
- Current standing with relevant professional bodies;
- English language proficiency and general communication skills;
- Cultural awareness, orientation and attitude; and
- Individual intentions and motivation for the position proposed.

This information is assessed in relation to the documented requirements of the medical vacancy in an approved area of need, in order to determine the TROTDs capacity to perform successfully in the job.

The degree to which employers, recruitment agents, rural workforce agencies (RWAs) and medical registration boards in the various jurisdictions collect, check and assess this information varies. For example, some medical boards rely solely on the IELTS language performance of the applicant to assess their English language proficiency, while another board may regard the IELTS pass as a screening test, and still assess the applicant's language and communication skills in a face-to-face interview process to better assess the competence of the OTD and his or her suitability to the area of need position.

The various organisations in any one jurisdiction, will also give varying attention to this information according to their respective role and priorities. A RWA, for example, will generally be more interested in using the assessment data collected from an applicant to identify longer term development and support needs after registration than most medical boards.

All states and territories follow a generic process, but there are significant variations in the way they approach the tasks involved. Key variations include:

- Ways in which an OTD's supporting documentation is prescribed and assessed;
- Whether a medical board conducts key assessment processes itself, delegates them to other agencies or relies on those done by employers or recruiters;
- The level of reliance on a face-to-face, telephone or video based interviews with applicant doctors;
- Approaches used in formal clinical assessment processes and interviews;
- Intensity of supervision of conditionally registered TROTDS; and
- Extent to which assessment processes are used to identify a doctor's training and support needs as a TROTD in general practice.

The jurisdictions also vary in regard to the numbers of OTDs seeking conditional registration in their state or territory, from the ACT with one in 2004 to QLD with around 200 OTDs per month[11].

Assessing the Assessment System

A question raised by these differences and the operations of the assessment systems in each jurisdiction is, "Do they all work effectively, efficiently and safely?"

In understanding how the 'assessment system' works in each jurisdiction, it is important to look at all the processes together. There can be several 'decision points', when:

- An OTD applies to DIMIA for a visa - health and criminal history checks;
- The recruiter or employer assesses and selects an OTD to support;
- An OTD's credentials and documents are verified, and referees followed up;
- Clinical assessments and formal interviews are conducted and results reported;
- Final registration decisions are made and conditions are determined; and
- Supervision arrangements implemented, with reporting as per conditions.

[11] The figure for Queensland covers all OTDs, including those going to hospital positions and Specialists.

It is also useful to consider how robust the whole system is. If a check or assessment fails at one point in the system will it be picked up at another point?

2.2 ASSESSMENT ISSUES

Assessment for Public Safety

The role of medical boards is commonly stated in terms of public safety. For example, the Medical Board of the ACT states its primary role as:

... to regulate the medical profession in the interests of public safety through firstly the registration of medical practitioners and secondly the promotion and maintenance of high standards of medical practice...[12]

It is important to note here that:

- Some overseas trained doctors will have levels of competence and capacity well above the threshold level required to achieve registration. This will be critical to employers in seeking and assessing the 'best matched candidate' for an area of need position, but not necessarily as important to the registering board;

- Public safety manifests in the actual performance of 'high standards of medical practice' under the practical conditions and pressures of each doctor's professional workplace, and a doctor's ability to pass an exam is not a full or automatic measure of this capacity to perform safely;

- A doctor's 'safe performance' in one workplace environment may be unsafe in a different workplace, for example, one with less supervision, different health issues or greater work pressure; and

- 'Safe performance' in a doctor is the result of a number of important factors, one of which is the doctor knowing his or her limits of knowledge or experience, and being willing to seek external help or support.

It is, therefore, very important that an effective understanding of what determines the capacity to perform safely in a general practitioner, and how it can be properly assessed, is available to and informs each jurisdiction's assessment process. This seems particularly relevant when we are seeking to place OTDs from different countries, work environments and cultures in demanding, responsible and commonly isolated area of need positions.

What needs to be clear here is that the prime role of medical boards is to ensure public safety in the practice of medicine in their particular jurisdiction for TROTDs destined for GP positions in areas of need.

[12] Medical Board of the ACT, Annual Report – 2003-2004

What Constitutes Effective Assessment?

The assessment of an OTD seeking to work in general practice in Australia under a temporary visa involves an evaluation of a range of information about the doctor (noted earlier) and their match to the position for which they are proposed. These assessments may be done in part or in whole by employers, recruitment agents, RWAs and/or the medical boards themselves.

The main methods used include documenting the requirements of the area of need position, verifying qualifications and documents of work experience and professional standing, using telephone, video or face-to-face interviews with applicant doctors, conducting clinical assessment and collecting referee data from nominated medical referees, who satisfy prescribed criteria.

These methods are used by medical boards or their agents in most jurisdictions, but not uniformly or consistently. For example, interview and clinical assessment approaches are generally specific to each state or territory. Further, most methods used do not follow any national standard or template[13], other than that that may be implicit within the medical practice profession. An exception is the proposal by the medical boards to use a common performance standard in the IELTS for English language proficiency.

For national consistency in the assessment processes there needs to be an explicit agreed model. It can be a broad model with substantial room for adaptation by each jurisdiction or it can be more detailed. One step might be to identify key process tasks in the following four stage framework (see Table 2.1). Typical process tasks for each stage are indicated. They are not necessarily sequential.

Within this framework it is possible to add or remove tasks depending on whether or not they are judged as essential. Essential tasks can then be considered in terms of how they can best be conducted, and who should be responsible for them.

These and other possible essential tasks need to be the focus of discussion and review about achieving enhanced national consistency. Is there an approach to an essential task in one or more jurisdictions that could provide a 'best practice' template if shared and adopted beneficially in other jurisdictions?

[13] It is noted that there are a number of templates used by the AMC, RACGP and ACRRM in other assessment processes, but not in this instance for processes that apply to TROTDs going to area of need GP positions

Table 2.1 An Assessment Process Framework

Process Stage	GP/Area of Need Position Requirements	Preliminary Assessment of OTD	Full Assessment of OTD for Position	Post Registration Supervision
Process Tasks	- Detailed profile of GP vacancy and community/practice context - Application for Area of Need certification - Profile of suitable doctor attributes	- Qualifications and experience - Professional standing - English language proficiency - Health check - Criminal history check - Referees' feedback data - ID and document certification - Employer sponsorship application to DIMIA - Applicant's visa application	- Medical knowledge - Clinical application and competence - Communication skills - Cultural awareness and sensitivity -OTD's motivation and intentions - OTD's awareness of practice realities - Fitness for proposed GP position - Medical Board decision and letter - Complete visa application	- Supervision process and arrangements - Post-registration training/orientation - Supervision reporting process and frequency

Who Provides the Assessment?

The range of current assessment tasks may be performed by an employer, a recruitment agent, the RWA, the medical boards, or a combination of them in any one jurisdiction.

Any assessments of medical knowledge and clinical competence for a medical board must serve the medical board's objectives (ie ensuring public safety). If the board relies on another organisation to carry out the assessment then they need to ensure themselves that their agent is competent and the assessment process used appropriate and robust.

Third party agents, such as, the AMC, the RACGP, ACRRM, university medical schools and independent training and assessment organisations could play a role in undertaking some assessment process to an agreed standard. Ultimately, there needs to be clarity of interests and clear objectives.

Appropriate Standards and the Level of Supervision

There is usually a much wider 'scope of practice' for general practitioners in rural and remote positions than their urban GP counterparts, together with high levels of clinical responsibility. This may require a greater involvement in primary care activities through to expectations to work competently in one or more medical procedural areas.

Therefore, employers, recruitment agents and RWAs generally prefer to recruit OTDs with substantial qualifications and relevant experience for GP positions in areas of need, as with NRP[14] category 1 and 2 doctors. These doctors are likely to be best suited to the positions and locations, and require less support and supervision than other doctors with fewer qualifications and less experience. As NRP category 1 and 2 doctors are increasing hard to recruit, employers are forced to seek suitable doctors in other NRP categories requiring greater levels of supervision and support.

[14] NRP – National Reference Panel, a scaled system of classifying doctors' qualifications and experience for the Australian environment.

Providing effective supervision in rural and remote locations is difficult. Medical boards take this into account in their registration decisions for TROTDs. Thus an OTD may be conditionally registered to work in a hospital, whereas the same OTD may not be conditionally registered for a general practice position.

Conditional registration requires a supervision arrangement to be in place for the TROTD and for periodic supervisory reports to be sent to the registering medical board. These can vary from monthly (for the first three months in NSW) to one at the end of one year. In setting the supervision and other conditions, the medical board takes into account the doctor's level of competence and experience.

Decisions about supervision are made on a case-by-case basis. There are explicit standards provided by RACGP and ACRRM for use in selecting supervisors and arranging supervision for the Australian General Practice Training Program (AGPTP). These supervisors do have a wide on-going educational role, and are paid for their contributions, so are not strictly comparable to supervisors of TROTDS in area of need positions.

Orientation and Induction of TROTDs

Nearly all TROTDs, regardless of their background require some orientation and familiarization training before commencing work, particularly in general practice positions.

To assist the OTD in this, there needs to be training or briefing that provides an effective understanding of the:

- Australian healthcare system, including the operation of Medicare and the Pharmaceuticals Benefits Scheme and specific terminology and language common used in medical practice;
- Typical disease profiles dealt with in a practice location and 'best practice' treatments used in the Australian context;
- Communication styles and cultural attitudes likely to be encountered in medical practice in rural and remote locations or in indigenous communities; and
- Wider non-medical structures, culture and processes in Australia and the particular jurisdiction that provide the context for the TROTD's work.

Employers, recruitment agents, RWAs, as well as medical boards provide access to orientation programs and training. However, there is a cost and the level to which these programs are provided varies within jurisdictions, between programs and across the jurisdictions nationally.

Examples of a Field Approach to Orientation

A field approach to orientation and induction is reflected in the following practices:

- One rural practice in South Australia regularly hosts an OTD for three to four weeks initial work experience before going to his or her appointed position in the same region. This relatively short experience provides a valuable orientation to rural general practice for the OTD at the start of their appointment, as well as establishing professional contacts. In the practice there are a number of other doctors to call on for support. Time is invested by the other doctors in supporting the OTD, but this is balanced by the chargeable consultations done by the OTD.

- An established general practitioner in WA has recruited an OTD, but rather than immediately locate him in a remote area where the GP vacancy is, the GP has first given him experience of working in a larger practice, followed by a series of short work visits (with the GP) to remote townships where the GP has a fly-in-fly-out practice. Gradually, the OTD spends more and more time in the remote location and eventually does so without the GP being present. From time to time the OTD is also able to take two or three week breaks to undertake further medical education and training.

These examples illustrate approaches that can provide better supervision, support, mentoring and progressive independence for the OTD as he (or she) learns and adapts to the conditions and context of the new general practice.

The Five Year Scheme

The Five Year Scheme for OTDs was established about six years ago and has placed nearly 300 general practitioners in remote areas of need positions. Last year it was up-graded with enhanced incentives and support for the Scheme doctors and families in the field. The OTDs on the Scheme were selected for their professional qualifications and extensive general practice experience.

The Scheme provides a clear career pathway for a select group of TROTDs to full registration, fellowship with the RACGP and freedom to practice with an unrestricted Medicare provider number.

3. SUMMARY

Overseas trained doctors (OTDs), or international medical graduates (IMGs), are an increasingly important part of Australia's medical workforce and will continue to be so for the foreseeable future. OTDs come to Australia via many routes. One method of entry of growing importance is for the OTDs to enter as a temporary resident OTDs to fill approved area of need general practice positions in rural and remote locations. 3,184 temporary resident medical practitioner visas (422 visas) were granted between December 2003 and January 2005 to doctors from over 70 countries.

This method of entry as temporary resident OTDs (TROTDs) requires the doctor to:

- Have sponsorship from an employer for a specific medical vacancy approved as an area of need position by the state of territory government;
- Be assessed by the relevant state or territory medical board as competent to practice medicine safely in the specific position and location; and
- Be registered to practice in this position only, subject to specific conditions including supervision.

This means of entry to Australia facilitates the flow of OTDs to hard to fill general practice vacancies in areas of workforce shortage.

The responsibility for assessing the competence and safety of these OTDs to practice as GPs in the sponsored position is held by the medical board or council in each state and territory. While the boards all share the same generic process for conditionally registering the OTDs, each board varies in its approach and methods. In addition, various other roles are played by other stakeholders such as employers, recruitment agents, rural workforce agencies, doctor support groups and the state departments of health. This makes a complex operating environment.

Key issues include:

- Adequately describing the vacant area of need positions and profiling the requirements to fill it - including communication skills, cultural sensitivity as well as clinical competencies, so a proper matching with the OTD can occur;

- Ensuring comprehensive and accurate information is collected and submitted - by the applicant OTD as a basis for an informed assessment;

- Deciding how best to assess an OTD's clinical competence and capacity to perform safely in the area of need position - including whether or not a face-to-face clinical assessment or structured interview type process is needed;

- Ensuring effective and practical supervision and support processes - for conditionally registered TROTDs in the field.

- Lengthy and unclear delays in assessment processes - assessments must be completely in a timely fashion in order to prevent an assessment 'bottle-neck' occurring, or discourage overseas trained doctors in seeking employment in the Australian medical workforce.

~~Colliota~~
Colleen

RS:dt

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13 November 2002

Associate Professor Lloyd Toft
President
Medical Board of Queensland
GPO Box 2438
Brisbane Qld 4001

Dear Professor Toft

As we have discussed verbally, I am keen to arrange a meeting between the Medical Board and AMAQ to address a number of issues in relation to Queensland's use of overseas trained doctors (OTDs) and temporary resident doctors (TRDs).

There is widespread concern amongst the medical profession regarding the standards of medical practitioners with overseas qualifications and this begs close investigation of the current processes of assessment and registration of such doctors in Queensland.

AMAQ would suggest that such investigation should include:

- Consideration of the conflicting pressures of need compared with quality given the current workforce landscape, and
- Closer investigation of assessment of skills and standards, registration, and later support of general practitioners from overseas, as it appears to be this area of medicine where problems arise with the most regularity.

AMAQ would also be hopeful that some new initiatives relating to use of OTDs and TRDs in Queensland could be implemented.

This would include monitoring recruiting agencies and the development of 'industry standards', along with the establishment of a mentor system for overseas trained doctors and a requirement that they be placed in established medical practice environments, rather than be asked to fill sole practitioner positions. However, if the vetting system resolved that in certain cases a doctor would be able to fill a sole practitioner position, this would be allowable.

Once these processes have been consolidated, it is equally important as outlined in my letter of 6 November, that these OTDs are supported by the profession and their conditions of service are satisfactory.

Yours sincerely

Dr Russell Stitz
President

Callista

RS:dt

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13 November 2002

Associate Professor Lloyd Toft
President
Medical Board of Queensland
GPO Box 2438
Brisbane Qld 4001

Dear Professor Toft

AMAQ wishes to establish a line of open communication with the Medical Board and Queensland Health regarding issues relating to the registration and introduction of Overseas Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs) in Queensland.

In August AMAQ fulfilled a long-held desire to establish its own TRD/OTD Sub-Committee to investigate issues impacting on overseas trained doctors working in Queensland.

During the past three months the sub-committee, which is chaired by Sarina GP and AMAQ Area Representative Dr Marsh Godsall, and is made up of a small group of OTDs and TRDs, has identified the key areas of concern affecting doctors from overseas who come to work in Queensland.

The areas of concern identified are as follows:

- Inadequate preparation and/or introduction to the style and mode of medicine and practice in the private sector (general practice) and the public hospital system (Queensland Health).
- Inappropriate terms and conditions of employment, and
- Lack of regard paid to the foreign doctor's personal requirements – to the extent that many nominate a "sense of insecurity" as the most common problem they face.

In an effort to begin to address these problems, AMAQ is keen to establish contact with foreign doctors upon their arrival for work in Queensland.

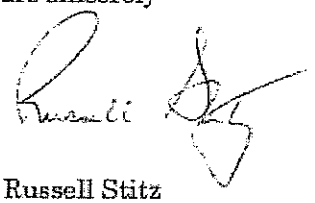
The Association is hopeful of achieving this via the Medical Board, and in the form of a welcome letter from AMAQ that would be included in the introductory package given to the OTD/TRD upon their arrival. The letter would outline a brief introduction to medicine in Queensland and would offer the doctor AMA assistance in gaining a full introduction and connecting with a support network for the duration of their time in our State.

It is unarguable that all States of Australia rely heavily on the use of OTDs and TRDs to fill a well-recognised medical workforce shortfall. It is therefore vital that we create a working environment in Queensland that looks after overseas trained doctors and one that ensures their Australian experience is rewarding and beneficial.

In doing so, we must ensure that the excellent standards of medicine which exist in the Australian medical workforce are complemented by foreign doctors of an equally high standard.

AMAQ representatives would appreciate the opportunity to meet with you to discuss these plans in further detail.

Yours sincerely



Dr Russell Stitz
President
Queensland Branch of Australian Medical Association

9 December 2002

Mr Jim O'Dempsey
GPO BOX 2438
BRISBANE QLD 4001

Dear Mr O'Dempsey

Re: Medical Board's Strategic Plan 2003-2007.

Thank you for inviting The Queensland Branch of the Australian Medical Association to comment on the direction of the Medical Board's Strategic Plan 2003-2007. In response to your invitation, the Association submits the following comments.

Following these comments, the Association would be interested to learn of the outcome of the strategic plan developed for 2003 – 2007 and any reforms to be implemented.

If you require any further information, please do not hesitate to contact either myself on 07 3872 2222, or AMAQ Policy Officer, Ms Colleen Smyth on 07 3872 2268.

Yours sincerely

Russell Stitz
President

Medical Board Strategic Plan
AMAQ COMMENTS

Following are the Queensland Branch of the Australian Medical Association's (AMAQ) specific comments on the consultation period for the Medical Board's Strategic Plan for 2003 – 2007.

Functions of the Board

OVERSEAS TRAINED DOCTORS AND TEMPORARY RESIDENT DOCTORS

Due to the fact that Queensland relies quite heavily upon Oversees Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs) to subsidise its well-recognised medical workforce shortfall, it is vital the working environment in Queensland looks after and monitors sufficiently OTDs.

OTDs should be expected to fulfil and maintain the same standards and requirements typically expected of medical practitioners in Australia. Under the Board's responsibilities governed by the *Registration Act*, the Board should give consideration to location, training and language when registering OTDs & TRDs.

Recommendation:

- **That the Board use more resources to adequately assess the requirements of, and the best location of OTDs and TRDs.**
- **AMAQ would also like to request permission to insert a welcoming letter to all registrants into the package given by the Board at the commencement of their time in Queensland.**

COMPLAINTS & INVESTIGATIONS

During the course of conducting the consultation process, members of the AMAQ have identified that the Board, in some instances, undertakes complaints handling against medical practitioners in an overly adversarial manner. AMAQ is also concerned with the inability of the Board to deal with lodges and complaints in a timely and efficient manner.

Streamlining Complaints Handling

In recognising the workforce constraints the Board itself is placed under, AMAQ calls upon the Board to review and re-structure the process by which complaints are received, handled and resolved. AMAQ believes that by streamlining the complaints process and reducing the timeframes for resolution, the Board would reduce the undue burden of stress and anxiety placed on a doctor under investigation.

Recommendation:

- **The Board revisits its policy on the handling of minor complaints and criteria which determines a complaint as either a Medical Board or**

could lessen the current administration burden by referring these complaints to the HRC.

- **The Board should seek to develop strategies that enable complaints and disciplinary matters to be dealt with expeditiously. Specific, key performance indicators should be implemented to monitor each individual complaint process. The time needs to be reduced to between 3 and 6 months depending on the gravity of the complaint. AMAQ believes this can be achieved by allocating more resources to the complaints handling function and streamlining the complaints handling process.**

COMMUNICATION BETWEEN THE BOARD AND PRACTITIONERS UNDER INVESTIGATION

Whilst it is acknowledged that in most instances, investigations of complaints by the Board are dealt with in an objective and balanced way - there is a feeling amongst the profession that, at times, the manner in which the Board investigates complaints is overly adversarial.

It has been identified that some investigations are carried out in such a way as to suggest the doctor is felt to be guilty even before the investigation has concluded. Also, some documents and information relevant to the complaint are not provided to the legal advisers assisting the doctor.

Evidence of this sentiment is demonstrated by the following comment submitted to AMAQ:

> *"To be stood down by the Royal Flying Doctor Service for 9 to 12 months while the Medical Board is investigating a complaint is akin to being found guilty until proven innocent. It is demoralising, de-motivating and deskilling".*
>
> Dr Balmain, General Practitioner

Recommendation:

- **AMAQ suggest the Board review its position on complaints handling, particularly in the way in which communication between the doctor and the Board is handled.**

RE-REGISTRATION

The Association would like to express concern regarding the process by which the Board handles renewals of registration, particularly the methods used to locate doctors when registration nears expiry or has lapsed. Some sections of the profession are typically transient, such as Doctors in Training, and rely heavily on communication from the Board. Failure to re-register, even by minor oversight has some significant ramifications for practitioners, including loss of medical indemnity coverage.

Recommendation:

- **AMAQ therefore requests that the Board undertake reasonable steps to locate practitioners due to re-register. These measures could include letters, email notifications and follow up phone calls.**

EXPERT MEDICAL REPORTS

In the course of this consultation, AMAQ was made aware by members that the Board conducts investigations into expert medical reports and their authors, based upon complaints made by a party to the proceedings.

AMAQ is concerned that:

- complaints may be made by aggrieved persons involved in the proceedings to which the report pertains. These complaints may be of a minor nature, fuelled by the emotionally charged time of litigation;
- defending the medical opinion in the report to the Board as well as to the proceedings becomes too time consuming and onerous for the practitioner;
- practitioners will consequently be discouraged from providing expert medical reports.

Recommendation:

- **That the Board refer all complaints regarding expert medical reports to the Colleges for their respective review. AMAQ makes this recommendation on the fact that it is the Colleges who have a greater knowledge of the speciality and the individual practitioner concerned. The Medical Board should endeavour to work cohesively with Colleges to uphold the high standards of the profession.**

RELATIONSHIP WITH THE COLLEGES AND UPCOMING CONSULTATION TO DEFINE CURRENCY OF PRACTICE

AMAQ looks forward to working with the Board, Queensland Health and the respective Colleges in future consultation processes to develop registration categories and to define Recency of Practice.

AMAQ strongly believes that this consultation process should be a co-operative effort between the Board and the respective Colleges to define recency of practice requirements and categories of registration as the Colleges are integral in defining and administering speciality requirements.

Conclusion

The Medical Board serves a vital role to both the profession and the public in maintaining safety and standards within profession.

The Board's extended functions include licensing, academic and industrial roles. In preventing these roles becoming mutually exclusive, the Plan should include an ongoing commitment to *understanding the needs* of registrants and the public and *responding to these needs* appropriately and efficiently.

Callista

RS:dt

Queensland Branch of Australian Medical Association

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13 November 2002

Associate Professor Lloyd Toft
President
Medical Board of Queensland
GPO Box 2438
Brisbane Qld 4001

Dear Professor Toft

AMAQ wishes to establish a line of open communication with the Medical Board and Queensland Health regarding issues relating to the registration and introduction of Overseas Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs) in Queensland.

In August AMAQ fulfilled a long-held desire to establish its own TRD/OTD Sub-Committee to investigate issues impacting on overseas trained doctors working in Queensland.

During the past three months the sub-committee, which is chaired by Sarina GP and AMAQ Area Representative Dr Marsh Godsall, and is made up of a small group of OTDs and TRDs, has identified the key areas of concern affecting doctors from overseas who come to work in Queensland.

The areas of concern identified are as follows:

- Inadequate preparation and/or introduction to the style and mode of medicine and practice in the private sector (general practice) and the public hospital system (Queensland Health).
- Inappropriate terms and conditions of employment, and
- Lack of regard paid to the foreign doctor's personal requirements – to the extent that many nominate a "sense of insecurity" as the most common problem they face.

In an effort to begin to address these problems, AMAQ is keen to establish contact with foreign doctors upon their arrival for work in Queensland.

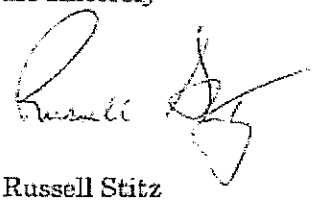
The Association is hopeful of achieving this via the Medical Board, and in the form of a welcome letter from AMAQ that would be included in the introductory package given to the OTD/TRD upon their arrival. The letter would outline a brief introduction to medicine in Queensland and would offer the doctor AMA assistance in gaining a full introduction and connecting with a support network for the duration of their time in our State.

It is unarguable that all States of Australia rely heavily on the use of OTDs and TRDs to fill a well-recognised medical workforce shortfall. It is therefore vital that we create a working environment in Queensland that looks after overseas trained doctors and one that ensures their Australian experience is rewarding and beneficial.

In doing so, we must ensure that the excellent standards of medicine which exist in the Australian medical workforce are complemented by foreign doctors of an equally high standard.

AMAQ representatives would appreciate the opportunity to meet with you to discuss these plans in further detail.

Yours sincerely



Dr Russell Stitz
President
Queensland Branch of Australian Medical Association

Colleen

Medical Board of Queensland

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RECORD NO M372:mdg

10 December 2002

REC'D AMAQ
13 DEC 2002

Dr Russell Stitz
President
AMAQ
PO Box 123
RED HILL QLD 4059

Dear Dr Stitz Russell

Thank you for your two letters of 13 November 2002 regarding standards of overseas trained doctors (OTDs) and temporary resident doctors (TRDs).

The Board has noted the areas of concern identified by the AMA sub-committee and the AMAQ proposals in this respect. The Board considers these issues are worthy of further discussion between AMAQ and the Board.

A meeting to deliberate on these issues will be convened early in the new year, and the Board's Executive Officer will contact Mr Kerry Gallagher to make the arrangement.

Yours sincerely

COPY

Associate Professor L Toft
President
Medical Board of Queensland

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