Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 03/06/2005

..DAY 9

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 10.10 A.M.

MR B BARTLEY (of Brian Bartley & Associates) for Mrs Linda Mulligan

COMMISSIONER: I'm sorry to have kept everyone waiting. After last night's marathon there were a few things that had to be dealt with. Mr Andrews, your first witness?

MR ASHTON: Commissioner, may I be heard?

COMMISSIONER: Yes.

MR ASHTON: You invited Mr Diehm and I at least to have our say, so to speak, in respect of the evidence last Thursday, and I foreshadowed that I would seek to do so today, and I think you agreed - is it convenient now, Commissioner? I'll be very brief.

COMMISSIONER: Well, certainly if it's going to be brief you're welcome to.

MR ASHTON: Thanks. In a sense we decided against the course of a comprehensive statement, so to speak, but there is one matter that I wish to clarify, if I may, Commissioner. At the conclusion of my client's evidence on Thursday last - and the relevant passage appears at page 389 line 20 - I said that we did not dissent about your authority and power to require Mr Leck to give evidence, and I said further that I didn't complain about your decision to do so.

My concern, Commissioner, is that that ought not to be thought to be an acquiescence in the implementation and the content of the questioning of Mr Leck. We say, respectfully, that that process was unfair, unnecessary, unexplained and, in the context of the treatment of witnesses in the commission so far, essentially unique to our client. We've come to the view-----

COMMISSIONER: I don't think Mr Diehm would agree with that.

MR ASHTON: I'm sorry?

COMMISSIONER: I don't think Mr Diehm would agree with that.

MR ASHTON: I use the word "essentially" advisedly because of the two - whether he agrees or not he can say, Commissioner. We've come to the view that there's nothing to be gained by statements in response on the run, so to speak, and rather it's our view that we should, if the position is reparable, we should seek to repair it by an orderly and developed statement, which was what the Commission had originally contemplated and asked us to do. We are in the process of complying with it. Evidence about those matters can be before

the Commission in due course.

I don't wish to say anything further, thanks, Commissioner.

COMMISSIONER: Thank you. Mr Diehm?

MR DIEHM: Well, Commissioner, I don't make the same complaint my learned friend does or the same reference. In my submission, whilst the cross-examination from you, Commissioner, of Dr Keating was vigorous, of itself my client doesn't make any complaint-----

COMMISSIONER: No.

MR DIEHM: -----at this point in time, and in my submission, for what it's worth, my client does view his cross-examination as different from that of Mr Leck's, but that's a matter for Mr Ashton to comment upon rather than me.

Commissioner, there is one other matter, though, that I wish to raise. Perhaps I should deal firstly with Mr Ashton's position versus mine with respect to responding.

COMMISSIONER: Yes.

MR DIEHM: As I indicated earlier in the week, it's my client's intention to respond to the allegations and matters concerning him comprehensively rather than in a piecemeal fashion.

COMMISSIONER: Certainly.

MR DIEHM: Work has been progressing on that continuously since the time this inquiry started. It's a big job and will take time.

COMMISSIONER: You'd expect to do that by the time we're in Bundaberg in two weeks' time?

MR DIEHM: Yes.

COMMISSIONER: That would be entirely satisfactory. Perhaps I can ask Mr Ashton whether that will be sufficient time for your client too.

MR ASHTON: I think so. We've been working hard at it and we think we'll be right.

COMMISSIONER: Yes.

MR DIEHM: The other matter that I wished to raise concerns the disclosure that you made yesterday regarding the meetings with witnesses.

COMMISSIONER: Yes.

MR DIEHM: I need to say this at this point in time, and if something further is required then it may well be I expect I

will put in a written submission to allow Mr Andrews to assist you by responding to it.

COMMISSIONER: Yes.

MR DIEHM: But to avoid any suggestion of acquiescence, it will be my submission that it is a requirement of procedural fairness that if the Commissioners have received information which affects adversely or favourably any party before the Commission, or any other person who may be affected by the commission's determinations, that at an appropriate time and in an appropriate way the party is entitled to be informed of the substance and effect of that information, and potentially its source as well.

COMMISSIONER: I accept the force of that entirely, Mr Diehm. I will ask counsel assisting to refresh my memory on this, but my recollection is that your client, Dr Keating - and for that matter Mr Ashton's client, Mr Leck - that their names were not even mentioned at any of the meetings that I've referred to. Mr Andrews and the other counsel assisting might reflect on that, but that's my recollection at the moment. Certainly if there were anything which had emerged - everyone will understand that the inquiry process is different from the Court. There's a lot of evidence gathering going on, some of it at meetings, a lot of it in the form of documents. We've had, I'm told, over 20,000 documents from Queensland Health. I don't pretend to have read every one of them, or even a substantial proportion of them.

Statements have been obtained from many, many witnesses, and ultimately we may well make a decision that we don't need to call on them. All of that information gathering has gone on. If anything emerges from any of that that reflects adversely on either your client or Mr Ashton's client, or any other individual, then of course you will be given the opportunity to respond to that, and if natural justice requires disclosure of the source, then the source will be disclosed. But I'm pretty confident in saying that there has been no information of that type - information revealed at meetings which I've attended, in any event - relevant to your client or Mr Ashton's client. If there is, I've no doubt that counsel assisting will remind me of it and your client will be given every opportunity to respond.

MR DIEHM: Thank you, Commissioner. In that circumstance, I won't trouble you with any further detailed written submission about the point, because I'm perfectly happy with what you've said in that respect.

COMMISSIONER: Mr Andrews, are you in a position to assist me with that at the moment?

MR ANDREWS: I have no recollection of the names of either Dr Keating or Mr Leck having been raised at meetings, and in respect of the request for natural justice, my understanding of the authorities is that in commissions of inquiry, as a minimum, if evidence emerges that adversely affects the

interests of any particular person, those persons are given at least the opportunity to make submissions after the evidence has been received. In an ideal situation - and I hope that this will be an ideal situation - they will also be given an indication of what sort of issue will be canvassed by the evidence in advance.

COMMISSIONER: Yes, I accept all of that, Mr Andrews, and I might only add for the benefit of Mr Diehm and Mr Ashton, and anyone else concerned in the matter, that really, I think it's fair to say that there was no detailed discussion of the substance of anyone's evidence at the meetings. As I said yesterday, their primary purpose was to reassure witnesses. Sometimes lines of inquiry were made known to us - and I mentioned yesterday the example of the Hervey Bay Orthopaedic Report, and that was followed up as a line of inquiry.

I don't want anyone to be under any misunderstanding that this was some sort of secret evidence gathering process. It wasn't, and should those witnesses ultimately be called to give evidence, all of their evidence will be given in a public forum and Mr Diehm, Mr Ashton, and anyone else will have the opportunity to cross-examine their evidence and, in accordance with the practices we've adopted, would be given statements in advance so that they can prepare that cross-examination in an appropriate way.

MR ANDREWS: That's my ambition, Commissioner.

COMMISSIONER: Does anyone else have anything to say arising out of Mr Ashton's and Mr Diehm's comments?

MR DIEHM: I just have one final thing I wanted to say, reverting to the earlier topic with respect to the questioning of Dr Keating last Thursday afternoon.

COMMISSIONER: Yes.

MR DIEHM: There is no doubt, in my respectful submission, that Dr Keating to a lesser extent than Mr Leck was treated differently than other witnesses who have been called before this inquiry. That in itself is not a problem, provided, of course, that he's given every opportunity to properly defend himself through cross-examination of other witnesses and through subsequent evidence he may give.

So that is the reason for my submitting that just because he was dealt with in that way, it's accepted that that in itself is not problematic for the inquiry as long as - as I'm sure you will afford him Commissioner - he has that opportunity to respond in due course.

COMMISSIONER: I thank you for that, and I'd also remind everyone that at that point in time we were under the misapprehension that we would not be in a position of having any witness exposed to cross-examination on matters potentially relevant to the CMC inquiry until the Bundaberg sittings, and that was why it was felt desirable to get

Mr Leck's and Dr Keating's response to the critical issues on the record at that stage. Obviously if events had taken a different course the approach to both witnesses' evidence might have been quite different, but that's a matter of history and none of us can do anything now.

MR DIEHM: Thank you.

MR ASHTON: I wouldn't want it thought that I acquiesce in that explanation of things either, with respect.

COMMISSIONER: Sorry, what are you saying?

MR ASHTON: I'm saying, Commissioner, that if that means that - well, for a start it would be our submission that our client was, in effect, cross-examined, if not in the sense of formal, legal nomenclature, but in so far as the - it's justified by reference to the anticipation that it might have been somehow defended in the following week in the CMC proceedings, we're left in confusion about that, Commissioner, because it implies that the interrogation, the questioning of my client, was somehow the charges, and the defence would come in the CMC the following week.

COMMISSIONER: Not like that at all.

MR ASHTON: May I finish?

COMMISSIONER: Say whatever you like.

MR ASHTON: We're left in particular confusion because on 13 May the CMC wrote this to us:

> "You are advised that for public hearings, as a general rule where a person is the subject of an allegation, that person will be given the opportunity to respond to the specific allegation in a formal interview or private hearing prior to the evidence being led in a public hearing. As I previously advised, it is likely that your client will be invited to participate in an interview prior to the public hearing."

COMMISSIONER: Yes.

MR ASHTON: That doesn't seem to accord with the anticipation that we would have a public hearing here and a defence there.

COMMISSIONER: Let me respond to that as clearly as I can. My concern has been that peoples reputations not be subjected to adverse evidence without those people having the opportunity to defend themselves promptly and in a public way. The fact that I required both Dr Keating and Mr Leck to give their version in relation to the evidence which we had already heard from both Nurse Hoffman and Dr Miach was in the expectation that they would have a public and open forum in which to respond fully to those matters within a short timeframe.

Regrettably that has not proved to be the case. As soon as it

became known to me that your client and Mr Diehm's client would not have that opportunity to defend themselves in a public forum, I sought by way of damage control to give them that opportunity by another means, and that was by inviting anyone who wished to do so to make a statement outlining their client's response to those matters. You have chosen not to avail yourself of that opportunity, and that's entirely a matter for you, but if there is some implicit challenge to the sincerity of our position - or my position, then I reject that.

The questions were asked in the clear understanding that Dr Keating and Mr Leck would have that public opportunity to vindicate their position. That was taken away from them by the decision of the CMC, and that is why I've given them an alternative opportunity to do so. They will have yet another opportunity to do so in two or three weeks' time in Bundaberg.

I don't know what else I can possibly do to give your client or Mr Diehm's client an opportunity to redress any adverse publicity to which they feel they might be subject. If there is another suggestion you have, Mr Ashton-----

MR ASHTON: No, I don't know how else it might be done either.

COMMISSIONER: Right. Mr Bartley, I see we're honoured by your presence.

MR BARTLEY: Well, I'm here in any event, Mr Commissioner. I act for the Director of Nursing, Mrs Linda Mulligan, and I seek leave to appear on her behalf.

COMMISSIONER: You have such leave. Mr Bartley, I'm sure you're aware that your client's name emerged in evidence, I think on Tuesday or Wednesday of last week. I don't have the exact date in my mind.

MR BARTLEY: Yes.

COMMISSIONER: It turned out that you were out of Brisbane at the time so a representative of your office was invited to attend, but your position will be the same as that of the representatives for all other individuals, that you are welcome to come or go as often and as much as you please. I'm conscious of the fact that it costs people money to have their legal representatives in Court, whether they're paying for it out of their own pockets or whether they're supported by an industry association or some other organisation, and I don't want to put anyone to unnecessary expense.

We will, of course, Mr Bartley, be delighted to have your presence whenever it suits your convenience to be here, but don't feel a need to remain the whole time or to seek leave to withdraw or anything like that. It's come and go as you please.

The extent of your participation is entirely a matter for you. Whether you wish to cross-examine witnesses, whether you wish

to lead evidence-in-chief from your client when she gives evidence, whether you want to make submissions at the end of proceedings, and indeed whether you want to take advantage of the opportunity extended to both Mr Ashton's client and Mr Diehm's client of making a public statement on behalf of Mrs Mulligan, those are all matters for you.

MR BARTLEY: Yes, thank you, Mr Commissioner. In fact I've been kept well informed by the Commission staff who have been very co-operative in providing me with copies of transcript as we go, and we appreciate that.

COMMISSIONER: I'm glad we've been able to please someone anyway.

MR BARTLEY: Might I inquire, the indication that you gave a moment ago about making available details of information obtained in private meetings, whether that would extend to information conveyed in interviews with the CMC?

COMMISSIONER: Now, the situation in relation to the CMC has changed somewhat since their decision not to proceed with their public sittings. I understand we now have blanket permission to disclose to the parties' representatives any statements which have been provided to us by the CMC. Is that your understanding, Mr Andrews?

MR ANDREWS: I was to be briefed on Monday as to those matters, Commissioner.

COMMISSIONER: That's my understanding. It's subject to correction when Mr Andrews speaks with the CMC on Monday, but I would foresee no difficulty in providing to your client and to the legal representatives of other individuals any of those CMC statements which mention or refer to your client either positively or adversely or in a neutral way.

MR BARTLEY: Thank you.

COMMISSIONER: We'll certainly do our best to facilitate that outcome. With other witnesses you will appreciate, Mr Bartley, that statements are being produced as we go, and if things come up that are relevant to your client they will be distributed to you as soon as they're available for distribution to everyone else.

MR BARTLEY: Thank you.

COMMISSIONER: Thank you. Yes?

MS McMILLAN: Mr Commissioner, just briefly, the witnesses today - I understand Dr Lennox will be first.

COMMISSIONER: Yes.

MS McMILLAN: His statement is fairly lengthy. It's only fairly recently become available. I imagine you will probably be taking a morning break as per usual, so perhaps we might

take instructions then. I think some of us have only fairly recently obtained that statement.

COMMISSIONER: Yes. If it proves to be the case that there's any inconvenience in either commencing or concluding cross-examination, we'll do what we can to accommodate that. I understand in precisely the same way Mr Boddice has raised with Mr Andrews a concern about another of the witnesses who is likely to be called after lunch, and again, Mr Boddice, if that doesn't give you sufficient time to obtain appropriate instructions, we'll do what we can to accommodate you.

MR BODDICE: Thank you.

MS McMILLAN: I was just going to raise that. Is that Mr Thomas?

COMMISSIONER: Yes.

MS McMILLAN: Mr Perrett, for instance, has asked me to advise him if that be the case, because he wishes to be present, so that I just wanted to be able to give him some notice if that be the case.

COMMISSIONER: Yes, I think Mr Perrett, along with everyone else, was sent a copy of the statement, but I understand there was a technical glitch in that some of the attachments were too large for peoples email inboxes.

MS McMILLAN: We've just been given them now. And I understand - I'll check with Mr Perrett that he's now got them, but I just wanted to be able to inform him as best as I could that it looks like after lunch for Mr Thomas.

COMMISSIONER: I think that would be the earliest. Anyone else? Mr Andrews?

MR ANDREWS: Commissioner, I call Dr Denis Roland Lennox.

MR BODDICE: Commissioners, we seek leave to appear on behalf of Dr Lennox. We have given written notice to the Commission.

COMMISSIONER: That's all right. Your leave is extended to include Dr Lennox.

DENIS ROLAND LENNOX, SWORN AND EXAMINED:

COMMISSIONER: Please be seated and make yourself comfortable, and thank you for travelling down from Toowoomba to be with us?-- My pleasure.

MR ANDREWS: Dr Lennox, would you tell the Commission your full name, please?-- My name is Denis Roland Lennox.

Doctor, have you prepared a statement signed on the 3rd of June 2005?-- Signed on the 2nd of June, if I can recall correctly.

It's difficult for me to read?-- Sorry.

It must be a doctor's handwriting. Doctor, do you have a copy of that statement with you?-- Yes, I have indeed.

And are the opinions expressed in it honestly held by you?-- They certainly are.

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

I tender that statement.

COMMISSIONER: Yes, the statement of Dr Lennox will be admitted into evidence and marked as Exhibit Number 55.

ADMITTED AND MARKED "EXHIBIT 55"

MR ANDREWS: Has a copy proceeded to the secretary?

COMMISSIONER: Yes.

MR ANDREWS: I have no further questions, Commissioner.

MR BODDICE: Commissioner, Mr Fitzpatrick will do the examination of Mr Lennox.

COMMISSIONER: Our pleasure, Mr Fitzpatrick.

MR FITZPATRICK: Thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR FITZPATRICK: Dr Lennox, we see from your CV, which is annexure 1 to your statement, that you hold the degrees of Bachelor of Medicine and Bachelor of Surgery?-- Yes.

And in addition the degree of Bachelor of House Administration?-- That's correct.

And we see also that you worked continuously for Queensland Health for almost 30 years?-- That's correct.

Including in the early stages of your career at the Bundaberg Base Hospital as an RMO?-- That's correct.

And since then as the Deputy Medical Superintendent and the Medical Superintendent of the Toowoomba Hospital?-- Yes.

And you are now based in Toowoomba?-- I am still based in Toowoomba, yes.

And since 1999 you've held your present job as Medical Adviser, Rural and Indigenous Workforce Group, Workforce Reform Branch, Innovation of Workforce Directorate of Queensland Health?-- That's correct.

Doctor, could you outline to the commission what it is that your current job entails?-- Certainly. Since '99 my work has been a professional advisory function, and of recent times with the recent creation of the new Directorate of Innovation

and Workforce Reform it's been my great pleasure to be part of that process within Queensland Health. The work involves working with the networked - a network of contacts in the medical profession, health services, rural communities, indigenous communities, health education providers, other education authorities to see innovation and workforce reform, not only within Queensland Health but for the workforce in Queensland, generally, and my particular interest, of course, is in rural and indigenous communities.

Yes, thank you, doctor. Doctor, in your present job do you also have delegation from the Minister of Health for this state to give area of need certification under section 135 of the Health Practitioners Registration Act?-- Yes, I do.

And have you had and do you currently have a special interest in IMGs, that is, International Medical Graduates?-- Yes, I certainly do, particularly from the position occupied in Toowoomba as medical superintendent and extensively so in my current position since '99.

Doctor, in paragraph 5 of your statement you say that the public hospital resident medical officer workforce was first impacted 20 years or so ago by a Federal Government policy to restrict the supply of doctors?-- There is no doubt in my mind that a principal cause of the commission's existence is the inconsistent national policy over the last 20 years which is based, of course, on the politics of Medicare funding.

COMMISSIONER: But can I ask you to explain that in more detail because it's an interesting and, possibly, controversial statement. Why do you say it's resulted in Medicare funding?-- It may be controversial, but I would submit, Commissioner, that it's supported very strongly by evidence that over the last-----

I don't doubt that for a moment?-- -----that over the last 20 years success of Federal Governments have restricted the supply of medical graduates and of general practitioners to the Australian community, and that's largely been based on the well articulated premise that expenditure of public funds on Medicare service bore direct relationship to the supply of doctors; restricting the supply of doctors would restrain Medicare expenditure.

I understand your point exactly. That, of course, doesn't directly account for why, for example, we had a Dr Patel in Bundaberg?-- No, but it's not too easy to connect a few points together to understand that if over the last 20 years, at least, in Queensland the supply of graduates has remained - the supply of medical graduates has remained the same during which period of time Queensland Health's population has grown each year equivalent to the size of a city of Rockhampton, we were inevitably heading for a railroad crash.

Yes. Very good point. Thank you, Mr Fitzpatrick.

MR FITZPATRICK: Thank you, Commissioner. Doctor, you also

say in paragraph 5 that the Commonwealth policy to which you have been referring remained in force until last year when it was reversed in a public statement which the Prime Minister made at that time?-- Indeed.

Are you able to inform the commission whether, in addition to the public statement, the Commonwealth Government has responded with any actual initiatives to reverse the under supply of doctors?-- They have, indeed. They have increased the number of medical student places in medical schools in Australia and they have increased the number of places for general practice vocational training and, thirdly, they have also lifted the restriction on or, at least, they have changed the status of the medical profession in immigration processes.

Yes, thank you. And would you expect that over a period of time in future that those initiatives would go some way towards addressing the imbalance of need over supply?-- There is no doubt those initiatives are in the right direction. It's not certain at this stage whether they will be sufficient. In particular, it takes a lead time of up to 12 years between the commencement of a medical student training and vocational practice for a medical practitioner and during this period of time, of course, there have been substantial changes in medical practice, whereas at the beginning of national calculations for medical workforce it was reasonable - it could be reasonably expected that one medical student trained equalled the career in medical practice. That's no longer the case, and I understand, though I have not yet had opportunity to study the report, that the Australian Medical Council has indicated, in fact, it will be many years yet before Australia's achieved an adequate supply of medical graduates.

Thank you, doctor.

COMMISSIONER: Mr Fitzpatrick, do you mind if I follow up something from that? One of the things that I have found quite fascinating as I have, sort of, read into this area for the purpose of this inquiry is that from what I have read, starting the 1930s, Queensland had probably what was the most successful public hospital system - free public hospital system anywhere in the world. You would agree with that?-- Indeed.

And when one goes back to the period under, for example, Sir Rafael Cilento, people from the UK setting up their national health system were looking at Queensland as the world's best practice model - I'm sure they didn't use that expression in those days - but the world's best practice model for a public health system; you agree with that, as well?-- Yes, I do.

And that really remained the situation until the early to mid 1970s when what is now called Medibank came on line and started to give the people in all other Australian states and territories the benefit of free medical care which had been available to Queenslanders then for some 40 years. Sorry, doctor, you are nodding from time to time. That doesn't get

taken down, so if - a verbal response-----?-- Yes.

-----is needed?-- Thank you.

You attribute the blame for the present system to the cutbacks in Federal funding, and for the moment I'm not disagreeing with you, but I just wonder how it's come to pass from having this world's best practice model of public hospitals, fully state funded, between the 1930s and the 1970s we now find ourselves in a situation where the Federal Government purse strings mean that we simply don't have enough doctors to look after the people of Queensland?-- Well, if I could, with respect, Commissioner, indicate that I am only attributing partial blame to this cause.

Of course?-- There are a number of principal causes, as well, but this is a very significant one, and in similar fashion there are a number of reasons why our status as a free public hospital system may be under challenge. One, of course, is our ability to supply the competent capable medical profession required to provide that service, particularly for a rapidly expanding population, firstly; and secondly, the major challenge is that in that period of time, of course, the capacity of the medical system apparently seems to have outstripped the willingness of the public purse to pay for the service potential.

In many ways, though, medicine - I have the impression, and please understand I'm really speaking only from what I have read in the course of this inquiry, medicine has, has it not, become in many ways more efficient over time; for example, an operation that would once have left a patient recuperating in a bed for two weeks now sees the patient going home within two days. There are those sort of efficiencies?-- It has, but expectation has raised, and if I could just give two specific examples that come to mind. In my experience when I was a junior doctor, for example, I remember as a second year house officer in the Bundaberg Hospital repairing the damaged fingers of a gentleman who foolishly placed his hands underneath his motor mower while it was still operating. I completed that repair myself. I imagine these days you probably would be immediately taken to surgery under an experienced surgeon at Bundaberg, if not referred to a hand surgeon in Brisbane.

Yes?-- Secondly, I can also recall caring for a significant - I should mention that these - the time I'm referring to are the mid 1970s.

Yes?-- That you identified, mid/late 1970s. I can remember as the medical Registrar caring for many elderly patients who suffered fractured neck or femurs, fractured hip, and if there was any concern at that stage about their mental competency we made them very, very comfortable in the medical ward, surgery wasn't offered. Today, you would have surgical procedure for that fractured hip regardless of your age, regardless of your mental competence. The standard - the expectation of medical services has risen rapidly in those decades.

Certainly. The other thing, though, is as I understand it, if you go back to doctors at - ten or more years older than yourself who came through Queensland medical school in the 1950s and 1960s, we seemed in those days to be producing enough doctors under, as I understand it, a bonding system where Queensland Health paid the medical fees in return for the doctor agreeing to spend a certain number of years in country hospitals and around the state. Is it the situation that now the Federal authorities have so much control of university funding that Queensland Health just doesn't have the option of increasing doctor numbers in that sort of way?-- Queensland Health simply has no option but to accept the current output of Australian medical schools, the Queensland medical school - University of Queensland Medical School, in particular, and to fill the deficit from the international medical workforce market.

Well, given that that's the situation, I suppose what had to be focussed on was how to make the best of that bad situation and get the best overseas doctors to fill those gaps in the system?-- Indeed.

And that was the subject of what's been referred to in these proceedings as the Lennox report where you identified a number of concerns in relation to the way in which overseas trained doctors were being brought to Australia?-- And, Commissioner, could I take the opportunity at that point to identify another significant contributor to the difficulties-----

Yes?-- -----which your questioning has brought us directly to, that is that up until that time that our supply of medical graduates wasn't adequate for our needs or began to be inadequate to our need, Australia operated a very protected local medical workforce market.

Yes?-- In fact, it probably was even at state level, it certainly progressed to a national level, but the supply difficulty, of course, required us to access the international market and, unfortunately, our systems were not adjusted to cope with the pressures that we would expect, and we have now experienced as a result of beginning to operate substantially in an international medical workforce market.

Well, one certainly hears stories, I don't know how true they are, of doctors coming to Australia, particularly in the post war - immediate post war era who were unable to obtain accreditation in the medical profession and stories, for example, of such doctors being required to redo their medical degrees in Australia where they were taught out of text books which they had written themselves, that sort of absurdity, but really your point is the whole situation has now gone to the other extreme where we're trying to find ways to get more and more foreign trained doctors to fill the gaps and-----?-- Indeed.

-----to try and maintain acceptable standard?-- Indeed, and beyond the issue of the inadequate supply of Australian

graduates the medical workforce market is globalising, like most other markets. Australian graduates are, in fact, a highly sought after commodity in that international market. So even if we were adequately supplied with Australian graduates we would still need to be adjusting our systems to adequately cope with an international medical workforce market rather than a local medical workforce market.

Dr Lennox, I'm probably jumping ahead to something Mr Fitzpatrick was going to come to anyway, but when you talk about the situation where Australian trained doctors are desired overseas and yet we're bringing in overseas trained doctors to fill the gaps, it also tends to raise what I would classify as a sociopolitical or geopolitical question that really does trouble me, this notion that whilst Australia is training doctors for wealthy families in Taiwan or Korea or other parts of South-East Asia, we're taking doctors from countries that, really, need all the medical assistance they can get?-- Commissioner, this issue has provided significant concern to many people functioning in this circumstance. In the early - in the early period to which you refer and in our first responses to recruit from the international market, Queensland - Queensland Health has recruited from the - market in the United Kingdom, Ireland, South Africa, mainly and of course in - at that time the medical training systems and health systems were relatively closely aligned. We could have a high degree of confidence in the graduates of those systems to recruit-----

Indeed-----?-- -----to Australia.

And that significant number of Australian specialists went to the UK and other Commonwealth countries to get their training?-- They did, indeed. So there is a close collaborative arrangement with those systems. However, as our demand increased and our circumstances changed in those principal supplying countries, increasingly the international medical graduates available to us were from everywhere else in the world, from systems whose training programs and whose medical service programs were vastly different to our own and, unfortunately, our system was not designed to cope with that challenge.

Well, from the evidence we've heard so far it would seem that that produces a number of problems and I would like to identify them, not only to ask whether you agree with them but to ask whether there are any further. Firstly, there are language problems?-- Yes.

And it's not a simple matter of having someone who speaks fluent conversational English, it's someone who needs to be able to discuss obvious complex medical matters in a way that's understandable by a native English speaker?-- Yes, it is and, in fact, beyond that it's also a question of the language in which they were trained in medicine.

Yes. The second area of difficulty that's been suggested is cultural, and we've again heard anecdotal horror stories about

overseas trained doctors who refuse to supply the contraceptive pill to unmarried women because of their own cultural beliefs, or terminate supply of pharmaceuticals to patients aged over 60 or 65 because they - their cultural belief system says that people of that age shouldn't be a burden on the tax payer?-- Cultural issues-----

I'm sorry, Sir Llew, in the way I put that.

D COMMISSIONER EDWARDS: I understand.

COMMISSIONER: But that's the way it's been suggested?-- Cultural issues are absolutely vital, not only to address to and assist an international medical graduate to practise in Australia, but in the interest of patient safety in Australia which is the reason why the Centre For International Graduates, the schools development centre, provides an employment program which, amongst other things, specifically addresses the readjustment of cultural perspectives.

The third category of difficulty that has been identified is simply the difficulty of translating overseas medical qualifications into the Australian arena; that one can't simply look at a surgical qualification in Uzbekistan and say that's the equivalent of being a Fellow of the Australasian College?-- That's very true, and as a result of Australia's localised market focus we have extremely minimal knowledge of the qualifications of medical schools overseas other than those with which we were most closely associated from our origins, obviously from the UK and Ireland.

Although, from what we've been told that failing is not unique to Australia, that even, for example, World Health Organisation data on the standard of medical schools around the world is quite inadequate to make those sorts of comparison?-- They would be, but I don't believe that means that we should not be directing a great deal of attention in the international - in understanding the international market, so that we can operate in a better, if we are to maintain our position that you described earlier in terms of our reputation for health services - we need to become particularly prudent in operating in the international medical market and that's simply going to require us to have greater knowledge of the qualifications provided by international medical schools. Commissioner, can I just add an important aspect there?

Yes?-- Because there is an assumption often made, as well, that international medical graduates trained in jurisdictions quite differently - quite different to ours, including different languages, different cultures, are probably not - are probably less able to perform well in the Australian setting. I understand from the evidence of the Australian Medical Council's examination in terms of the - the results obtained by international medical graduates at that examination, there is no particular country or group of countries who stand out either in having deficiency in training or excellence in training. In fact, I think, if I can recall the information correctly, in fact, UK and Ireland

don't feature quite as well as some other countries not traditional centres of our international medical graduates.

Of course there are a number of possible explanations for that, one may be that the best UK graduates get jobs in the UK or Europe or North America, so we're not looking at the crème of the crop?-- There may be many explanations, but I guess it's fairly evident, however, that there isn't - there isn't a narrow source of competent capable doctors in the international market from which Australia can recruit. Commissioner, if I could return to the point of your earlier question, it certainly has given many people a great deal of concern about our circumstance in recruiting from the international market. What I can tell you, however, is that Queensland as a state has not actively recruited from countries other than Ireland, UK and South Africa, and I know in our own experience we've often struggled with applications from countries who are - whose health system is in desperate need of the graduates they're training and in more recent times, for example, this has been a real dilemma with respect to graduates from Fiji.

Yes?-- But the difficulty is at the moment when our supply of graduates isn't adequate and we don't have an adequate pool of Australian graduates to positions advertised service demands require that we consider the international graduates who apply and if they apply from Nigeria or Fiji, we don't have a natural justice reason to deny the legitimacy of their application for those vacancies.

And being realistic about it, if we knock back a Nigerian or Fijian applicant on the footing that we feel we shouldn't be taking doctors away from those countries the chances are that that person will be accepted in another first world country in any event?-- It's true, and of course we could be accused of discriminating, as well, against good candidates in the international market.

Dr Lennox, just going back to the series of problems that seemed to be identified in the evidence one other category of problems mentioned by, I think particularly Dr Molloy, is a lack of familiarity with the environment in which medicine is practiced in this country referring to things like understanding the Medicare system, understanding the private health care system, understanding the workers' compensation system and the need for certificates and documents and so on. There's a suggestion that there is a significant need for an educational process to train overseas trained doctors in things that most Australian trained doctors know from their childhood onwards?-- That's very correct. The centre for international medical graduates already provides that service, but unfortunately because over the years since its institution its funding has been limited that service is only available to a limited number of international medical graduates, firstly, and, secondly, even though it perhaps is more widely available in the sense of the opportunity for international medical graduates to access it, there is no other requirement of their practice in Queensland which would insist on that being a

prerequisite to commencement of practice.

Another category of difficulty that seems to have been identified is that overseas trained doctors don't fit into the - or don't readily fit into the collegiate nature of the medical profession in Australia, they don't - particularly those working in the public system, they don't join the AMA, they don't have particular rapport with local medical associations or other bodies and, therefore, they don't - don't have that sort of informal peer review and interchange of ideas that Australian trained doctors have with those with whom they went through university and have practiced all their lives?-- My response, Commissioner, is I probably should indicate to you that wouldn't be considered to be a central player within the medical establishment in this state or country either, myself.

No?-- So my perspective, I certainly haven't, in all of my dealings with Australian - with international medical graduates, that's not been of great concern to me.

Yes. You are accepting it may be the case, but you are saying it is not a problem?-- I don't perceive it to be a significant problem.

Another category of problem mentioned is simply a lack of familiarity with the equipment and technology used in Australian hospitals; that an overseas-trained doctor may have trained on state-of-the-art equipment in their own country but that may be very different from what's state of the art in Australia?-- Commissioner, all of the reasons you've given are the justification for comprehensive assessment of the competence and capability of international medical graduates in the first instance, and then an appropriate response in terms of their supervision in early practice and case management of their circumstances until they attain the same status of an Australian graduate with vocational qualifications.

Well, then, I will come to another potential area of problem which is perhaps more controversial, and that is that there seems to be a tendency for overseas-trained doctors to receive positions in remote and provincial and rural areas of the State rather than, for example, in the major training hospitals in Brisbane, and that puts them further out of touch with supervision and the opportunity to upgrade their educational standards?-- Unfortunately, Commissioner, that's not a regularly perceived fault in the system, that the very doctors that we are recruiting to Area of Need positions, which by definition either have no doctors or too few doctors, are the very doctors which in the most instance require significant supervision, orientation to practice and support in their practice. The whole process, unfortunately, has an inherent dilemma.

That then leads on to another suggested problem, and it is simply this - as we see with the case of Dr Patel: there is said to be a tendency on the part of Queensland Health to place overseas-trained doctors, who do not satisfy standards for registration in specialist category in Australia, in positions where they are designated as senior medical officers or even directors of particular departments, but are without supervision. Do you feel comfortable in commenting on that suggestion?-- Yes, I do. It is not, in my experience, a common event, but I would have to conclude that it's - it is almost inevitable that that would happen. The international medical graduate on arrival in Australia is extremely vulnerable. They are facing an extremely complex array of registration, vocational status, immigration, orientation, cultural issues, the whole gamut that you have indicated earlier. They're entirely dependent upon their employers and closest advisors to negotiate this complex system. Unfortunately, there is evidence that, both in the public system and in the Medicare system, that vulnerability has been abused and, unfortunately, as well, we don't have at this stage a sufficiently managed system with appropriate checks and balances to ensure that that's minimised. I should also add that in my view - this brings me to another point as a significant contributor to our circumstances, that is that

within Queensland Health, at least, we have experienced, both in system design and, I would submit, in culture, a reduced capacity for the level of professional leadership and clinical governance that's warranted to provide this protection for international medical graduates and safety for our community.

I would like to come back to that in a moment. I am sorry, Mr Fitzpatrick, I seem to have stolen some of your thunder here, but if you don't mind I would like to continue because I think this is a very useful flow of information from Dr Lennox. You have really, I think, dealt with what I would have perceived as two separate points. The first one is simply the practice of putting overseas-trained doctors, who aren't qualified as specialists and don't meet Australian specialist standards, in what are, for all practical purposes, specialist positions, like Patel at Bundaberg. Is that a common practice or is it just - or is Patel a one-off?-- I am not familiar with every appointment of international medical graduate within Queensland Health.

Yes?-- It is not, in my experience, a common practice but I guess this is my point: without an adequate line of accountability and clinical governance - and particularly due to the vulnerability of international medical graduates this is a risk - it is one of the reasons - one of the significant reasons why our proposal for integrated management of international medical graduates includes a period of case management of those graduates in the time of appointment to a position until they have obtained vocational status in Australia.

Well, I see Mr O'Dempsey is sitting in the Court. Let's look exactly at what happened with Dr Patel. He was registered by the Medical Board as - for a position of staff medical - senior medical officer, an SMO. You would agree with me that that normally implies working under the supervision of a qualified specialist?-- Yes, indeed.

Right. It appears that either on arrival in Bundaberg, or very shortly after arrival, he was immediately appointed to the position of Director of Surgery, which I think you will agree is a position which would ordinarily be held by qualified specialist?-- Yes.

Would you agree with the suggestion that that is something that just should not happen?-- I would.

Are you aware of any steps that have been taken within Queensland Health to prevent that from happening in the future?-- I am not aware at the moment of any particular steps that have been taken.

Let's then move on to the point you make about vulnerability. I have used, perhaps in a rather politically incorrect way - you will understand I am not very sensitive about political correctness - but I have used the expression "bonded slave" to describe the overseas doctors that come to Queensland Health, because essentially they are in a position where they either

do what they are told or they are sent back to where they came from. That's the practical reality, isn't it?-- That adequately describes their vulnerability.

Yes?-- But I should be careful to point out to the Commission that that vulnerability is not limited to Queensland Health.

No?-- It occurs in any employment circumstance within the public or Medicare sectors.

Well, that's true to a limited extent, but, for example, you know, again, if we take Dr Patel, he came to Australia to practise surgery even though he wasn't qualified as a surgeon. There was only one place, certainly in Queensland, where he could get away with practising surgery, and that was if someone in Queensland Health gave him an SMO position. He couldn't have done that in the private sector; he couldn't have done it at The Wesley, or St Andrew's, or Mater Private. Queensland Health was his only opportunity to practise surgery in Queensland. You will agree with that?-- Yes, I do.

And that meant that if he didn't toe the line to the satisfaction of his area manager or divisional manager, or whoever was up the line from him, his only real alternative was to pack his bags and go home?-- That's correct.

And in that sense, this is a distinction between the public and private sector. See, if we were talking about Dr - Dr Patel could not have been a surgeon in the private sector unless he had got-----?-- That's correct.

-----Medical Board approval?-- He is-----

If he had Medical Board approval, he could get a provider number and practise?-- I understand your point, Commissioner. I guess I am also considering - and should point out that there is a different circumstance between specialists and general practitioners.

Right, yes?-- And I guess I am looking more broadly to identify the fact that that vulnerability exists in precisely the way that you have described it for general practitioners employed in the Medicare sector.

Yes?-- And I am not speculating about that. I know of specific examples of that, which is no different to the vulnerability faced by a specialist employed within an SMO position or any other position, for that matter, within the public sector.

So let's just follow up that-----?-- Or a doctor, sorry. Not necessarily a specialist, but a doctor with international specialist qualifications employed within the public sector.

Let's take - and this will be perhaps an extreme example - some might say fanciful - but let's say that the butcher in Eidsvold decides he can make some money by setting up a 24 hour medical clinic but he can't get any GPs to come to

Eidsvold to run that clinic, so he recruits an overseas-trained doctor to take that position and sponsors the overseas-trained doctor through the immigration process, and so on. In a sense, that doctor working at that clinic in Eidsvold has the same vulnerability to his employer as the SMO working in the public health system?-- Yes.

But he does have this advantage: he can at least change his sponsor. If he really feels he is being abused in the clinic that he is working at at Eidsvold, he can go to another GP clinic somewhere else in the State, if he gets the paperwork in order?-- That's correct.

Whereas an SMO like Dr Patel, there is no-one else that he can work for?-- Well, there is, and there are examples of that. In fact, immediately comes to mind, a predecessor of Dr Patel's in Bundaberg who had been employed as an SMO but had also been employed as an SMO in two other jurisdictions in Australia, in fact he moved from one to the other-----

I see?-- -----for nine years without progressing his vocational status.

Yes?-- And after nine years of service in three jurisdictions in Australia, in which he was registered to practise or at least he was permitted to practise - I am not quite sure about his registration status - but he was permitted to practise as a specialist surgeon, he now doesn't - he has now run out of opportunities. Nobody will employ him as a specialist surgeon - as a surgeon. He cannot progress his vocational status in Australia, he has been unable to obtain recognition of his credentials in surgery from Russia.

Yes?-- He is required by the college to in fact retrain in surgery in Australia and is not able to compete with Australian graduates to enter into training. He has - he has nowhere to go.

Yes, I see. I suppose, really the point I was trying to make - and perhaps it is not a major point - is that the SMO example we're talking about has only one potential employer in Queensland, whereas at least the GP working in a private clinic has numerous potential employers, and if they have a falling out with one, there is-----?-- Capacity is indeed limited within the State, but, of course, there are other jurisdictions, as the case I have indicated shows.

But it is going to be difficult, I mean in a real world sense, if Dr Patel - perhaps I shouldn't use him as an example - if an SMO who is appointed as Director of Surgery in a Queensland hospital makes a nuisance of himself by complaining that the facilities aren't adequate, or that the wards aren't clean enough, or that the hospital administration isn't providing the services that he needs to perform his job well and ends up resigning, he is going to have trouble getting a job in any public sector?-- That's true, although there is an additional consideration with respect to immigration status, Commissioner, and I don't have detailed expertise on that

subject, but my best recollection is that to be able to transfer from one sponsor to another requires the agreement of the first. So I understand that general practitioners in private - in Medicare employment are not in a dissimilar situation. I guess I am having difficulty being persuaded by your argument that there is a significant difference between the two.

Well, it probably doesn't matter, the important point to come out of all of that is that both private and public overseas-trained doctors, leaving aside specialists for the moment, who are in a slightly different category, but both in the private and public sector non-specialists are in an acute position of vulnerability?-- They are, which is also one of the reasons why I believe that one of the very important processes involved in recruitment of international medical graduates is to be able to provide them accurate and detailed advice of the opportunity for their progression to vocational status and permanent resident practice in Australia if that's their choice from the outset. Unfortunately, many international medical graduates are not provided that advice.

You began your evidence by pointing out to us the lack of training - sorry, the lack of university education positions over the last 20 years or so and the impact of Federal decisions in that regard. There has also been some at least implicit criticism of the colleges for not making enough training positions available, but what we heard last night from Dr Molloy is that the colleges in fact make training positions available for every one of the graduates that comes out of the Australian universities. The problem is there aren't enough graduates, not that there aren't enough training positions for the available graduates?-- Commissioner, that is a more recent development and that raises the second of the major contributing factors which I believe have resulted in the events in Bundaberg, and that's the politics of vocational status and vocational training.

Yes?-- Anything - anything said about that in general terms, of course, is a generalisation for which there are exceptions, and indeed there are, but there is no doubt, for the reasons I have mentioned earlier about the protected medical workforce market here, there is an establishment within the medical profession which has operated for years to preserve the interests of medical practice in Australia. And I don't doubt that there is opportunity to find evidence that there have been - there have been restrictions on the opportunities for Australian graduates to train in specialist disciplines. However, as a result of the continued development of vocational training opportunities for specialists in particular, and the limited supply of Australian graduates, we have actually now reached a point where the opportunity for vocational training outstrips our supply.

Yes?-- But that's only a relatively recent development.

But for the purposes of this inquiry, would it be fair to say that that is no longer a current problem, that the

availability of vocational training isn't a current problem that we need to address?-- It is not a priority problem, in the circumstance that our supply of graduates isn't sufficient to meet even the training opportunities for vocational training. Nevertheless, the issue remains central to the whole - to a significant conflict between government and colleges.

Yes?-- Where governments, as a result of the State's responsibility for public hospital system and the Commonwealth responsibility for Medicare, have an obligation to ensure that service is provided, and in the circumstance where insufficient Australian graduates are available, wish to access the international medical market, only to find that the bodies which determine the vocational status of the international medical graduates have a - I am talking now, I guess, from a government perspective - tight control on that status and therefore limit the capacity of government to supply service. There is no doubt, in my mind, that a very significant contributor to the current problem is the politics of vocational status and training as between those responsible for service and those responsible for training and standards.

We might pick up on that after the morning break. We will adjourn for 20 minutes.

THE COMMISSION ADJOURNED AT 11.19 A.M.

THE COMMISSION RESUMED AT 11.39 A.M.

DENIS ROLAND LENNOX, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Doctor, we might resume when you're comfortable?-- I'm comfortable, thank you.

Before the break we were talking about training positions and the role of the colleges. Let me see if I've got it right up to this stage. Your evidence, as I understand it, is that there has been a problem in years past with colleges making sufficient training positions available, that that problem doesn't exist at this moment in time because there are sufficient training positions for all graduates, but we've heard that the number of graduates going to be produced in Queensland over the next decade or so is going to increase substantially. I think it's between a third and 50 per cent increase in the number of graduates. To your knowledge, are the systems in place to address the number of training positions that will be required for those graduates?-- No, they're not adequate, and the statement that there isn't a problem at the moment is a general statement to which, of course, there are some specific exceptions.

Yes?-- But if there is no change to current circumstances, when supply becomes adequate or more than adequate to the number of vocational training positions currently existing, then yes, we will have the same problem again, and the politics of vocational status and vocational training will be with us again in that form. But of course, it remains in any case in terms of college control of the vocational status of international medical graduates.

Just again to put to you something that we've heard from particularly Dr Molloy, the suggestion that is made is that the colleges are hamstrung as to the number of training positions that they can make available because the vast majority of training positions are in public hospitals, and that requires two things. One, it requires Queensland Health or the public hospital to pay the wage of the registrar or other trainee, but it also requires that supervisors of an appropriate level of skill in seniority are available, and that the colleges are unable to rapidly increase the number of training positions because those two criteria aren't satisfied. Are you able to comment on that suggestion?-- Yes, indeed, with one notable exception, that of the vocational training for general practice. Vocational training of all other specialists requires an extensive collaboration between the colleges and employer of the registrars - in Queensland, Queensland Health. I guess the significant difficulty is that there is no single authority oversighting vocational training of doctors for Queensland or for Australia. Queensland Health has other significant interests than the training of registrars into specialist status, and of

course the colleges have other interests as well, and it's a very simple recipe for conflict.

I guess the point that Dr Molloy would make is that it's a bit unfair to blame the colleges for the looming problem when they can't solve the problem without Queensland Health's cooperation, and at least according to Dr Molloy, they're quite willing to participate in solving that problem if the registrar positions are available under appropriate supervision?-- Commissioner, it's too easy for both parties in this matter simply to point the finger to the other and blame them for the problem.

Yes. Right. Well, let's then move on to the situation with overseas trained doctors. As I understand it under the Queensland Medical Board legislation, an overseas trained doctor can receive accreditation as a specialist, to use - I'm not talking in technical language, but can be accredited as a specialist in Australia either by satisfying the requirements of the relevant college, or by getting deemed authority as a specialist, which again involves the college approving that person as a specialist on a temporary basis. Are those the only two avenues?-- Yes.

Do I infer from your evidence just before the break that you feel there is some restrictiveness in the way in which the colleges participate in that process?-- In general terms, yes. With some more specific examples and some notable exceptions to that rule, yes.

I for one would be very interested to hear the examples and the exceptions?-- Well, I guess a significant exception in the first instance is vocational training for general practice for which an authority has now been established by the Commonwealth, and the federal government funds that authority. The training for general practice is also provided by independent education providers on a regionalised basis, and the college role in that circumstance is to specify the conditions of training, the standards of training, the assessment of training and conferring of the qualification to the end of that period. I'm aware of the fact that other colleges - and if I can recall correctly, notably the College of Psychiatry is seriously considering that separation of functions to some extent, although of course as I indicated, no single authority exists for oversight of specialist training, and, for example, the College of Physicians has traditionally had a very open approach to the accreditation of training positions in which, in effect, it doesn't control the number of positions, but I'm sure the college would acknowledge there are significant aspects of the training program from their point of view that need attention nevertheless, to the other situation where colleges very tightly and strictly control the number of training positions by their accreditation process.

Again supporters of the status quo would say that when colleges do that it's not for political or economic reasons, it's simply to maintain standards of excellence. Are you able

to comment on that?-- I'm willing to offer an opinion on it, Commissioner. There is no doubt that Australian medical colleges have made an enormous contribution to the excellence in medical practice and health services in Australia that you referred to earlier, and there is no way that I would advocate the contribution may be in any way diminished. Nevertheless we're still left with the politics of this issue, as I indicated earlier, and until that's resolved I believe there will continue to be the sorts of conflict that I've indicated. Exactly what the solution to that may be is not entirely certain, but I know there are considerable interests in perhaps college responsibility being more narrowly focused on the issue of setting standards, curriculum, standards of training, assessment of training and conferring of qualifications and other bodies such as tertiary education providers becoming more significantly involved in the training process to help remove the dichotomy currently existing between colleges and governments supplying both the positions of registrars in training and also having an imperative to provide medical services in those specialist disciplines.

Doctor, it's my turn to be a bit controversial, and I just want to float for your comment an idea which I also canvassed with Dr Molloy last night that I think it's fair to say he rejected very firmly. It seems to me that when you have a body, or a group of bodies who are accused of operating as a cartel in a monopolistic, restrictive way and they say, "No, we're not really a cartel. We're just doing it for the community good", the best way to test that question is to open it up for competition, and the way one would open this up for competition is to say to some appropriate authority - I suspect it might be the Medical Board, but I'm not wedded to that idea, but to give some appropriate authority the capacity to say, "Well, yes, anyone who is approved by the Australasian College of Surgeons gets our tick", but to say they don't have sole control over that, and if we can be satisfied that the Canadian College of Surgeons is just as good as the Australian college then we'll give anyone who has come through that system a tick, and if we're satisfied that the University of Queensland has a surgeon training scheme that's as good as the college we'll give that a tick as well. So that without forcing the colleges into a situation of competition, at least expose them to the prospect that if they're demonstrated to be operating in a monopolistic way, there is the opportunity for specialists to obtain accreditation via other routes?-- With due care to ensure that standards - the excellent standards of specialist practice in Australia can be maintained, changes to the current system which avoid some of the problems that we've been addressing to date, I believe, would be most welcome, and it does seem to be appropriate. As in most other circumstances we have opportunities and some competition between suppliers, a relatively well controlled, regulated, competitive system in vocational training of medical practice, as is happening, in effect, in general practice training now and apparently working well, I certainly wouldn't argue against it, no.

I mentioned the Medical Board as possibly the appropriate authority to oversee such a thing, and that also raises questions that have come up over the last few days about the Medical Board - there being a perception that it is the process for choosing members of the Board being entirely in the discretion of the Minister. Even accepting that the Minister's appointments are generally very - of the very highest standards, it doesn't have the sort of transparency that's desirable in a good medical system. Would you prefer to see a system where membership of the Medical Board is appointed on a more transparent basis?-- It's not a subject that I have given a great deal of personal attention to. I guess I haven't had reason to do that, but I certainly - I wouldn't argue against that proposal in the context of wider reform of the process of registration of medical practitioners, particularly with a focus to remove us from the local market/national market focus that we have had to capacity to handle competently and capably our access to the international medical workforce market.

Doctor, in your statement you refer - I think it's in paragraph 30 and thereabouts - to what, perhaps embarrassingly for you, has been referred to in these proceedings as the Lennox report?-- Excuse me, Commissioner, paragraph 30 or 13?

Paragraph 30, I think, your paper titled, "Management of International Medical Graduates". I'd be interested to know how that paper actually came into existence?-- It is regrettable that it has my name attached to it, not in the sense that I'm unhappy to claim it, but its contribution is much, much wider than mine.

Yes?-- I think, as my statement explains, to some degree the origins of this were firstly in the first managed international medical graduate program in Queensland called Doctors for the Bush. We were naive in the extreme when we commenced that program, but fortunately, because we obtained good counsel very widely, including from the AMA who were a member of the steering committee, as were other significant professional representative bodies, it was relatively successful, and there was a significant learning from that experience as well. It became immediately apparent that we were providing - with all of the limitations of Doctors for the Bush which I readily recognise, we were nevertheless providing an opportunity for international medical graduates and a management of international medical graduates which was only available for a very select few, and a significant proportion, particularly in general practice, of international medical graduates progressing through the 10 year program - that is subject to the 10 year moratorium - were totally outside of all those benefits.

Yes?-- It was also very obvious that this program represented a very significant advance in terms of providing safety and a level of security for those communities who were receiving these practitioners, as well as safety for the vulnerable international medical graduate group themselves. So towards - at least during 2002, into the beginning of 2003 we began to

document some of that learning and extend it into the development of another program for those general practitioners in the 10 year scheme with potential extension to specialists. But we certainly extended it to a wider concept of management of international medical graduates to attend to many of the issues we've already discussed. That document was already - at least a document putting those concepts together was in existence in early 2003 when the joint OTDTRD committee was established by the general manager upon request - at least on representation by Australian Medical Association. So the joint committee was comprised of Queensland Health, Australian Medical Association, Medical Board was represented, Commonwealth Department of Health and Ageing was represented, and Commonwealth Department of Immigration, Multicultural and Indigenous Affairs was represented, and the original - the documentation already prepared was presented to that group. Discussion resulted in some iterations, and finally - I think probably in about June/July of 2003 - a final form of that first report was to some extent agreed to in principle. But what we had done at that point related specifically to international medical graduates proceeding to permanent resident status, and there was a very large cohort of doctors referred to generally at that time as temporary resident doctors for whom we hadn't any specific plans, and the reason for that was because we found it extremely difficult to know what on earth to do about that group who were coming for a relatively limited period of time to practice in Queensland. However, the AMA representation at that joint committee insisted that we should address the temporary resident doctor group as well. So I offered, as the facilitator of its functions, to prepare a second paper to address the temporary resident doctors and I took a systems approach, knowing that I was presented with a particularly complex and difficult task. So I assumed that perhaps we didn't have an international medical graduate at all - any graduates at all, but we wanted to embark upon a program to bring them here, how would we go about it? And it became very evident that the terminology and the categorisation of international medical graduates that had evolved in traditions was actually proving to be a hindrance to the whole process. So from a zero based approach, if you like, I, with assistance, developed a concept of management - integrated management of international medical graduates. So instead of producing two papers, I finally produced one single paper which is now referred to, I think, as the Lennox report, and I think the version that is generally available is in August 2003, and that was presented, I think, in early - the first form of it was presented in late July to that subcommittee, and the version dated August was another iteration based upon feedback from the joint committee.

Just in relation to the final form of that report, you've been very modest in recognising the role of other people in assisting in its preparation, but you were the principal author?-- Yes.

And the views expressed in that are ones to which you adhere?-- Indeed.

And you would agree, I think it's fair to say, that for anyone reading that report it was something of an alarm bell in relation to problems which confront Queensland in relation to international medical graduates?-- It wasn't intended to do so, and not - principally because the question of the need to address the problem was evident to all parties. I had - neither myself or anyone else had any need to convince any of the parties at that table that we had a significant problem to address.

So as far as Queensland Health, for example, was concerned, they knew there was a problem anyway?-- Absolutely.

You didn't have to tell them?-- No.

I'll cut to the chase, doctor. There has been the suggestion from various quarters that you were cut adrift with this document, and after it was produced Queensland Health hold journalists it wasn't official and, you know, it wasn't an official Queensland Health document and had no status or standing or relevance. I take it you weren't just off on a frolic of your own. This was part of your employment in Queensland Health to prepare such a report?-- Absolutely.

The copy we have has "draft" stamped on it. Is there anything other than the fact it has "draft" stamped on it that is incomplete or unfinal about the report?-- No. The version completed in August, as far as I was concerned in terms of status of dialogue within the joint committee and the discussions that I'd held within Queensland Health including with the General Manager, and in terms of the discussions I'd held with the President and Deputy President and others of the Board, and feedback I'd received from the AMAQ at that stage, gave me to understand that this was certainly not a document that I needed to place "draft" upon, although I was quite certain that in terms of its ongoing movement towards implementation would perhaps require some further iterations. But no, I was very confident about its contents at that stage.

So far as you were concerned you were ready to sign off on it?-- Absolutely. In fact it was the subject of a business case prepared at about that time, I think, which is included in my witness statement.

How then did it come to be spoken of by Queensland Health as not an official document and not a final document and all those other epithets that were applied to it?-- Commissioner, I do not know the answer to that question.

It's been suggested to us - and I think in fairness I should give you the opportunity to respond to the suggestion - that this is an example of what's been described as a culture within Queensland Health of doing two things. One is burying any report that might be regarded as embarrassing to Queensland Health, and secondly, sending the author of any such report to Coventry for having the temerity to say things that might be embarrassing to Queensland Health. I don't require you to respond to those suggestions, but you have the

opportunity to do so if you wish?-- I have no knowledge of what happened to the report within the senior management of Queensland Health from the end of August until it appeared in the media, and Commissioner, may I also take the opportunity to indicate very clearly that this was not a leaked document.

You didn't leak it, no?-- Well, I didn't leak it. In fact it didn't need to be made publicly available because it was already in the hands of the Australian Medical Association.

Yes?-- I guess I was very aware of that. I'm not inexperienced in the business of government authority. I guess I proceeded on the basis that I had understanding from senior management of Queensland Health that the directions that we were taking were not unacceptable, though at the same time I was also very aware of my responsibility - not as a line manager, but as a medical professional advisor - to provide advice regardless of whether it was requested or welcomed, and I've always taken that responsibility very, very seriously. So it certainly came as a great surprise to me to find that when it was released to the media that it was stated to be not an official government document, and it was even more surprising to me to discover at that time that in fact its recommendations or the concepts within it were not going to be implemented.

Dr Lennox, I think it's not inappropriate - I indicate to you that during the break I spoke with the two Deputy Commissioners and all three of us have been extremely grateful for your evidence this morning. It's been a breath of fresh air to hear from someone who has thought about these things and addressed them from the viewpoint of what's best for the patients rather than what's best for the corporate entity or what will save the most dollars, that sort of thing. So again, I'll give you the opportunity - and I don't require you to answer this, but if you feel it appropriate to do so, we do have these repeated suggestions - mainly at an anecdotal level - of things like bullying, secrecy, suppression, what's been described as a shoot-the-messenger culture, that sort of thing in Queensland Health, which, it is said, creates a sort of emperor's new clothes situation where no-one is prepared to tell the truth for fear that (a) the outcome will be suppressed or buried and (b) they will be the individuals who end up bearing the brunt of the enmity of their superiors for doing so.

Do you feel comfortable about responding to those suggestions?-- Commissioner, I don't feel comfortable, simply because it's not a comfortable thing to do, but I appreciate the opportunity to respond and to say that what you describe certainly was my personal experience of the department and witnessed very closely during the course of the period that I have just outlined to you in the experience of a colleague that I was working very closely with and probably the principal reason that I was acting principal medical advisor fore a period, but I have experienced far more significant forms of what you describe than I experienced at the public disclosure of this document

Doctor, on what you have said we have a real problem. This inquiry, I think, is the first time in a generation that there's been any sort of public inquiry of what goes on in Queensland Health. What can we do to make Queensland Health more accountable, accessible, responsive, and just have a better relationship with the committed individuals who, I'm sure, are a vast proportion of the employees of Queensland Health who just want to do the good thing for the patient? What, if anything, can we do?-- That question, Commissioner, invites a very, very, lengthy answer and I'm trying to avoid embarking upon that and to narrow down some key issues. I guess, probably, one of the most significant from my point of view is a commitment at the most senior level for openness and transparency in the dilemma that faces us all as Queenslanders, and that is that we have capacity to provide medical services at the moment well and truly beyond the level of - the level of funding, and I would think that it was the experience of the majority of professional people within the system that they are there because they have a passion to provide top quality services in a system of excellence and be very satisfied and content at the end of the day that they have served in their profession well and they have served their community well, but the lack of transparency in that question has meant that it has to be resolved at some place within the delivery of health services and somebody somewhere in the system has to make a decision about rationing of the service. I know, from my personal experience, that any attempt to openly discuss that is not - was not accepted and those professionals who were in management roles and, therefore, carrying a very heavy burden of balancing the requirements of corporate management as well as clinical governance and professional leadership have not only been largely burnt out in the process, I would submit, but their contribution has also been devalued and I would believe that the two key things that we need to do is to have openness and transparency about the decisions about what the public health service will provide and what its limitations are and a reinstitution of a significant capacity of health professionals and health professional leaders to provide good advice to management and to Government about those key issues of professional leadership in clinical governance.

One of the matters that we've heard a lot about is the level of bureaucracy or bureaucratisation within Queensland Health. Just to give you one example, Dr Molloy again gave evidence,

and this wasn't challenged by the representatives of Queensland Health, that a clinical director in a hospital needs to go through several layers of bureaucracy, six or seven or even eight layers of bureaucracy, to get a decision and what makes that particularly distressing, according to Dr Molloy's evidence, is that, say, a Director of Surgery has a proposal for a new business plan or something, it goes to his manager, regional managers, zone manager, all the way up the chain, six months later the answer comes back, "No, you can't do that", but no explanation as to who made the decision, what it was based on, what considerations were relevant, whether it's worth retrying again at some later stage. Is it really necessary for Queensland Health to have so many levels of bureaucracy?-- Health service delivery is an extremely complex function - I need to make that statement - involving a huge number of people. I think we have been relatively naive over successive decades in terms of management of an increasingly complex, increasingly demanding and increasingly fund consuming service, and I'm quite sure we haven't put to that task the best management solutions possible. There was no doubt that in - on regionalisation in the early '90s that there was a great need to change a system which had been in place for decades, largely untouched, if I can recall, since the Hospitals Act of 1920s, but partly because it had been in place for so long I don't think we appreciated or had a very mature view about how best to manage such a large and complex system. Change was - everyone agreed that change was needed at that time and we rushed into change, and we've had some iteration of that since then and part of that change secured a great advantage, I suppose, in centralising some of the functions that had previously been fairly distributed at hospital board level, including industrial issues, purchasing issues, and certainly under pressure of funding there was great need for the health system to become much more efficient, but the risk, I think, is now what we've experienced. Certainly we have a very large organisation and it's a very centralised organisation and, therefore, a very significant bureaucracy. I don't think anyone would deny that, and it's not a circumstance in which health professionals delight. We have an organisation which is, basically, an information organisation. Those people who know are the people working at the front line.

Yes?-- And we need a system that makes it far easier for them to carry out their task at a level of excellence and a level of guaranteed safety to the community than is possible at the moment, and I guess central to that, as I have indicated in my view, is the need for us to reinstitute in a more modern version, perhaps, a much more significant clinical Government's function than we've had more recently. I'm sure deputy Commissioner Edwards would remember the time in which the Medical Director General was the senior medical professional within the department, the Chief Executive Officer was designated Undersecretary. At that time while there's a lot of things about that arrangement which would obviously be agonistic now, and I'm not advocating that we return to it, but nevertheless there was a significant capacity at that stage to provide guaranteed safety to the

community in terms of the medical professional staff employed by the organisation. A clinical Government's function extended right to the level of the Director General who had power/veto over appointment of any medical practitioner in Queensland hospital system and, of course, that power related to - was also - included a direct relationship with the Minister of the day. So at that most senior level the interest of health professionals and the interests of the public in terms of safety and service quality was represented to the Minister. We now have a system, in fact, where that has to proceed through many layers of non-health professionals who, nevertheless, are doing a very good job but whose primary focus isn't clinical governance and professional leadership.

His primary focus is budgetary than standards driven?-- Whose primary focus is directed by the responsibility of corporate governance downwards rather than their responsibilities of representing the interests of patients upwards. I'm not, Commissioner, advocating one against the other. I'm simply saying we need to return to a much better balance of those responsibilities than we do have at the moment.

In fact, you raise a number of the things that I have raised myself with, I think, virtually every witness we've heard so far, and some have agreed and I candidly say some have not agreed, but I have some difficulty in understanding how the ultimate decision maker in any hospital can be anyone other than a clinician. How you can have someone who has no medical background or qualifications being the person in charge at a hospital?-- I'm not entirely sure that I would agree that that was correct, but the person in charge needs to have a very close working relationship with key professional leaders and clinical governors who can provide fearless information to that person on which they could make sound decisions, and they must feel that they are in a position, actually, to make decisions in the interests of safety and of service as well as the responsibilities of budgetary integrity.

Sir Llew?

D COMMISSIONER EDWARDS: Dr Lennox, I have a few questions seeking your comments. What is the position in other states relative to the shortage of Australian trained doctors?-- I'm not overly familiar with the details of circumstances of other states, but I do network with colleagues in similar positions and I know we battle with the same issues. Australia is experiencing a - an undersupply of doctors generally. However, the undersupply of medical graduates is clearly more acute in Queensland than it is interstate and Queensland has a far greater number of international medical graduates in practice in both the Medicare and public sectors than do the other states.

There was a system in many years ago and may still be in existence relative to bonded students, medical students who under that system had to spend a certain amount of time in regional Queensland and provided, from what I hear even to this day and in past days, a fairly outstanding service in

making certain that, at least, a doctor was available in most of those regional and smaller country areas. Is that system in place still and certainly - secondly, is it something that the commission should look at so that the increase in number of so called bonded students could be available to the system?-- Yes, that system is still in place. It's been one of the long standing icons in Queensland, one of the most long standing and successful mechanisms of recruitment into rural practice, but the system is in need of - desperate need of repair and it's been my privilege in the current position to be involved in that process, and if I could address your question back to the previous one of Commissioner Morris, when in the end of 2003 it was evident to me that I didn't have capacity to progress the program designed for international medical graduates. I considered that was an appropriate time to consider what other opportunities presented at that time, and on reflection it became evident that a significant amount of our attention was being directed to the issue of management of international medical graduates and while that still was warranted we also needed to look at the question of how we improve the supply of Australian graduates and what then I asked myself was had we done all that we could, and I concluded at the time that we probably hadn't, and I can certainly indicate now with a resounding no that we have not. I'm not sure that the bonded scholar scheme is necessarily the most suitable to current circumstances, particularly when our generation or the current generation, younger generation, is particularly renowned for its desire to keep its options open. To press them into service in a bonded situation, I think, is - well, the scheme is struggling to cope with that situation. I believe, however, that we're able - we certainly have capacity within Queensland, without a doubt, because of our unique decentralised population circumstance and excellent clinicians in major rural centres within Queensland who are still practicing in the rural generalist model, that is, they are engaged in primary care medicine as well as secondary level services, obstetrics, anaesthetics, emergency medicine, in that we have a pro vocational training program in Queensland to attract Australian graduates. I have been working intensely in the last little while with colleagues in colleges in the general practice training consortia, university, my rural medical colleagues and others to devise such a scheme and it's near completion in its development at the moment. In the first instance I would hope to be able to implement that scheme for our Queensland bonded scholars, but it's the observation of the - some of the education providers in the development of that program that if we did establish it we would soon have nonbonded scholars asking for entry into it. I would hope - I would be fairly optimistic that that would be true in fact and I would hope that we may then be able to transition the bonded scholar scheme into a more premier vocational pathway which didn't - which no longer required a bonding in service. But I guess principal - a principal premise underpinning this development is the shift in paradigm from the idea that we are recruiting junior doctors to a lifetime of practice in a particular locality to understand that for a range of reasons we must expect a limited tenure of practice in rural communities, particularly

from Australian graduates. That tender - that tenure based upon current evidence will be early in practice when partners, spouses and families are best able to enjoy life in a rural setting rather than later. Therefore, we need an intensive preparation and case managed program to ensure that we have an adequate supply of Australian graduates to a remote Queensland and I believe that - I believe that is possible and I'm delighted with the support we've had from many sources to make that a reality in the near future.

We've had a lot of information given to us and a lot of the functions of the Health Department in the decision making process and the return of information back down the line could be transformed enormously, and if it goes in it sometimes never comes out; I think somebody did use those words. I'm just wondering do you have a view as a senior health administrator that there are other ways - are there any other ways by which the bureaucracy and the obstruction associated with such could allow a lot more - a lot quicker form of replies, answers, solutions, directions, rather than coming in and never coming out almost?-- Deputy Commissioner, I can't claim to be - to have expertise in the area of organisational management, but I guess from a professional point of view and based upon experience to date I think we do have opportunity to be able to evolve the operation of health services in Queensland to take into account the variety of pressures that are placed upon the system. One of which, of course, is to be immediately responsive to local communities and I guess I have been - I have long advocated the need to have local communities have greater involvement in the management and delivery of health services. I'm not in any way advocating the reestablishment of another level of bureaucracy in the system, but in particular would strongly suggest that Local Government must surely be in a prime position to be involved in that process. We certainly do need to have a strong corporate management of key functions in health, like public health, like management of the decisions, and I would hope - hopefully transparent decisions about what it is the public health system will provide and what it won't provide. There obviously are distinct advantages in having some functions, such as industrial relations and procured services, marketing in the internation market in a centralised fashion. I guess without prescribing the detail of it, some sort of arrangement in which there is an integration of those centralised - necessary centralised functions, but local responsiveness would be a circumstance and I would imagine that health professionals would like functioning in, and I'm sure would be appreciated by community members who understood they had a service that was directly responsive to their local needs.

COMMISSIONER: Sir Llew, do you mind if I just pick up on that? Again at the risk of being controversial, let me run past you one model that's been suggested and, in fact, this model takes its origin, from of all places, the Federal Defence Department where the situation arose some years ago that admirals and generals were being told by bean counters how many bullets they can fire and what equipment they needed, and so on, and they really didn't like that idea, so the

department was restructured on the footing that there came into being what's described now as the Department of Defence Support with the clear understanding that its function wasn't to govern those who are in the field, but in fact provide support to them, and it seems to me that some of what you have been saying is a bit like that, that Charlotte Street should be a resource for the hospitals rather than a place that sets the tone for what goes on in the hospitals; is that overstating it?-- No, it's not overstating it. I guess - I guess it's important and I don't claim to have the expertise to nominate all the key considerations, but I believe that there are key principles which would, perhaps, dictate the direction in which service management - health service management in this country and in our state should proceed. One certainly is funding and very current subject today I understand in Canberra, but it's very evident that it's time - it's high time that this country moved to establish a better mechanism of funding of health services than the very difficult current - current, very difficult circumstances. It would make sense, I would think, that we had a situation where State and Federal Governments in the first instance were prepared to collaborate and may be prepared to establish, even on state level, a joint commission that was responsible for funding health services. It may be appropriate that a body be established to be principally the prior of those services and, certainly, I would perceive that a State Department of Health would always retain central responsibility to oversee the outcome of services, the efficiency of services, public health interests, and other related matters.

Well, when you talk about a State Department of Health overseeing those things, I guess this is a slightly philosophical approach, but it's been my professional experience for many years that it simply doesn't work when you have a service prior who is also a legislator. Many of us will remember back to the days of Telecom and Telstra, as it became, when if you had a problem with the phone system provided to you by Telecom you would complain to Telecom and if you don't like the answer you complain to Telecom. It seems to me that at the moment the structure of health administration in Queensland as Queensland Health has by far and away the biggest prior of health services in Queensland and, indeed, I think in the country, one of the largest in the country, anyway, but at the same time the sort of central repository of health regulation, as well, and one of the things I am wondering is whether it isn't desirable to separate those functions so that Queensland Health has its traditional role back to the Ned Hanlon days of being the provider of the public hospital system, but an independent body of commission, of similar standing, for example, to the Crime and Misconduct Commission which has overall responsibility for health regulation and branches of that would include existing authorities like the Medical Board for Accreditation, the Health Rights Commission for the types of complaints it investigates, perhaps, to bring in one of the other ideas which we have been floating, a health ombudsman who deals with complaints at a different level, but to have that body quite away from the health service provision

functions of Queensland Health; do you have any thoughts about that?-- That's, in my mind, an eminently logical conclusion to reach based upon the key issues that we've not only been considering today, but are more widely evident within the health system.

D COMMISSIONER EDWARDS: I just have two other questions. In Dr Patel's case, it seems that the major person who was prepared to go public, perhaps with the risk of castigation, goodness knows what, was a Sister in intensive care. Mechanisms within a hospital system or in a region by which such a performance by a doctor or a senior nurse, or whatever it might be, but certainly a position relative to the management of patient care can be reported to an authority that won't get bogged down in bureaucracy, lost in the system, and in the meantime any deaths or injuries occur - how would you advise this Commission to think about a mechanism by which concerns of professional people can be aired without fear of retribution, and can have an impact of changing the system to cope with such problem?-- If I could respond to your question, Deputy Commissioner Edwards, in two parts: firstly, to address specifically the issue relating to Dr Patel, it is fairly evident to me that one of the key mechanisms that is normally in place to manage the circumstance of questionable competence and capability of a specialist practitioner is their fellowship, the peer review of their colleagues within the respective college. That's not an explicit mechanism but I think this circumstance demonstrates its power in terms of being able to govern the clinical competence and capability of medical professionals. But to answer your question more generally, my experience in all of the positions which I have occupied in Queensland Health, and even to now, demonstrates to me that we do not have - in all of the processes currently available to us, which include the Medical Board's processes within Queensland Health as a public health service, our competence management or performance appraisal process, disciplinary action, credentialing processes, we do not have yet adequate capacity to deal with the question of clinical competence. All of those programs are inevitably fraught currently with significant risks in a number of dimensions, and those risks, in fact, were documented - at least we attempted to document those in one of the attachments to my witness statement which detailed the applicant assessment process plan for medical jobs at health, not least of which amongst the risks is the risk of legal action, and, in fact, in many circumstances, my experience has been that people who are aware of or concerned about the competence of a health professional find that risk overcomes their willingness to step forward to take action in the first instance, and I believe that that's - that's a genuine concern. I don't think any assurance can be clearly given to anyone that that doesn't exist, and then even those mechanisms that currently exist are all inadequate to deal with the task. I have only very recently been involved in the process of providing advice regarding the management of a rural practitioner whose competence was questioned, and at every stage in that process there were enormous difficulties, and it was only through enormous goodwill and commitment of the key people involved that were able to progress that through to a very good conclusion. But it was very evident to myself and other key players in the process that the wheels could have fallen off that at any stage, and one of the key players indicated to me that they felt totally and absolutely unsupported - not in the sense of personally unsupported, but they had very little

system support in that whole process to deal with it. It is also very - the process of dealing with competence is very time consuming and expensive, and I guess to bring that to a bit of a conclusion, it would seem to me that it is very necessary for the registration authorities to oversee some process - I am carefully choosing that word, to oversee the process not necessarily to perform it - but to oversee some mandatory process which provides adequate protection for both the subject of the concern, so that natural justice is afforded to them, as well as those who are expressing their concern leading to a reasonable conclusion which would satisfy the public interest for safety and individual interest for natural justice and recognition of the risks involved in a question of clinical competence being directed to any clinical practitioner.

COMMISSIONER: Perhaps to add to that, something Mr O'Dempsey said to us a couple of days ago, that when it comes to clinical competence, dealing with it in an adversarial way, such as disciplinary proceedings, is a disaster because the only possible outcome is either the doctor continues practising or the doctor stops practising; that there should be systems in place to deal with those matters in an educational and supportive way rather than an adversarial forum?-- Indeed, Commissioner, and all parties simply take legal advice at that point as well.

Yes?-- Which is an extraordinary impediment to resolution of - if I could say, with respect, to the resolution of professional competence and capability issues.

I would be the first to agree with you, doctor.

D COMMISSIONER VIDER: My areas of interest have been covered thank you.

COMMISSIONER: Doctor, there is something else I wanted to ask you - and I won't ask you for a response straight away, but it is something you might like to think about over lunch and perhaps speak with the counsel who are representing you here. I appreciate that you are a very busy man and in a very responsible position, but you did mention, in answer to one of my earlier questions, that you could have provided a very lengthy response. I was wondering whether you would at least give some consideration to the possibility of some form of secondment for a week or two over the next couple of months to enable you to come to this inquiry and spend some time working out that response at length, and giving us your considered and detailed views as to the sort of reforms we should be looking at, rather than expecting you to do that on the fly in the witness-box or fitting it in with your other responsibilities?-- Commissioner, I am almost lost for words and very humbled by the invitation and very honoured by it. I am obviously very passionate about the issue of securing safety of health services for the community, so I would be very willing to put that request to my superiors and be very willing to consider it with them.

Thank you. Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. Dr Lennox, for how long have you held ministerial delegation to certify to Area of Need?-- Almost for the whole period of my appointment, since '99, I believe. I couldn't be accurate about that but.

All right. If there was in existence a policy of Queensland Health to take perhaps unconscientious advantage of what's been described as vulnerable IMGs in their placement in the workforce, do you expect that in the exercise of your delegated functions you would have become aware of it?-- No, not necessarily.

All right. And why is that?-- Because the function is strictly limited to making a decision about whether a particular locality justifies the status of Area of Need. I guess we have, by ministerial policy in Queensland, determined that the decision making about Area of Need will be determined on a case-by-case basis which gives us an opportunity to make some inquiry about the capacity of the applicant or the person for whom the application is being made and, therefore, also to have some idea of the implications, or at least the possibility of adverse treatment of that person, but they are very - they are quite clearly - how shall I put it - not secondary functions, but they are not the primary exercise of our duty in terms of determining, as a delegate of the Minister, Area of Need status.

All right. Well, do you - I am sorry?-- If I could just explain a bit more, we have simply - we have accepted the opportunity presented by the need for declaration of Area of Need to make further inquiry, but that process is not authorised by the Medical Practitioners' Registrations Act.

And have you availed yourself of the opportunity to make inquiries as to what becomes of the candidates who are the subject of your certificates?-- To the extent of our capacity, yes, but that's extremely limited because of the sheer workload involved in the process.

All right. Can I put it then in this way, doctor: in paragraph 12 of your statement, you say that as recently as 2002 when you were exercising your function as one of the operatives of medical jobs at health, you and Dr Catchpole, I think, experienced - or you received up to 80 job applications a month?-- Yes, I did.

From IMGs, is that so?-- That's so.

If it were known in the market that Queensland Health was an opportunistic employer of those candidates, would you expect to have received applications in that number from those persons?-- Certainly not.

Doctor, it was put to you that in so far as the Lennox Report either expressly or implicitly levelled criticism at those responsible for the then existing system of recruiting and

placing and managing IMGs, that that was a source or should have been a source of embarrassment to Queensland Health. Do you remember that being suggested to you by Commissioner Morris?-- Yes, I did.

Is it not the theme of your report that Queensland Health was one of a number of jurisdictional authorities charged with the then existing system for IMGs?-- Yes, it was, and I had no doubt whatsoever that all of those authorities, as I indicated to the Commissioner, had full knowledge of the risks involved.

Can you identify any reason why, if your report was or should have been a source of embarrassment to Queensland Health, that Queensland Health bore an unequal share of that embarrassment than the other jurisdictional entities?

COMMISSIONER: Dr Lennox, I would ask you not to answer that question just for the moment. Mr Fitzpatrick - and I see Mr Boddice is here as well - with the best will in the world, it keeps haunting me that there is this problem here when you are representing Queensland Health. I mean, here is a witness that you are also representing telling us that Queensland Health knew about these problems before his report came on line and did nothing about them. I suppose if that's your instructions from the current Director-General, it doesn't create a problem, but unless those are your instructions from the current Director-General, there would seem to be the most diametric conflict between the interests of one of your clients and the interests of another. Should we perhaps have an early lunch to let you consult with your learned leader about that and consider the position?

MR FITZPATRICK: I am happy to do so, Commissioner.

COMMISSIONER: Only if you want to?

MR FITZPATRICK: Well, Commissioner, I was merely seeking to clarify the witness's position by reference to his report, which in my respectful submission is aimed at all of the jurisdictional-----

COMMISSIONER: Of course, and the witness has said that, but the more fundamental problem is that what he seems to be telling us is Queensland Health knew that they had this problem with overseas-trained doctors even before his report was written and unless - unless the Director-General accepts that that's the position, there are obvious problems, aren't there?

MR FITZPATRICK: Well, Commissioner, I am merely seeking to have him acknowledge that there was knowledge on the part of other jurisdictional entities as well.

COMMISSIONER: I think you have already told us that Queensland Health wasn't the only one that knew there were problems?-- No.

MR FITZPATRICK: Thank you, Commissioner. Well, that's as far

as I wish to take it-----

COMMISSIONER: All right, certainly.

MR FITZPATRICK: -----at present. Dr Lennox, was medical jobs at Health some sort of hybrid recruiting or management agency for those seeking entry into the public sector medical workforce in Queensland?-- Can I ask - I am not quite sure what you mean by hybrid?

Well, was at least one of its functions the recruiting into the public sector medical workforce?-- Yes, indeed, though we considered that its operation was not specifically to Queensland Health's public service. In fact, we recommended applicants through the system to private hospitals and private Medicare employment.

I see. In that respect, was it similar to a recruiting operation sponsored by the AMAQ?-- Yes, it was. We hadn't - we hadn't progressed to implement the full described functions of medical jobs at Health, we had simply done what we could with the resources available to us, and while it certainly was recruiting, it wasn't marketing in a significant extent. We had simply operated from the Queensland Health website and provided an email address for applicants and standardised application form and CV to respond to. But, yes, I guess there is no doubt that we knew at the time that there was some perception that the work that we were doing, perhaps, might cause some concern to the operation of private agencies recruiting the same market.

Yes, I see?-- And, of course, the AMAQ has an agency of its own.

I see. And was that because the greater proportion of IMGs are recruited into the public sector health system operated by Queensland Health?-- Well, I am not quite sure it was a greater proportion but certainly a very large proportion. At any case, I believe that we simply considered as a jurisdiction we had a problem - we had a responsibility to deal with this issue and the proposal that we had put - designed in cooperation with the relevant parties, including the AMAQ, provided opportunity for private agencies to be doing exactly as Queensland Health proposed to do.

I see. Doctor, at Exhibit 6 of your statement - I think in fact it is attachment 1 to Exhibit 6 - attachment 1 to Exhibit 6. Do you have that?-- This is a submission, the subject of which is Medical Workforce Management?

Actually, could I direct you to attachment 1, which is the extract immediate response received-----?-- Sorry, yes.

COMMISSIONER: DRL1?-- And attachment 1.

MR FITZPATRICK: Commissioner, I am sorry, it is in fact DRL6, and attachment 1 to DRL6.

COMMISSIONER: Right. So DRL6 is the submission from Dr Lennox to Catchpole and Nori and then attachment 1 is an email response received by Ms Jennifer Young.

MR FITZPATRICK: Yes.

COMMISSIONER: Right.

MR FITZPATRICK: This is the example of the overseas-trained doctor who is deficient in the written English language. Is that the one that you have?-- That's correct, yes.

Who was failed, as it were, when assessed by the centre for overseas doctors, as suitable for employment but then subsequently recruited into the public sector by a private agency?-- Yes, the Centre for International medical Graduates - Centre for OTDs, as it was known then, assessed him as unsuitable for entry into one of its courses, which certainly - which certainly implied unsuitability for employment.

I see?-- But, in fact, even more so determined that he was unsuitable even for a bridging course or preparation for training course, yes - preparation for employment course.

Do you happen to know which was the private agency who recruited him?-- I don't know with confidence, which is the reason why I didn't include that in the document.

All right. Mr O'Dempsey from the Medical Board has given evidence to the inquiry that the Board, as I understood, had recently instituted some conditions for proficiency in the English language on the part of IMGs?-- Yes.

Have you seen that in the transcripts?-- Yes, indeed.

Does that go some way, or perhaps all of the way, towards allaying any fears that you might have about recurrence of this situation that we see in attachment 1?-- This is an excellent development on the Board's part, in fact of Medical Boards in Australia, but in our experience, and particularly in my association with the Centre for International Medical Graduates, we are of the opinion that this is simply just a first screening process, that passing of the IELT score is simply the first screening process, and further assessment of English language competence in clinical practice is a necessary part of assessment.

Yes. Could we then move, please, to the - as I call it the Centre for Overseas-trained Doctors?-- Yes.

Maybe that's out of date?-- Centre for International Medical Graduates is its title now.

At paragraph 17 of your statement, you describe how in late 2002 or late 2003 the then Centre for Overseas-trained Doctors became insecure and certainly under threat because of a withdrawal of Commonwealth funding?-- Yes.

Is that so?-- That's so.

Can you inform the Commission, please, as to what is the Centre for Overseas-trained Doctors?-- The Centre for International Medical Graduates, previously centre of the University of Queensland, has now been incorporated within the Skills Development Centre of Queensland Health, and Ms Jenny Young, who was the previous director, remains its director within the Skills Development Centre. It continues to supply the services previously, with its emphasis upon provision of bridging courses to Australian doctors trained overseas, that is international medical graduates who have obtained permanent resident status by a means other than their professional status, and it provides bridging courses for them to prepare for the Australian Medical Council's multiple choice examination and the clinical examination, and it also provides a preparation for employment program.

I see. And is it part of your current responsibilities to liaise with the centre, if not in fact to work in it?-- It is. I have a close association with it and continue to provide a lecture to the doctors in the Preparation for Employment Program on the Australian Healthcare System.

And is it the case that the centre was relocated from the Herston Medical School to the campus at the Royal Brisbane and Women's Hospital in about September last year?-- Yes, that's correct.

Where it is housed in a new facility?-- Indeed.

And have you inspected that facility?-- I have.

And what is your assessment of it?-- It is an excellent facility. I am advised by colleagues that it probably represents some benchmark best, as far as skills development centre is concerned, perhaps in the world at the moment.

All right. If the resources available at the centre were to be applied to overseas-trained doctors mandatorily by Queensland Health, that is if all of the overseas-trained doctors were to pass through the centre and if they were to be assessed and if they were to be trained as necessary before going out into the districts, out into the hospitals, would that alleviate or in fact affect many of the recommendations that you made in the so-called Lennox Report?-- It would indeed, and perhaps I - it may be appropriate for me to also advise that in addition, or perhaps even more important than the facility, the centre for overseas-trained doctors over a period of time has been supported by an extraordinary group of extremely passionate clinicians and others who have been committed to assist international medical graduates through the bridging courses in preparation for employment program and, as such, I have no doubt at all represents the premier centre for international medical graduates, premier centre of its type in Australia. I don't doubt its capacity whatsoever to take on the additional tasks previously specified in Medical Jobs at Health Program. In fact, they would

complement the existing functions of a centre for international medical graduates.

COMMISSIONER: It will just need more funds?-- It will need more funds.

MR FITZPATRICK: Thank you, doctor.

COMMISSIONER: If you are moving on to something else, would that be a convenient time?

MR FITZPATRICK: Yes, yes, it would be, Commissioner.

COMMISSIONER: How long do you have to go? I am happy to keep sitting.

MR FITZPATRICK: Commissioner, I think I will probably be 20 minutes.

COMMISSIONER: We will take the break now, then, and resume at 2 p.m. Is that suitable?

MR ALLEN: Excuse me, Commissioner.

COMMISSIONER: Yes, of course.

MR ALLEN: Just before the end of proceedings on Monday, my learned friend Mr Boddice handed to the Commission a copy of a report from Doctors Johnson and Farlow in relation to a matter concerning Charters Towers.

COMMISSIONER: Yes.

MR ALLEN: Could I have the Commission's leave to approach the secretary so as to be able to peruse a copy of that report?

COMMISSIONER: I have no difficulty with that at all. You might have to give us some time to find it. There is a lot of papers up there. Certainly we will do our best to help you.

MR ALLEN: Thank you.

COMMISSIONER: Anything else?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: 2 o'clock.

THE COMMISSION ADJOURNED AT 1.00 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.04 P.M.

DENIS ROLAND LENNOX, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Fitzpatrick?

MR FITZPATRICK: Commissioners, I think there's something that Dr Lennox wishes to raise.

COMMISSIONER: Certainly, Dr Lennox?-- Thank you. I wonder if I was sufficiently clear in my answer to your question in the earlier session about my previous ill-experience in Queensland Health had related to a previous administration, not the current.

Not the current. When you say the previous and not the current administration, I think it would be helpful if you were more specific about that?-- It relates to the period of time when Dr Robert Stable was the Director General of Health.

All right. Am I right in understanding that during that period of time the current Director General had the position of General Manager?-- For a limited period at the end of that.

And it was he who commissioned - I'm sorry, he who created the committee which led to the writing of what's called the Lennox report?-- Indeed, that's correct.

Was he still in the position of General Manager at the time when Queensland Health repudiated that report as being an official document?-- Either in that position or Acting Director General. I'm not quite sure which, but that's correct.

Thank you. Yes, Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. Dr Lennox, could I just take you to paragraphs 18 and 19 of your statement?-- Yes, I have those.

These are the paragraphs in which you describe how you prepared a briefing at Dr Buckland's request seeking a commitment for implementation of the relevant parts of your report from the Medical Board of Queensland. Is that so?-- That's correct, yes.

Now, at Annexure 9 of your statement you attach the briefing that you prepared?-- Yes.

And it appears that it comprises the August 2003 version of the Lennox report?-- Yes.

Together with a draft letter which you prepared for Dr Buckland's signature?-- Yes.

Addressed to the then Chairman, is that right, of the Medical Board, Professor Tuft?-- President, to be precise.

President. Thank you. Thank you, doctor. Now, it seems that the briefing came into existence because Dr Buckland thought that the implementation of your report required a commitment from the Medical Board?-- Yes, indeed.

Do you agree with that assessment?-- Yes, I do.

And do you agree that it was reasonable for the report to issue to the Board seeking that commitment?-- Yes, it was. It may be evident from the medical joint health document itself that the solution proposed required the collaborative commitment to the task of the three jurisdictions, Queensland Health, Commonwealth Department of Health and Ageing. And the Medical Board of Queensland. Some of that commitment overlapped, but we believed it was necessary, in the interests of the risk that was being addressed, to ensure that, in effect, this was a belts and braces response.

Yes. See, Dr Lennox, just for the purposes of clarification, is in fact the briefing - the Lennox report which is annexured DRL9 to your statement, is it identical or identical in all material respects with the version of the report which later in your statement you describe was tabled before the joint AMAQ committee?-- Yes. It's identical in all material respects.

All right, thank you. Now, in paragraph 19 of your statement you profess to some uncertainty as to whether Dr Buckland's letter of 8 September 2003 ever issued to Professor Toft?-- I was simply unaware-----

What happened?-- -----what happened to it.

All right. Two officers of the Medical Board of Queensland have given evidence to the inquiry, those being Deputy Registrar Demy-Geroe, who I think you've said you know?-- Yes.

And also Mr O'Dempsey who is, I think you told us before, the Registrar?-- Yes, indeed.

And that's what he told us as well. Do you know both of those persons?-- I have - I know Mr O'Dempsey. I have much more frequent contact with Michael Demy-Geroe.

Do you know also Professor Toft?-- Indeed.

All right. Do you know who it was who made up the Medical Board of Queensland in September 2003, who the Board members were?-- I'm not sure that I can recall all of the Board members, but I know that Professor Lloyd Toft was the President, Dr Mary Mahoney was the Deputy President, other

members included Professor Laurie Geffen, Professor Brian Campbell, Dr Ian Wilkie, and general practitioner from the north of Brisbane whose name escapes me for the moment, and a legal representative and a lay representative whose names I can't recall at the moment.

Thank you, Dr Lennox.

COMMISSIONER: I assume in your position you had fairly regular dealings with the Board, so even if you can't recall the names now, you knew most or all of the members then?-- Yes, and my dealings, of course, weren't with the whole Board. I specifically related to the officers of the Board and particularly to the President and Deputy President.

Of course.

MR FITZGERALD: Dr Lennox, this is an account which has been given to the Commission by both Deputy Registrar Demy-Geroe and Mr O'Dempsey about how your report, the Lennox report, was viewed by at least Professor Toft and Mr O'Dempsey, and can I read that to you?-- Yes.

It appears at the transcript in so far as Mr Demy-Geroe's evidence goes at page 476 lines 50 to 70 when-----

COMMISSIONER: I think if we're being perfectly accurate about this, wasn't it the evidence of Mr O'Dempsey that he himself never saw the report, simply that the President, Dr Toft - or Associate Professor Toft saw it, and Mr Demy-Geroe saw it and these were the views that were formed by Toft and Demy-Geroe?

MR FITZGERALD: That's so, Commissioner, and also that Mr O'Dempsey was accepting of those views.

COMMISSIONER: Yes, Mr O'Dempsey accepted them, but he didn't see the report so he didn't-----

MR FITZGERALD: That's quite so.

COMMISSIONER: -----himself form any views.

MR FITZGERALD: Commissioner, can I read to the witness what was said?

COMMISSIONER: Of course.

MR FITZGERALD: In answer to a question from my learned friend Mr Boddice to Mr Demy-Geroe - Mr Demy-Geroe was asked, "You've seen this letter before", and that was the letter from Dr Buckland, the one that you drafted, and the witness said, "Only today. I could have seen it earlier. I have no particular recollection of it." The witness went on to say, "This was something that was raised" - I'm sorry, Mr Boddice said, "This was something that was raised. It's under the hand of Dr Buckland in his previous role as General Manager of Health Services, but it was a suggestion about, in effect, the Medical Board and Queensland Health being able to devise some

system of accreditation for overseas trained doctors", and the witness was asked, "Is that the case?" Mr Demy-Geroe said, "Yes, yes." Mr Boddice went on to say, "And it spoke about action by Queensland Health, the Australian government and the Medical Board being necessary in order to implement the proposal. Do you know whether that was advanced at all from the point of view of the Board?" The witness said, "Yes, it refers to a meeting that took place between Dr Toft and Denis Lennox and some others. I was at that meeting and there was a report which - a draft report which Denis Lennox had prepared which was - went into great detail about a lot of these matters that are referred to here. I remember generally there was agreement that these are good things, but - and in a practical way whether they could be implemented was a separate issue. I don't have any particular recollection of it going to the Board for any discussion. It remained a draft report, and my memory is that it was never promulgated to a final report. It did go to an AMA committee on which I am a representative which discussed it, and again people agreed that these are worthy objectives, but whether they could be actually implemented - they were - that was a separate matter. But I don't have any clear recollection of what happened with this. It seemed to have just gone away." So far as the evidence of Mr Demy-Geroe stands, his evidence was that your report was considered at least by Dr Toft, and also by the AMAQ joint committee - in other words, there were two separate occasions - and it had support, but the persons to whom it was submitted had some concerns about practical implementation of it?-- Yes.

COMMISSIONER: Were those concerns ever conveyed to you?-- The concerns in relation to the practical detail, yes. They were the subject of the ongoing discussion in the joint OTDTRD committee, as it was called, and which resulted in iterations of the report. Relevant concerns were addressed in the iterations of the report until we reached the document which I now consider to be the final document about which, as my witness statement indicates further, there were some continued considerations raised by the AMA and subsequent advice that I'd considered had arrived at sufficient clarity of the principles by the key jurisdictions as to be worthy of consideration by the Director General and our Minister to proceed, and the Director General obviously confirmed that view by himself being prepared - in fact I think it was his initiative, if I can recall correctly, to so write to the Board and include a copy of the report.

I see. I think your evidence this morning was that the report in what you regard as its final form expressed your views as to what was a desirable resolution of these problems, and you remain of that view?-- Indeed.

So whatever is being suggested to you as being the view of the Medical Board, you adhere to your view that these practices are desirable, although you accept the practical reality that people have to have both the funds and the political will to carry them out?-- Indeed, Commissioner, and further to counsel's question, the letter would not have proceeded if I

had not received a sound response from the President and Deputy President of the Board that the principles being proposed were acceptable. In fact my recollection - and I think it's relatively clear because it was such a critical issue, and I certainly would have been concerned and we certainly wouldn't have proceeded if any significant concerns had been raised by the Board at the meeting referred to. My recollection was that Professor Lloyd Toft indicated his enthusiastic support for the proposal and that that was reiterated at a subsequent meeting of the Medical Workforce Advisory Committee which Dr Toft attended, and at which there was a very significant gathering of representatives of the various colleges and other workforce agencies in Queensland, and reinforced at that meeting the Board's considerable enthusiasm and interest about the proposal.

If it were the position of Dr Buckland at the time that this report had no official status, it wasn't a Queensland Health document and had no significance, why would it be his business as General Manager Health Services to send a copy of it on Queensland Health letterhead to the President of the Medical Board of Queensland?-- I'm not sure that I fully understood your question, Commissioner.

Well, we've been told that Queensland Health subsequently repudiated-----?-- Indeed.

-----the report as having any official status within Queensland Health?-- I believe I was in a very good position, based upon my personal communications with the Director General and his proposal to write the letter and his obvious receipt and signature to the letter, that in fact he had accepted this proposal as sufficiently official and sufficiently well formed at this stage to be the subject of a reference to the Medical Board to seek the Medical Board's commitment to the process proposed.

It was only when the press started stirring up trouble that he said it had no status?-- Indeed.

MR FITZGERALD: Dr Lennox, Commissioner Morris was referring to Mr O'Dempsey's evidence which at page 664 lines 10 to 20 of the transcript on this topic was as follows: my learned friend Mr Mullins asked him, "Why didn't you get a copy of the Lennox report then?" Mr O'Dempsey replied, "Because I was aware that my Deputy Registrar" - who I think was Mr Demy-Geroe - "and the President of the Board had considered a draft and had said that most of the material in it didn't have any responsibility for the Medical Board and most of it was unworkable. Now, they were the specifics from both the Deputy Registrar and the Chair. I will respect their assessment of it." Can I ask you to assume for the moment that Dr Toft and Deputy Registrar Demy-Geroe had indeed expressed those opinions, and that Mr O'Dempsey had respected that assessment. Do you think, in those circumstances, that the Lennox report was likely to win approval from the Medical Board of Queensland?-- In those stated circumstances probably not, but I should say that that advice represents a

significant surprise to me when the Medical Board, through its representation through Michael Demy-Geroe on the joint committee, had every opportunity to convey those views and I don't recall that they were. If they had been, the report wouldn't have been in the form that it was in, and in any case, the observation that the requirements of the Medical Board as stated in the report - I'm just not quite sure that I can recall the exact words used, but were impractical or - I'm just not sure-----

The exact words used by the witnesses-----?-- Indeed. Again, I would have expected I would have heard about that very clearly at least in three fora. Firstly, the joint committee, secondly, the direct meeting between myself and the President Toft and Vice President Mahoney, and the Medical Workforce Advisory Committee meeting subsequently, and in neither of those meetings did I receive any intimation at all that the principles were not eminently practical.

Yes, I see?-- In fact can I ask - can I state further, counsel, that the requirements of the Board, while substantial in terms of the decision making that the Board would need to embark upon and commitment they would need to make, as far as we are able to ascertain at that point - and we obviously were keen to receive the advice of the Board - were well within the Board's capacities within the legislation - within the Act at that time to implement.

All right, Dr Lennox. Could I perhaps explore that a little further with you.

COMMISSIONER: Well, I'm not sure that you can. It's almost now reaching the point where you're cross-examining your own witness. You've had a very emphatic answer from your own witness rejecting what you've put to him. I would have thought taking it any further just becomes cross-examination, doesn't it?

MR FITZPATRICK: All right, Commissioner. I won't-----

COMMISSIONER: I'm willing to be persuaded otherwise. I'm not stopping you, but-----

MR FITZGERALD: No. Thank you, Commissioner. Dr Lennox, you describe how your report was also submitted to the joint OTDTRD committee sponsored by the AMAQ a little further in your statement?-- It was submitted indeed, although it was - to be complete, it was, in effect, commissioned by that body as well. So it was prepared at the guidance and direction of that body and finally submitted to it indeed.

Thank you. In paragraph 25 of your statement you acknowledge that the AMAQ had a legitimate interest, and I think you say an essential role in the consultative process whereby your report could be implemented?-- Yes.

Is that, in effect, saying that the AMAQ support was practically a necessity?-- It was going to be rather

difficult - it was going to be orders of magnitude more difficult to proceed with a proposal like this if it wasn't supported by the representative body of the medical profession in Queensland.

COMMISSIONER: Do I understand though the significance of AMAQ support was political in the sense that it would add to the profession putting its weight behind the proposal? The AMAQ wasn't expected to have any functional role in giving effect to the proposal if it was adopted?-- No.

So really, when Mr Fitzpatrick says that AMAQ support was critical, that was only in the sense of engendering support for the recommendations amongst the practising profession?-- Yes.

MR FITZGERALD: Dr Lennox, at Annexure 13 of your statement you annex a letter dated September 2003 on the letterhead of the AMAQ?-- Yes.

The first paragraph of the letter says that, "A committee of AMAQ met with individuals representing various other groups impacted on by this paper on 16 September. The group asked me to advise you of the following concerns they had with the paper". Can you help us, please, as to who it was that the AMAQ committee would have met with? Who were the individuals representing various other groups impacted on? Do you know?-- I can't be certain of all of the groups who may have been included in the AMA statement, but I was certainly aware that that would have involved private recruitment agencies who obviously had a significant interest in the outcome of this process.

I see?-- Can I take the opportunity to point out that of course the circumstance of our significant undersupply of medical graduates from Australia and the need to recruit from overseas has seen the development of significant business enterprise in the area of medical workforce recruitment. It was obviously a significant factor for us to take into account in terms of being able to progress this proposal.

I see.

COMMISSIONER: Dr Lennox, since you've been taken to that AMAQ letter, I must say that on my reading of it it doesn't involve a rejection of any part of the substance of your report. It strikes me very much as what might be called fine tuning of some of the detail of the report?-- That was precisely as I understood it, and the detail that's referred to, I don't recall - my best recollection is that that didn't relate to specific content of the current report, but to further operationalise details that would obviously be determined at a later stage once the principles of the concept were accepted, and I certainly accepted the last line of the AMA's letter to indicate endorsement in principle of the proposal.

And just to take it one step further, most of the fine tuning details raised in that letter would seem to be consistent with

the philosophy of the Lennox report proposal. In other words, they seem to be working with you to make it a better proposal rather than working against you?-- That's how it was happening, without a doubt, at the time.

MR FITZGERALD: Dr Lennox, the fine tuning, as it's been called, included, did it not, in the fourth paragraph of the letter, in the last sentence, a requirement that, "In all cases for a defined period the registrant's practice would be oversighted by a process to be established to ensure the initial quality check was accurate...that that would necessitate mentoring, reporting deficiencies to the quality control process which must then respond appropriately by suspending a registrant from practice if necessary, or ensuring remedial work is undertaken." There are a number of other mechanical matters that are set out further on in the letter, including also, I think, two paragraphs down in the last sentence, a requirement that "the overseas trained registrant should retain freedom of choice of where they will work within the Area of Need restrictions of the Commonwealth and the State with the only limitation to this being the quality issue."

And that was a further requirement that in the previous paragraph that consideration be given to a system being as outlined, but run by a consortium of interested and involved groups both funded by Queensland Health with some recovery of costs from applicants. Do you think that those - that any of those matters were substantial impediments to the implementation of your report?-- I considered none of those to be substantial impediments. Those contained in paragraph four of the document, in fact, are quite consistent with the detail of the medical jobs at - the health assessment module, which is detailed in another attachment to my statement and I certainly had no reason to be concerned about those requirements or, at least, those specifications provided by the AMA. The issue about freedom of choice, I certainly would have - would not have interpreted as being freedom of choice practice in any occasion, but that if Queensland Health was operating a major agency, providing assessment of the international medical graduates and including case management of those graduates and placement that, in fact, we would not be preventing the applicants from choosing certain places in Medicare practice. So this was from the outset, in fact, in the current operation at that time with medical jobs at health the commitment that we had made. Queensland Health's interest extended beyond simply the provision of public hospital services to the whole jurisdictional responsibility for health in the state. We were, even at this stage, committed to ensure that the state was benefitting by the application of Government power in the international market place which was one of the reasons for the proposal in the first instance, while at the same time preserving the right of private agencies to be involved in the recruitment business providing they committed to the standards, hence the process requiring accreditation by the Medical Board of the assessment processes. Queensland Health obviously was committed to do that in this process and private agencies, likewise, could participate in the process by doing the same. So there was a strong commitment right throughout the development of this program to ensure maximum choice and delivery of quality international medical graduates in terms of capacity and capability to all sectors of medical service in Queensland.

Dr Lennox, in paragraph 37, which is the final paragraph of your statement, you say that from your experience in administering Area of Need certifications it became evident to you that reform of that area was necessary and that you prepared a ministerial paper and that significant refinement of the processes progressed within the last 12 months?-- Yes.

But that some further reform is necessary in your opinion?-- Yes.

Have you, and if not I invite you to outline to the Commissioners, if you've not covered it already in your evidence, what refinements of the Area of Need process have progressed within the last 12 months. Is that something that you've addressed when speaking to the Commissioners before?-- No, I have not addressed that before.

Well, could you, in brief outline, tell the Commissioners what has happened in the last 12 months in relation to those?-- In the last 12 months there's been considerable refinement of the administrative process regarding Area of Need certification, including documentation of the applicant - of the applications, the decision making process, making the process - making efficient the process of communication of that information to the Medical Board, increasing the security of that communication to the Board, increasing the quality of the documentation required of applicants, they're evenly processed. There have been a series of provisions of the Area of Need application form and there's been substantial work over the last 12 months or more in consultation with colleagues in similar positions in other states and with our colleagues in the Australian Government Department of Health and Ageing regarding their delegated responsibility for district and medical workforce decision making to ensure that there is an alignment of both of those critical processes so that from the point of view of applicant's there's effectively - almost effectively a single streamline process. So there's been considerable reform of that process, but with my colleague - colleagues within the health advisory unit we have still the need, perhaps, to reform the process further to consider a shift away from declarations of Area of Need based upon an application by an international medical graduate or on behalf of an international medical graduate to a process which declares Area of Need as a standing declaration which may apply for a period of time, subject to changes, in medical workforce; supply in that locality. There also is consideration of the need for us to progress a process which, perhaps, provides greater transparency in the decision making process, as well.

Thank you, Dr Lennox. Commissioners, subject only to this, that completes my examination of Dr Lennox. Can I inform the commission that approval has been given from my client for the secondment which you raised, Commissioner Morris, and that Dr Lennox is happy to make himself available to the commission on that premise.

COMMISSIONER: I'm delighted to hear that, and please convey to the Director General my thanks for that situation. I hope Dr Lennox is as pleased about that as we are, and I will ask Dr Lennox whether it would be in order for the secretary to contact you next week to work out logistical arrangements to allow to that happen?-- Indeed, Commissioner, I hope the commission is just as pleased at the end of my service as at the beginning.

I have absolutely no reservations, doctor, thank you. And thank you, Mr Fitzpatrick. Shall we go around the table? Mr Mullins? Mr Devlin?

MR DEVLIN: I will be fairly brief.

COMMISSIONER: Yes.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Dr Lennox, my name is Ralph Devlin, and I represent the Medical Board of Queensland. Just going to paragraph 19 of your statement-----?-- Yes, I have that

-----and focussing for a moment on your choice of words in the sentence beginning, "I am not aware of the fate of the accompanying letter to the Medical Board for Dr Buckland's signature. However, a copy signed and dated 8 September is held on record." I take it given the form in which it comes to us, that is, a signed letterhead letter on a file it would not surprise you to know that the letter was never forwarded to the Medical Board?-- Since I had no further contact from the Medical Board on the matter and since my name is given as the contact point, no, that would not surprise me.

Would not surprise you?-- No.

No, but it is implicit, it seems, and see if you agree with this: that Dr Toft had expressed concerns about aspects of the matters you raised in your discussions with him?-- I don't recall Dr Toft expressed anything-----

No, what I meant was he agreed with the general nature of your concerns?-- Indeed, indeed.

Thank you.

COMMISSIONER: Thank you, Mr Devlin. Mr Mullins?

MR MULLINS: No cross-examination, thank you. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Lennox, John Allen, I am appearing for the Queensland Nurses Union. You gave an anecdotal example of the difficulties experienced by some overseas trained doctors to gain specialty accreditation in Australia?-- Yes.

You mentioned someone who had Russian qualifications?-- Yes.

Can you just expand upon that situation as an illustrative example of the problems that may exist under the current system?-- This doctor - I'm not quite sure at this stage - I'm not sure at the moment, in fact, how this doctor arrived in Australia in the first instance. I have the impression,

perhaps, he sought practice opportunity in Australia and he was granted that. I'm not quite sure which jurisdiction, but I do recall, in fact, he was employed as a surgeon - he had practiced in surgery in three states in Australia. I'm not sure what his employment status was, and it just so happened, in fact, that he was employed at the Bundaberg Hospital, as well. It's very evident that at the beginning of his employment no-one traced for him the pathway that he needed to follow in Australia to achieve permanent resident practice status and in my view represents, as we previously discussed, an instance of abuse of the vulnerability of international medical graduates in a minefield which faces them on arrival in Australia.

Yes?-- He obviously had a reasonable expectation that being permitted to practice in surgery he had some future opportunities available to him in this country. He progressed from one jurisdiction to another until, I guess you could say, his service was exhausted and maybe, perhaps - perhaps there were some limitations to his capacity, let's say, because his training was in paediatric surgery and his - he was practicing in general surgery in Australia. Eventually he arrived at a situation where no further practice opportunities were offered to him in that capacity. After a period of nine years practice in senior status in this country he has nowhere to go. He has - he has sought, over a lengthy period of time, opportunity to access the surgical training program in Australia. He's been assured by the college that, yes, that's possible, but for a variety of reasons finds that he simply cannot compete with Australian graduate applicants and at this stage after - well, it must now be ten years, in fact, in this country, still has no clear future. And, fortunately, there are some compassionate colleagues who have provided him to function at a junior level, very unsatisfying to him, but his predicament is too extreme now. In fact, he doesn't have an opportunity to return to his country of origin to practise.

When you say he faces the difficulty of competing with Australian trained graduates, is that in relation to competition to gain accreditation by a - one of the colleges?

COMMISSIONER: Or to get a teaching - a learning position?-- It relates to the fact that the college of surgeons has deemed his qualifications in the specialist discipline of surgery to be insufficient for practice as a surgeon in Australia and they would require him to participate for, at least, a period of the Standard Australian Surgical Training Program before sitting for Australian examination.

MR ALLEN: I see. So it's really the competition to get into that program?-- The competition to get into the program.

I see. You were asked about the - whether systems were in place addressing the future situation of more medical graduates in relation to training positions that could allow accreditation by colleges and you said that, indeed, that is a worry for the future but, in fact, the present situation is not such that there are sufficient training positions for that

purpose; is that how I understand your evidence?-- That's correct.

What are the-----

COMMISSIONER: Well, there are no sufficient positions at the moment for that purpose, but the new graduates haven't come on line yet?-- Yes, I need to clarify that.

Yes?-- I know for certain there are not sufficient vocational training opportunities in specialist disciplines in Queensland to meet our requirements for specialists in the future. It's not an issue so much at the moment because we don't even have an adequate number of graduates to supply those available positions, but as our graduates supply increases I'm sure we will arrive - unless there some changes we will arrive again at the problems experienced in the past.

MR ALLEN: And do I take it from the tenor of your evidence on that topic that you certainly are of the view that the colleges shouldn't have ultimate control as to the number of specialists available to the Australian community?-- I'm of the very firm view that the colleges' responsibility relates to professional standards in the relative disciplines, but certainly not in relation to the workforce supply.

And are there any factors presently where the colleges, perhaps, have too much influence as to workforce supply?-- I guess it becomes a point of perception as to whether the colleges' process of accrediting training positions is done purely for purposes of setting standards and doesn't double at the same time as the mechanism by which control of supply is exercised by colleagues.

COMMISSIONER: And I think, doctor, if we debated that for a week we still wouldn't be any closer to an answer?-- I'm sure we wouldn't, but I think if I could say, Commissioner, that there is - despite that general problem there are a couple of examples in which colleges quite deliberately have not exercised that capacity and the college of physicians, in particular, has not exercised its potential capacity to control supply and in consequence of that, in particular, if anything, we are well supplied with paediatricians in this country. We are still undersupplied by general physicians and other subcategories of specialist physician practice, but that - that relates more to the availability of graduates to train than it does to the colleges' control. Similarly - sorry, the College of General Practitioners, of course, has no control over the number of physicians, although it does exercise some control in terms of accreditation of training positions.

MR ALLEN: You also gave an example of the College of Psychiatrists as being an exception to any type of restrictive practice?-- Only as an example. There may be other colleges who are worthy of the example, as well, but I'm aware of consideration within the College of Psychiatry to limit their responsibilities to the issue of setting standards, standards

of training, assessment of training, conferring of qualification and to have others actually provide the training program.

COMMISSIONER: But, Dr Lennox, you've been helpful in identifying some colleges that you see as having good attitude in the sense that they're not operating restrictively; would you feel comfortable about identifying any that you would put in the other category of being restrictive?-- Commissioner, I would feel uncomfortable in the sense that my primary responsibility is - has a focus on rural workforce. I don't deal directly with a number of the specialist colleges, so my experience is both a little dated and not direct. I do have a direct working relationship with the College of Radiology because, in fact, I participate still on the Steering Committee of Radiology Training as Queensland Health representative at this time, so I'm a little bit - I don't consider my expertise is sufficient to give a clear answer to that question.

No. I thank you for that.

MR ALLEN: So when in response to some questions from the Commissioner that there are some examples of some colleges totally controlling the accreditation process; you wouldn't feel comfortable identifying such?-- It's not first hand information on my part, but certainly that information would be readily available from other sources.

Now, you mentioned in the same context that one of the possible overseers for such a problem is the involvement of other bodies, such as tertiary institutions being involved in the training process, and are you aware of a particular example of that in the Hunter Valley in New South Wales?-- No, I don't think I am. Can I say that I am, however, aware of one example in relation to psychiatry where an institute independent of the college, in fact, provides the training program in Sydney, I understand. Again, I'm not particularly familiar with the detail.

Certainly. Now, could I ask you in this context, perhaps, to offer any comments you feel you can in relation to some reported statements of a Commissioner of the ACCC on this subject. Now, in August last-----

COMMISSIONER: Mr Allen, I'm not sure how helpful it is. I think Dr Lennox has been extremely helpful to the inquiry by exhausting the information which he can provide to us based on his first hand knowledge, and he's been very careful not to go beyond his first hand knowledge to implicate colleges that he may have suspicions about, but not based on that sort of first hand knowledge. How does it really help then to put to him things by an ACCC Commissioner?

MR ALLEN: I'm not asking him to comment on particular colleges, I'm asking him to comment upon some particular propositions in relation to the broadening or transparency of the procedure for accrediting specialists.

COMMISSIONER: All right. Put the propositions to him.

MR ALLEN: Yes.

COMMISSIONER: If at some stage you want to put the ACCC report into evidence that will have whatever weight it bears based on the source from which it's come, but all you can do for the moment is ask Dr Lennox whether he agrees or disagrees with the propositions, and if so why.

MR ALLEN: Thank you, Commissioner. In relation to accreditation of hospitals and training programs, do you agree that the criteria for assessment should be readily available?-- Indeed.

That results of assessments should be publicly available?-- Yes.

And that jurisdictions and, I suppose, that would include Queensland Health, in this state, should have the opportunity to proposed training posts and participate on accreditation assessment panels?-- Indeed.

In relation to training selection process, would you agree that the selection criteria should be publicly available and procedurally fair?-- Yes.

That information about numbers of trainees should be publicly available?-- Yes.

That information about training requirements and results should be publicly available?-- Yes.

In relation to the assessment of overseas trained practitioners, would you agree that such assessment should be consistent, transparent and fair?-- Yes.

That assessment criteria should be available to applicants?-- Yes.

Assessment processes should be publicly available?-- Yes.

And jurisdictions should have the opportunity to nominate persons to be included on assessment panels?-- Yes.

In relation to appeals processes, that they should be available for training accreditation and selection processes?-- Yes.

With criteria for and results of such processes being publicly available?-- Yes.

That jurisdictions should have the opportunity to nominate persons for appeals committees?-- Yes.

And in relation to stakeholder involvement in college processes, that mechanisms should exist to facilitate

stakeholder involvement from jurisdictions, consumer and user groups where appropriate, in addition making processes regarding trainee numbers, accreditation of training facilities and assessment of overseas trained practitioners?-- I do.

COMMISSIONER: Mr Allen, at a convenient time you might like to tender the report from which those propositions appear.

MR ALLEN: Yes, I will arrange.

COMMISSIONER: Particularly given that Dr Lennox has embraced all of them.

MR ALLEN: I will arrange for a copy to be obtained, Commissioner.

COMMISSIONER: Thank you.

MR ALLEN: Now, if we could just move onto another matter, quickly. You were asked some questions by the Commissioner which really touched upon this broad question of the culture in Queensland Health that might seek to discourage someone going against the party line, a broad summary?-- Yes.

Now, without naming any names and being as discrete as you see fit, do you feel comfortable in providing by way of an example the - what you witnessed in relation to the experience of a colleague that you mentioned?

COMMISSIONER: I don't require you to answer that question unless you feel that you are able to answer it in any way that won't cause embarrassment either for you or for the colleague?-- Commissioner and counsel, I'm not concerned about causing embarrassment to myself but I'm not certain that it would be appropriate for me to discuss the experience of a colleague without, first, communicating with them about it and receiving-----

Can I ask whether that colleague is still with Queensland Health or-----?-- Commissioner, I have a number of colleagues I could - some of whom are with Queensland Health and some of whom are not.

Mr Allen, I'm not sure we need to take this any further. There's been no challenge either to the evidence of this witness or to the evidence of Dr Molloy in relation to the so called culture of Queensland Health. Given that that's the state of affairs I think it's - we've really reached the end of the road on that issue.

MR ALLEN: Given the answer I'm not going to press the question.

COMMISSIONER: I appreciate that.

MR ALLEN: It's entirely a matter for the witness whether he feels he wants to investigate that further for the commission.

COMMISSIONER: Thank you.

MR ALLEN: And at the risk of being seen not to take on board the Commissioner's comments just then, and with the same caveat as to whether or not you feel comfortable answering the question, you said that you, yourself, had suffered a more significant example of being a victim of that culture in previous years?-- Yes.

Now, your CV indicates that up until 1999, March 1999, you were the Medical Superintendent of the Toowoomba Hospital?-- Yes.

Do you feel comfortable in outlining to the commission the circumstances which led up to you ceasing that position?-- I certainly don't feel comfortable, Commissioner, in the sense that I don't particularly wish to divert the attention of the commission from its more important considerations to a personal one.

COMMISSIONER: I think you have said enough in the first-----?-- I think I have said sufficient if, perhaps, I'm-----

Thank you, Dr Lennox, I won't ask you to take that any further.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen.

MR ALLEN: At paragraph 13 of your statement you point to one of the factors that impact upon the availability of suitably qualified IMGs as being "The dominance of corporate management functions required of medical managers at the expense of their professional leadership and clinical governance functions"?-- Yes.

Is that something of which you have personal experience in being a medical manager, so as to speak?-- Yes, indeed.

What sort of factors impact upon someone in a position such as that in seeking to provide the best health service available to the public of Queensland?-- I think - my answer to that question relates back to questions from the Commissioners earlier. That one of the most challenging tasks in management of the health system is the role of the professional managers who carry responsibility both for corporate management - and I don't resile from that responsibility at all - but also carries responsibility for professional leadership and clinical governance, and both the system and the culture of that system needs to be particularly conducive to developing an adequate supply of very capable people to carry that function within the health system, otherwise we will not be able to maintain the quality workforce that we require and care for their needs and at the same time protect the interests of the safety and service delivery for the public. I am not quite sure that I have adequately answered your question, but-----

When you talk about the dominance of the corporate management functions at the expense of professional leadership and clinical governance?-- Corporate management functions, of course, have always existed and they meet - they have a particular interface with professional leadership in clinical governance responsibilities in those professional heads, many of whom, in fact, are trained as specialists in that discipline and have additional training above their professional training in management in particular.

Could I put it in fairly simple terms: is it your experience that if someone in the position of a medical manager spends more than the budget permitted so as to provide adequate health care for users of such a service, that they're penalised by Queensland Health?-- They would certainly be subject to significant censure in terms of their corporate management responsibilities, but I think even more importantly is the fact that there hasn't been adequate support of their functions in the system to deal with that issue beforehand - and I guess I am speaking from very personal experience here. The person in that position, of course, has an obligation to corporate management and that means at times that there is a disparity between the available funding and service need. There are a variety of ways in which that can be resolved. One of them is that corporate management can dominate and subjugate the interests of professional leadership and clinical governance.

That's not desirable, obviously?-- It is not desirable.

Is it your experience that has been the case?-- Indeed.

Over what period of time?-- At least the last decade.

COMMISSIONER: Dr Lennox, given the reference to your position at Toowoomba, superintendent there, one of the names that people often put forward as an example of the old style medical superintendent was one of your predecessors, Dr Des

O'Rourke, who really had no time at all, as far as we can tell, for any form of corporate responsibility or management or bureaucracy; he was just interested in running a hospital?-- That's the purpose for which I went to Toowoomba in the first instance, following a review of the functionings of the Toowoomba Hospital, particularly in respect of its medical management, and a position of Deputy Medical Superintendent was created so that those medical management functions actually could be performed. But I - it's probably appropriate, Commissioner, to say that that also represented my first experience of having to grapple with the issue and realising, in fact, that there is no system support and there is no due process for dealing with the issue of clinical competence and capability.

Yes, yes.

MR ALLEN: At paragraph 25 of your statement you, in relation to the proposal that the joint committee be involved in the process of considering this problem of overseas-trained doctors, said that you "considered it inappropriate for the key jurisdictional bodies to work with the AMAQ in the manner proposed because of the AMAQ's representative and political interests." Is that a long way of saying that you were concerned that the AMAQ would have apparent or actual conflict of interest in considering those matters?

COMMISSIONER: What does this go to, Mr Allen?

MR ALLEN: I am simply asking the witness to explain that part of his statement, Commissioner.

COMMISSIONER: Why? I mean, does it go to any term of reference whether he thought it was a conflict of interest or not?

MR ALLEN: Well, this Commission may, no doubt, in formulating recommendations, consider what is the appropriate involvement of perspective stakeholders in any new system that's constituted.

COMMISSIONER: If it then comes to a question of whether there is a conflict of interest, I think we can form our own view without putting Dr Lennox to the trouble of asking why he formed a view in an entirely different context as to whether or not there was a conflict of interest.

MR ALLEN: Well, his opinion-----

COMMISSIONER: No, Mr Allen, I won't stop you. If you think it is important, you go ahead, but frankly, I think you are wasting time.

MR ALLEN: Do you understand the question?-- I understand the question. I am happy to answer the question-----

COMMISSIONER: Thank you, doctor?-- -----Commissioner. No, it wasn't a question so much of conflict of interest, it was

simply that the AMAQ had an interest in the matter undoubtedly, as I have indicated earlier, and consultation with the AMAQ was obviously going to be absolutely paramount - of paramount importance in progressing this issue, and, in fact, we were already in consultation with the AMAQ. But they didn't have responsibility for the issues. That responsibility rested with the other jurisdictions represented at the table, and I was particularly aware of the sensitivity of the issues to be considered and particularly wished those jurisdictions to be able to handle those very openly amongst themselves without having the possibility that that discussion may be disclosed publicly for political interests.

MR ALLEN: I see, thank you. You, in your statement, mention that it was particularly - it was from the mid-80s but particularly during the period commencing 1999 through to 2001 that you learned valuable lessons regarding the recruitment of IMGs?-- Yes.

And that it was by 2001 that Dr Catchpole, yourself and other colleagues were looking at ways at which you could best apply your learning?-- Yes.

In the position that you then held in 2001, would you have expected that you would have received, by virtue of that position, knowledge as to the contents of any internal Queensland Health reports regarding unsatisfactory competence of any overseas-trained doctor employed by Queensland Health?-- No.

All right. Even if such report made general recommendations in relation to the process of recruiting and supervising overseas-trained doctors?-- No, it was very clear, and the instruction was reiterated to the both of us, that is Dr Michael Catchpole and myself, on numerous occasions that our function was not to interfere in the line management of Queensland Health. We therefore weren't included in the line management process, our function was as professional advisors.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. Anyone else got any questions in cross-examination at the Bar table? No. I remind members of the public of what I said yesterday, that if you have any issues that you want to raise that you think should be put to a particular witness or canvassed with the witness, anyone is welcome to approach the legal staff of the Commission of Inquiry and raise those issues. Before you - I am sorry, Mr Boddice.

MR BODDICE: I just wanted to place on record that earlier, before lunch, you asked Dr Lennox whether he was prepared to assist. I can indicate that I have received instructions that Queensland Health will facilitate that process, so if the Commission wished to have Dr Lennox seconded at any time to assist, if the Commission solicitors simply write to my solicitors we will ensure that that process takes place.

COMMISSIONER: Thank you. In fact, Mr Fitzpatrick had dealt with that in your absence. Any re-examination, Mr Fitzpatrick?

MR FITZPATRICK: No, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Thank you. One hopefully short topic.

RE-EXAMINATION:

MR ANDREWS: Dr Lennox, within your what's called the Lennox Report - I beg your pardon - within that report I note that for doctors of the category that Dr Patel fell into, categorised as Category 4, meaning those who would be "temporarily resident", to this reader it is not entirely obvious what training you would propose at the Centre for International Medical Graduates. What I seek to understand is how practical it would be for either the employer or the Medical Board to insist that a temporary resident, who has probably just arrived in the country, should undergo some kind of course at the Centre for International Medical Graduates. How long would it run for, how much would it cost?-- I guess the answer to that question is simply how long is a piece of string. There obviously is a compromise to be achieved between the need to ensure safety and the need to have medical service, but I guess in particular keen to ensure that the system does its level best to deliver both and not compromise on either. There is no doubt that we do need, for the reasons we have previously discussed, a program of preparation of international medical graduates prior to taking up practice in Australia. The extent of that preparation must surely be judged on their capacities, as determined by an appropriate assessment process, upfront. It may be necessary for some to actually proceed through a detailed course over a period of time in a full-time capacity. Others may be determined, for example as with graduates we've previously recruited from the United Kingdom, to have a brief orientation and perhaps a continuing distance program over a short period of time to bring them up to speed, but with the technologies available to us now, we're certainly not necessarily talking about a program requiring a doctor to be in a specific location for a very lengthy period of time. We obviously would need to decentralise preparation for training and other orientation programs so that we don't hinder, any more than necessary to achieve safety, the need to find practitioners for service requirements.

Well, for example, if one - if you had an international medical graduate who was adept with English, would you regard that person as someone still requiring to undergo some kind of formal assessment by way of passing some kind of examination before being permitted to be sent off to a regional

hospital?-- No, the program as it was designed included a staged assessment process so that the succeeding levels of assessment will determine upon the outcome of the first. So there was an initial screening, and if, for example, in that screening it was determined that this applicant's primary language was English, trained in English, passed the Board's requirements, then we probably wouldn't be concerned about any further assessment of their English language skills. However, if English was a second language more recently learned, they haven't trained in English and the initial screening indicated some concern about English language capacity despite succeeding with the Medical Board's requirements, then obviously it would be appropriate to include some additional assessment of their English language capacity in clinical practice prior to their employment.

For someone whose qualifications were as apparently impressive as Dr Patel's, who was articulate, who was recruited and registered by the Medical Board, would it really be supervision at Bundaberg that would be the staged management of that IMG? What I mean is, the staged management of that particular person, would it be done - you mentioned decentralised management. Would it be done by the supervisor at the hospital?-- Yes, indeed. Somebody in that situation - I mean, I guess there are a lot of preliminary considerations at this point and I guess - I mean, it is easy for me after the event to second guess the decision-making process that's preceded, but in the very first instance I certainly would have had reservations about Dr Patel proceeding to a senior medical officer position in the normal capacity of senior medical officer position. In his international capacity he obviously was used to practising as a consultant surgeon and I would have expected that if he had been placed in a traditional senior medical officer position, that is serving consultant surgeon in practice in hospital in this State, that would have been an unsuitable placement.

Because he would quickly progress to doing more complicated surgery than-----?-- I think it would be an unreasonable expectation for an international medical graduate to severely limit his practice in surgery to the extent required by our circumstances, and his lack of credentialling and recognition in Australia. I certainly would have recommended to Patel that that wasn't a suitable position for him.

COMMISSIONER: In fact, doctor, it would be fair to say that the only logical explanation for anyone employing Dr Patel to go to Bundaberg was in the expectation that he would take over a role that would normally be held by a specialist surgeon?-- Indeed, and he was not going - in the normal course of events that was an opportunity that was not going to be available to him.

MR ANDREWS: I have no further questions, Commissioner.

COMMISSIONER: Thank you so much, Mr Andrews. Dr Lennox, we do very much appreciate not only the fact that you came down from Toowoomba to give evidence, but also the evidence you

have given. As I indicated, we'll be in touch about the proposal for you to contribute further to the work of the inquiry and we look forward to putting that in place. Thank you again for your time?-- Thank you, Commissioner, Commissioners. That's been my privilege. Thank you.

COMMISSIONER: Just before we-----

MR ALLEN: Excuse me, Commissioner, just while the witness is still fresh in your minds, can I hand up a copy of the document I referred to, which was a presentation to the National Health Summit 2004, entitled "ACCC Interface with the Medical Profession, A Prescription for Good Practice", presented by John Martin, Commissioner of the ACCC on 27 October 2004.

COMMISSIONER: Well, in fact, I was also going to deal with another document for which you asked the other day, Mr Allen. You remember you asked about the Johnson Farlow report relating to Charters Towers. The situation is, so there is no misunderstanding, that the delay in getting this document is that it was brought to our attention by the solicitors instructing Mr Mullins, the solicitors for the victims - I think that's right - or was it your solicitors?

MR ALLEN: My solicitors.

COMMISSIONER: Your solicitors, all right. But it was put on the basis that you could inform us of the existence of the document but would have to obtain our own copy, as it were, either from the Coroner's office or from Queensland Health. We now have a copy which has come from Queensland Health, as I can tell by the stamping on it. So that report will be admitted into evidence as Exhibit 56. I will describe it as the Johnson Farlow report but its full title is "Investigation report regarding allegations of carelessness, incompetence or inefficient conduct", by Dr Isak Maree, and the report is dated February 2001. So that will be Exhibit 56.

MR BODDICE: Could I just be heard in relation to one aspect, just to bring it to your attention more than anything else.

COMMISSIONER: Of course.

MR BODDICE: As I understand it, that report was made a confidential exhibit in the Coroner's Court, and I actually don't know why, but obviously by putting it as an exhibit on the website, that may override whatever was the reason for the Coroner - I am not asking that it be confidential, but I am just bringing it to your attention that, as I understand, it was made a confidential exhibit in what is an ongoing Coroner's Court matter, and I just don't know why that is so.

MR ALLEN: Perhaps I could assist a little bit there. My instructing solicitor, Mr Rebetzke, actually appeared before the Coroner in relation to directions concerning an inquest in relation to the death dealt with in that report. The counsel assisting the Coroner did ask that although the report be

admitted as an exhibit, there be a non-publication order. The Coroner, at Mr Rebetzke's request, specifically granted Mr Rebetzke's permission to draw to the attention of the Commission the existence of such a report. It may well be the case that a non-publication order by that Coroner still stands in relation to that report.

COMMISSIONER: That's so, but under the Commissions of Inquiry Act, there are protocols about the interrelationship between Commissions of Inquiry and Courts. The essence of it is that we don't interfere with their business and they don't interfere with ours. I have been through the report. I can't see anything in it that would be appropriate for the subject of a non-publication order in these proceedings, subject to the general order that I have articulated on many occasions, that the names of patients and patients' families are not to be mentioned in the press or media without their permission. That is the only thing that I could conceive as being a sensitive issue that should be the subject of a non-publication order.

MR ALLEN: For my part I agree entirely, Commissioner.

COMMISSIONER: Unless anyone has anything further to say, that will be Exhibit 56.

ADMITTED AND MARKED "EXHIBIT 56"

COMMISSIONER: And will be available in the usual way. Exhibit 57 will be the document identified by Mr Allen presented to the National Health Summit 2004, entitled "ACCC Interface with the Medical Profession, A Prescription for Good Practice", presented by John Martin, Commissioner of the Australian Competition and Consumer Commission, 27 October 2004.

ADMITTED AND MARKED "EXHIBIT 57"

MS McMILLAN: In relation to that coronial inquiry.

COMMISSIONER: Yes.

MS McMILLAN: We have located the Medical Board file in relation to that matter which includes that report. We were requested to find that by my learned friend. It is coming up to the Commission under cover of a letter from my instructing solicitors and should be here in the next day or so. We apologise for the delay but because I understand Mr Rebetzke wasn't able to give us even the doctor's name, it has taken about eight hours to find it, so we have located-----

COMMISSIONER: We appreciate your effort. If it arrives in the next day or so, I am afraid there will be no-one here to receive it, but when it does come in, unless there is any reason to the contrary, it will become an exhibit and become available in the same way. In the meantime, it will just come to the inquiry offices and be dealt with as part of our records.

MS McMILLAN: Thank you, Mr Commissioner.

WITNESS EXCUSED

COMMISSIONER: The next witness is Dr Huxley.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: We might take a 10 or 15 minute break before we proceed with her evidence.

THE COMMISSION ADJOURNED AT 3.24 P.M.

THE COMMISSION RESUMED AT 3.43 P.M.

MR ANDREWS: I call Dr Suzanne Amanda Huxley.

MR BODDICE: We seek leave to appear.

COMMISSIONER: Such leave is granted, Mr Boddice.

SUZANNE AMANDA HUXLEY, SWORN AND EXAMINED:

COMMISSIONER: Please take a seat and make yourself comfortable. I might say, if it assists, Mr Boddice, I've read through the statement. I'm not sure that the Deputy Commissioners have had the chance to do so yet, but looking at it, most of it seems pretty self-explanatory. It's a very comprehensive statement, and I don't think we'll need to be taken through it at any great length.

MR BODDICE: There are two areas I wanted to highlight, and there's an additional area she might be able to help the Commission with, but that's it. It does seem to speak for itself.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Would you tell the Commission your full name, please?-- Suzanne Amanda Huxley.

Doctor, did you sign a statement on the 1st of June 2005?-- Yes, I did.

Are the opinions you express in that honestly held by you?-- Yes, they are.

And the facts you recite in it, they're true to the best of your knowledge?-- Yes, they are.

I tender that statement.

COMMISSIONER: The statement of Dr Suzanne Amanda Huxley will be admitted into evidence and marked as Exhibit 58.

ADMITTED AND MARKED "EXHIBIT 58"

COMMISSIONER: I don't think either of the Deputy Commissioners had a copy yesterday, and I was only handed one as I asked for it when we came back after lunch. Can you make sure a couple of additional copies are obtained?

MR ANDREWS: I can. I have a man in the courtroom who can attend to that.

COMMISSIONER: As I said, that will be Exhibit 58.

MR ANDREWS: I have no questions.

COMMISSIONER: Thank you, Mr Andrews. Mr Boddice?

EXAMINATION-IN-CHIEF:

MR BODDICE: Dr Huxley, in the statement you have set out your CV and what your role is. You're the principle medical adviser, and in that role you have to provide informative and timely advice on strategic medical workforce issues?-- Yes.

But you also have, in effect, two subroles. One is that you are one of the persons that has the ministerial delegation for Area of Need?-- I am.

And determining those applications, and the second is that at a national level you have a role in terms of the review of the colleges?-- My role is wider than that representing the Department on certain issues to do with the medical workforce. So, for example, medical workforce issues related to AHWOC I'm involved in, and other national committees. I sit on the Medical Training Review Panel and I'm jurisdictional representative on the Board of Specialist Surgical Training.

Dr Huxley, the statement really speaks for itself, but there's a couple of areas that I wanted you to explain to the Commission because it has become an issue. The first is Area of Need. You explain in your statement that under the Commonwealth system there's this District of Workplace Shortage?-- Workforce Shortage, yes.

Workforce Shortage, and Queensland has an Area of Need. In Queensland Health's submission there was an encapsulated statement of Queensland effectively being delegated an Area of Need, that is the whole of Queensland. Can you just explain to the Commission how the Area of Need system works?-- Area of Need basically means that either a public or a private sector position can't be filled by a suitable Australian graduate, so when we're looking at private sector applications, we don't accept applications unless they're supported by the Commonwealth's District of Workforce Shortage, which is a preliminary assessment of District of Workforce Shortage that is to get a provider number, Area of Need is purely for registration purposes. So we do the private sector based on Australian government information with the District of Workforce Shortage. For the public sector, the applications that we receive are for junior and senior positions and each of those applications is assessed on its

merit. The reality at the moment is that the workforce shortages are so great that in my time in the position which has been full-time since October 2003, we haven't rejected an Area of Need application for the public sector.

So in summary, a shortform explanation is that the whole of Queensland is potentially capable of being an Area of Need, but each application is a separate application considered on its merits?-- Yes.

For a particular position?-- That's correct, and certainly all of Queensland is not an Area of Need when you're looking at the private sector because we're guided by the Australian government for their Districts of Workforce Shortage, and all of Queensland is definitely not a District of Workforce Shortage for the private sector.

The private sector is essentially done to the Medicare system of a provider number?-- They base their information on the Medicare system and population data and a number of other sources of information that they have, and it means that they are - that a community has significantly less practitioners to provide a service than in general. So they are using Medicare data and population data.

D COMMISSIONER VIDER: Could I just ask for clarification. Dr Huxley, so when you talk about Queensland being an Area of Need, that may then help in recruitment in so far as you can publicise the whole of the State of Queensland in what it has to offer and then particularise that down to a particular location?-- I don't quite understand what you're saying. Technically all of Queensland could be an Area of Need, but there's certainly been no ministerial statement to say that all of Queensland is an Area of Need.

I'm looking at it more from a recruitment point of view. Instead of just looking at a particular position in Queensland, they could look at the whole of Queensland for an overseas graduate and then come back to the particular-----?-- They could, yes, and - but it's much easier to recruit in the metropolitan centres.

Yes?-- So from the perspective of how we would advertise, I would prefer to be looking at the benefits of working in the provincial and rural areas.

Thank you.

MR BODDICE: The second area I wanted to cover with you is that from paragraph 14 of your statement you candidly acknowledge that there's deficiencies in the process of declaring an Area of Need, and you set out what those deficiencies are, and then you indicate that there has been some reform. Can you just explain the reform that has taken place and when it took place?-- The major reform for this year took place after the Dr Patel issue, and we - apart from a few structural changes with the Area of Need form, for all Queensland Health senior positions we've added an additional

requirement which is to basically document that a recruitment process has taken place, so there has been an interview, reference checks have been done, and that a supervisor has been provided for all senior applicants, and that's then required to be signed off by the District Manager.

So that's something that's been put in almost as a safeguard to ensure that those processes have been undertaken?-- To ensure the Department centrally that the processes have been undertaken.

D COMMISSIONER VIDER: Then could I take you back in particular to the Dr Patel situation whereby he was appointed as a Senior Medical Officer - Surgery which meant it was a position that required supervision, but in actual fact there was no-one there to provide that supervision?-- I wasn't in my role at the time, but from reading the transcripts that appears to be what has come out.

COMMISSIONER: In your present role, if you were asked to approve a position as an Area of Need which was for a Senior Medical Officer, would you approach that on the understanding that the appointee would have supervision from a qualified specialist?-- I would approach that on the understanding that the SMO has the required competencies to do the job, and that there was an adequate level of supervision. Now, if that supervision is provided by a specialist, which would be the best situation, that may be onsite supervision, and in some cases the supervision has to be at a distance.

Sometimes it would be VMO supervision?-- Yes, external, yes.

What do you mean "at a distance"?-- If - some of the supervision may be provided from someone in, say, the next town if there's not a VMO available or a specialist available to provide direct supervision.

How would that work with a Senior Medical Officer in Surgery, for example, which Dr Patel was? How do you supervise a Senior Medical Officer in Surgery?-- I don't think that that - in my knowledge, that's happened, but for example, radiology you may have supervision at a distance.

All right. But given that Dr Patel was a surgeon and the application related to an SMO position in surgery, it would be your expectation, if that application came in today, that you were approving a position for a person who was going to work under the supervision of a qualified specialist who would be either a staff specialist or a visiting medical officer?-- Yes.

Right.

MR BODDICE: So when you spoke of "at a distance", it may be that the Visiting Medical Officer lives in one town but comes to the hospital a certain number of sessions a week. Is that what you mean?-- No, I was talking more about things like radiology where supervision at a distance is possible because

of telecommuting.

COMMISSIONER: Or pathology would be another example?-- Pathology is another example, yes.

MR BODDICE: You also said there's been some changes to the forms. Is that the case?-- It used to be all in capitals and we've turned it back into formal script. Apparently it's easier to read.

That's just a cosmetic change as such?-- Cosmetic change.

Is it also the case that the form now specifically states that they have to specify what other qualifications of the doctor-----?-- That's always been on the form. The issue for my office when we're processing Area of Need - we don't undertake any form of clinical assessment. Frequently we will only get our Area of Need form. The CV and other information often goes straight to the Medical Board - so the Form 1, the Form 2, which were discussed this week. The CV and other information on the doctor may never come to our office. We're purely assessing an Area of Need.

So you're assessing, in effect, being satisfied that the Area of Need requirements have been met on the basis that you understand the Medical Board, of course, is satisfying - is ensuring that the requirements for registration are satisfied?-- Yes.

Of the particular doctor.

D COMMISSIONER VIDER: Does your office oversee any sort of ongoing monitoring?-- No, no.

Is it intended that it ever would? I'm thinking of the fact that if you get someone who comes in on a temporary arrangement, it they want to renew their registration for a further 12 months, it wouldn't be your office that would remain at local level?-- The ongoing monitoring, so the reporting back on conditions of registration is the responsibility of the Medical Board. So the hospital would ensure that those conditions are met and then that would be reported to the Board.

If those conditions were not being met, as in for some other reason the supervision that you had put in place was no longer available, you would expect the hospital then to notify your office?-- We don't put the supervision conditions in place. That's put in place by the Board.

I know the Medical Board does, but it then has to see that the supervision that is available - is that totally up to the local authority, the direct employer, or does your office have any role in that?-- We have no role in that at the moment. I imagine that things will change, and whether that is my office or whether that's the Chief Health Officer's office or some other area - with the project that's being undertaken at the Centre for International Medical Graduates, that may form part

of what that project delves into.

COMMISSIONER: In the case of Dr Patel, the position was initially given Area of Need status as a Senior Medical Officer position and then it was - that status was, in effect, renewed, as I think a Senior Medical - SMO-----

MR DEVLIN: Director of Surgery.

COMMISSIONER: Director of surgery. Was any re-evaluation-----?-- Not by my office, no.

So that was - I don't mean this critically, but that was merely rubber stamped. The hospital asked for it and no-one felt the need to review that?-- No. We do check, for example, if a position status changes - so if someone goes from an SMO to specialist then we can check on the Medical Board register to ensure that that's actually the case.

Right.

D COMMISSIONER EDWARDS: Dr Huxley, is the Area of Need, once it's filled by, say, an overseas doctor, the appointment is made in that position as an Area of Need for six months, 12 months, and a review done as to how many applicants may be around at that time, or is it a permanent - they could stay there for five years in that hospital?-- They'd stay there, yes. We wouldn't put someone out of a job. If we have given an individual Area of Need status we would not say after a year, "Sorry, you have to move on." If they leave that position then that would be reviewed if someone else came in, and the position should be advertised.

COMMISSIONER: I'm sorry, Dr Huxley. It seems to me that defeats the whole purpose of the legislation. When parliament allowed for these Areas of Need, the whole idea was that it would be temporary for 12 months and every 12 months Queensland Health would ascertain afresh whether it still remains an Area of Need. What you seem to be telling us is that Queensland Health totally ignores parliament's intention and would allow something to go on as an Area of Need for 20 years if that's how long the doctor wanted to stay there?-- At the moment, yes, that's the case, and again, as I said, it's likely through all this that it will be assessed. One of the issues that we have is that under the Medical Act, after four years someone should progress to either general or specialist registration. Up until recently that wasn't enforced. So it was very difficult - for example, you could give someone an Area of Need, renew it each year for four years, and at that time they should have progressed to general or specialist registration, and would not require Area of Need.

Attachment 6 to your statement is the ministerial policy on Area of Need, and that ministerial statement is now at least four years out of date because it relates to legislation that was repealed four years ago. I think you suggest that there's a need to do up a new policy statement?-- The process review

of Area of Need has been on our work plan since I came into my job in August 2003. Unfortunately the workload of just processing the Area of Needs has been such, and the other workload of my unit, that we've not been able to do that at this stage, and that will be taking priority.

Innovation Workforce Reform is understaffed, is it? You've had to work with a document which relates to repealed legislation because no-one has time to spend a few days renewing a six page policy statement?-- Yes.

Yes, Mr Boddice?

MR BODDICE: At paragraph 15 you identify that as something that needs to be done?-- Yes.

COMMISSIONER: How long is that going to take? A week?-- I think it may take longer than that, simply because the policy is so out of date. I mean, it's not reflecting the workforce shortages that we're seeing at the moment, and the other issue with the policy as it stood in 1996 is that it's also not taking into consideration the large number of junior - of interns that are going to be coming into our workforce. So to change it, it's going to be quite significant because we will be saying that someone can come from overseas for only a year, and that they may need to go back because we can't have Australian doctors - Queensland graduates who are not being employed.

MR BODDICE: What you're referring to there is because of the increase in medical places that has occurred in the last couple of years, as those graduates come online, that will mean that there are more graduates available to fill the spaces so the Area of Need requirements will change?-- Yes. The first graduates come out in 2006 from JCU, and there will be an increase every year until at least 2010. We will still need overseas trained doctors in the system, I believe, because I don't think that the number of graduates is going to meet the requirements of the medical workforce in Queensland.

COMMISSIONER: How many staff are there in the Division of Innovation and Workforce Reform?-- In my area or in the whole-----

In the whole division or whatever it is?-- I couldn't tell you, I'm sorry. I work in the Health Advisory Unit, so within my area there is myself and one staff member, and then we have access at the moment to about 1.5 FTE of staff to help us with the Area of Need.

So you work in a Health Advisory Unit and that's part of a Workforce Reform Branch, and that's part of an Innovation and Workforce Reform Division?-- Directorate, sorry.

How many people are in your branch then, the Workforce Reform Branch?-- Probably 30.

Thirty people doing workforce reform, and then - you just don't know how many there are in the Directorate of Innovation and Workforce Reform?-- The Directorate includes the Skills Development Centre and all of the quality and safety area, and they're based at the Herston campus.

Doesn't include anyone who actually ever sees a patient, I take it?-- Some of the clinicians involved with the Skills Development Centre, and also in the quality and safety area would be clinicians who I would expect are still having some clinical contact, yes.

MR BODDICE: The final area, Dr Huxley, was in relation to the Centre of International Medical Graduates. In your role do you have something to do with that?-- I do, and I've also been involved with the centre while it was still based at the university while I was a Deputy Medical Superintendent at Ipswich.

We've heard evidence that in 2003 when it was first set up it was funded by Queensland Health and also by the Commonwealth Government, but in 2003 the Commonwealth Government stopped funding it?-- They changed their funding model which meant it wasn't a cash payment. It was sort of like a HECS funded scheme for doctors using the program.

We've heard some evidence that that put the centre at risk. Was the centre, however, funded by Queensland Health?-- The centre at the time still had a small amount of funding from Queensland Health. Queensland Health funded it to do a specific program, which was the Preparation for Employment Course. So there was a small amount of funding for that which, once the Commonwealth funding was not available any more, meant that the centre was at risk.

But it has continued on?-- Yes, it has. Queensland Health committed to funding the centre while it stayed at UQ until we could bring it across to the Skills Development Centre so that it could then form part of Queensland Health.

So it's still funded by Queensland Health?-- Yes.

But it's actually physically shifted its location?-- Yes.

From being a University of Queensland based entity to now being at the Herston complex?-- Yes.

And do you now have - do you know something about the courses that it provides, and what assistance it provides for international medical board graduates?-- The centre runs two courses to prepare - help prepare doctors for their Australian Medical Council examinations. There's a preparation for MCQ, multiple choice question, exam which is the first examination for the AMC. Then they also run a preparation for employment course which is, I think it's a 20 week course now, so three weeks of lectures and 16 weeks based in hospital doing observership. They also run a preparation for clinical course and as part of those programs they do very in-depth assessments to assess the doctors before they come for their MCQ course. They assess them for their PFE, preparation for employment course, and then also to attend the clinical course, so that they have got quite well developed assessment. At the moment this has mainly been for permanent resident overseas trained doctors who aren't in the workforce, apart from the clinical course, which is usually only employed doctors who access the preparation for clinical course.

And is it aiming to also deal with the temporary overseas doctors?-- It will expand to look at the temporary resident overseas trained doctors. So that's the recruitment assessment training preparation and support place - and support program, which is being developed now and should be up and running by the end of the year.

And so by the end of this year it would cover, not only the permanent resident Medical Board - international medical board graduates but also the temporary international medical board graduates?-- Yes.

And to provide the education and support courses that you referred to?-- Yes.

And when it moved to the Herston campus is now the situation where Queensland Health has the formal responsibility in management of the centre?-- Yes.

And did that occur in July 2004 that that management was taken over?-- Management was taken over in 2004, but the centre didn't move until the Skills Development Centre opened in September of that year.

Yes, thank you.

COMMISSIONER: How many fresh Area of Need applications does your office deal with each year?-- Each year - I have some figures; can I can just check?

Yes?-- Probably - oh, I can tell you the total figures. There are about 1700 for, I think, the last financial year.

But a lot of those would be-----?-- But many of them are renewals.

How many new ones would you - as I take it from your evidence earlier if it's a renewal there's really no reexamination at

all if it's the same doctor in the same position in the same hospital, it's just automatically renewed?-- Generally, yes.

So how many new ones have to be dealt with?-- If I said - off the top of my head I would say probably 50 per cent of those who come through are new, that's both private sector and public sector, because we deal with both, but we can certainly provide the commission with the exact information.

Just a rough figure would be quite sufficient?-- Probably 7 to 800 new a year and each new from the private sector requires usually a bit of work because we - my staff - staff have to generally contact the private sector agencies to ensure that information is correct, so dates are correct and things like that.

Yes, thank you, Mr Boddice. Anything else?

MR BODDICE: No, thank you.

COMMISSIONER: Cross-examination. Mr Mullins?

MR MULLINS: Thank you.

CROSS-EXAMINATION:

MR MULLINS: Dr Huxley, can I ask you to turn to attachment 2 and the final three or four pages of attachment 2 is the Area of Need application for Dr Patel that was processed by your department in 2002/2003; that's correct?-- It was middle of January 2003, yes.

And the title of physician is Senior Medical Officer; that's correct?-- Sorry, yes, Senior Medical Officer - Surgery.

Sorry, the pages are numbered on the bottom right-hand side, 27?-- Yeah, this is a form for the Medical Board, yes.

Can you just take me to the application for Area of Need certification for that year, 2003?-- Whatever page that is - 15.

I'm sorry, page 15 and that application is for certification for a Senior Medical Officer?-- Yes.

And that's what the certification was for; that's correct?-- Senior Medical Officer, yes.

Can I ask you to turn to page 30, which is attachment 3? This was the application that was processed by you-----?-- Mmm.

-----in about November 2003; that's correct?-- Yes.

On the second page of that application, which is page 31 of

the bundle which you have, the position is described as Director of Surgery - SMO?-- Yes.

That's not the same application for certification for Area of Need as was received the year prior, was it?-- We would have processed as an SMO. At that - certainly at that stage having the title of Director of Surgery would not have been of interest to us because we were processing an Area of Need for an SMO.

Did you understand that the term Director of Surgery meant the person in charge of surgery?-- Director titles to me usually mean an additional administrative role on top of a clinical role.

COMMISSIONER: Does it mean the person in charge of surgery?-- Administratively, yes. So they would be the people who do the rosters, make sure that the paperwork is done. If there is a complaint about the department that would frequently go to them, unless it was specifically about the director.

D COMMISSIONER EDWARDS: It's fully administrative?-- Yes.

D COMMISSIONER VIDER: On Dr Patel's position description, though, for an SMO, the position description says that position reports to the director. So the SMO - Surgery reported to the Director of Surgery?-- Is the PD in-----

If mightn't be in this bundle but we have seen-----?-- I think the PD was submitted in the first application, but not in the second, which is the one that I signed.

COMMISSIONER: Well, regardless of when it was submitted, the simple fact is this, isn't it: that what was authorised as a - an Area of Need was a position as a staff Medical Board officer reporting to a Director of Surgery?-- In the original, yes and we would not have checked back with the original when we signed the second.

And Dr Patel wasn't appointed to such a position, was he, he was appointed to a position of Director of Surgery not a staff Medical Board officer reporting to a Director of Surgery?-- As I said before, we would have assessed this - him as a Senior Medical Officer. I can only, in my role, assume that the correct supervision was in place. So we would not go back to check with the hospital-----

But it's apparent, isn't it, that the correct supervision didn't take place, the man was given the job of Director of Surgery from the outset?-- Not apparent to us at the time, no.

Whether it's apparent to you or not someone's broken the rules, haven't they?-- Not necessarily. I came into Queensland Health from Ipswich Hospital. Our Director of Emergency Medicine is an SMO. He's an Australian trained doctor, and he is the director.

No, but this isn't about an Australian trained doctor, this is about a position which was authorised on the footing that it would be an SMO reporting to a Director of Surgery, and specifically on that footing; isn't that right?-- Coming out in evidence, yes.

Yes. And Dr Patel was not appointed to the position of an SMO reporting to the Director of Surgery, he was appointed as the Director of Surgery reporting to no-one in the surgical department?-- That may be the case, but we would not have been aware of that office.

Whether you are aware of it or not someone's broken the rules, haven't they?-- It appears so.

What's been done about that by Queensland Health in the last two years?-- I'm sorry, I don't understand the question.

Well, we hear about the 30 bureaucrats here and doing these things and the ones out at Herston doing other things, what has Queensland Health actually done in the last two years to address the fact that this man was illegally appointed to the Director of Surgery at Bundaberg?-- I'm sorry, I can't answer that question.

Who can? Do we need Mr Buckland down here to tell us? Who can explain to this commission, that's been going on for two weeks now, why it is that Dr Patel was illegally appointed to that position?-- Would it be considered illegally appointed to that position if he had suitable supervision, and he may not have done, but if he had been supervised by a VMO in the private sector, would you consider that that was still illegal?

But that wasn't the case, was it?-- But it wasn't the case as it appears in evidence. We were not aware of that so-----

I'm not saying it's your fault. I want to know whose fault it is. You can't tell us and no-one else seems to be able to tell us?-- I don't think it's my job to apportion blame.

But it is our job, and I'm wondering if you can tell us?-- I'm sorry, I can't.

When was this - you described it as the Innovation Workforce Reform Directorate; when was that set up?-- The department was restructured last year, so the Innovation and Workforce Reform Directorate is one of five. I believe that it was the middle of last year when the change occurred from two divisions to five directorates.

And what does this directorate actually do?-- Within the Innovation and Workforce Reform Directorate, in my area we have the Nursing Medical Board and Allied Health Advisory Units, so our role is to do - is to advise to the Minister, DG and also looking at jurisdictional issues; so working with the other states and at a national level as far as-----

None of that sounds as if it has anything to do with innovation or workforce reform?-- The role of the directorate is changing, but as you can imagine it's something that would take a while.

Apart from providing advice to the Minister, what else goes on in this directorate?-- The other areas of the directorate, as I said before, is the skills development centre, the quality and safety areas, there's a workforce planning area.

Well, quality and safety areas, where were they functioning when Dr Patel was killing patients in Bundaberg?

MR BODDICE: Commissioner, with respect, that's unfair to this witness.

COMMISSIONER: Okay, well-----

WITNESS: I'm very happy to answer that.

COMMISSIONER: I withdraw the question. You can tell me Mr Boddice. I won't be unfair to the witness. Where were those people?

MR BODDICE: With respect, Commissioner, it's a matter of hearing the evidence, with the greatest of respect.

COMMISSIONER: What evidence are you going to give us where those people were-----

MR BODDICE: Well, there's people being called in Bundaberg that will address those issues.

COMMISSIONER: Which witnesses are going to tell us what this directorate was doing in relation to Dr Patel? Who are they? Who are these people?

MR BODDICE: I can't answer that.

COMMISSIONER: I will adjourn.

WITNESS: May I please answer the question?

MR BODDICE: Commissioner, yesterday to witnesses you expressly said, "We're not here to apportion blame", and to this witness you have said, with the greatest of respect, "We are here to apportion blame."

COMMISSIONER: You are quoting that out of context; I'm sorry, but you are.

MR BODDICE: From this witness' point of view, with respect, that's not so.

COMMISSIONER: Yes, I have withdrawn the question to the witness.

WITNESS: May I please answer the question?

COMMISSIONER: I would be more pleased to hear from you Mr Boddice.

MR BODDICE: Commissioner, when the evidence is called, and I am undertaking that evidence will be called in relation to what occurred, but at the moment we are not in a position to know what occurred in Bundaberg because the evidence has not unfolded, and I'm simply taking objection that from the point of view of this witness it is unfair. She has indicated what her role was.

COMMISSIONER: Yes. Okay. You wanted to say something?-- I just wanted to say that I was brought in by the department in, I think, 2002/2003. The quality and safety - there was quality and safety money provided to Queensland Health in the late 90s and a number of - many projects were set up over a five year period. I and another person were brought into review the projects and to find out where we could sustain them in the future because, unfortunately, at that time quality and safety did not have a specific hub, so there was no corporate centre to drive things. Like, for example, we now have a medication chart which is uniform across the state. So those types of projects we had nowhere to put them. One of the things that Dr Buckland did, because he asked me to do the original review - one of the things that he did when he became DG was to ensure that quality and safety did have a home within Queensland Health. There was something driving the quality and safety agenda across the state.

What are these quality and safety projects?-- There were, in my memory, about 38 projects that were occurring at the time. The main projects that they are looking at now, the main things are the - to do with pharmaceutical safety, to do with clinical improvement, and also standardisation. John Wakefield's area is looking at safety officers and the whole issue of - I'm not going to remember this but I should, but I'm a bit rattled. Anyway, all of that information I could easily make available and is probably very worthwhile things that the department has done within the last year and a half since Dr Buckland came in.

And how much - do you know how much these 38 quality and safety projects are costing the tax payers?-- Those projects are not happening now when we did - when we reviewed them.

I understand that. Do you know how much they cost them when they were on foot?-- That was an Australian Government funded area for quality and safety, and I think it was many millions.

D COMMISSIONER EDWARDS: Commissioner, could I ask Dr Huxley-----

COMMISSIONER: Yes, certainly.

D COMMISSIONER EDWARDS: -----in page five of your submission to us you say that it does not, and I take it that - the principal Medical Board Officer reform branch does not assess

the doctor being suitable to be employed in that specified position?-- No, we do no clinical assessments.

Who does that then?-- That is the role of the employer, being the hospital district or whatever.

And, secondly, is there a - do you know if there is a performance audit done on those people that comes back to your area?-- There is not, no.

And, secondly, once the doctor is appointed do you know if it's always for a limited time until that Area of Need is reassessed?-- We do our Area of Needs on an annual basis and we're not aware of contract conditions, so whether someone is brought in for a year or an extended period of time.

So as long as the position is filled it's no longer an Area of Need, so that person could be reappointed by the hospital continuously?-- Technically, yes, but as I said before they should be progressing. If they are truly temporary then we would expect them to go back, and if not they should be progressing to Australian general or specialist registration. That has not been happening in the past, but I believe that the Board - the Medical Board will now enforce that.

One other question, Commissioner.

COMMISSIONER: Certainly.

D COMMISSIONER EDWARDS: On page 7 you say for the Board to consider a doctor for special purpose registration under Area of Need the Board needs written notification from the Queensland Minister for Health or his delegate. Who prepares that submission?-- That's just the Area of Need, so the two page form that we-----

It's just a routine form?-- Yes.

No recommendations, no references to his or her ability to work?-- No.

Thank you.

COMMISSIONER: Mr Boddice?

MR MULLINS: I think it was me, your Honour.

COMMISSIONER: Oh, sorry, Mr Mullins.

MR MULLINS: Dr Huxley, just taking you back to one point that you made there briefly, you said that if an Area of Need certification is approved for a 12 month period then the following year, assuming the area certification is the same, it would be simply rubber stamped; that's correct?-- We would check to make sure that the information was correct, but generally, yes.

You said you wouldn't pull up the first year's to check it?--

No, we - we have a database. So we would check the information that we have in our database, but as I said, if we are approving an SMO we would not put any extra information in it. It's an SMO provision or a specialist or JHO position, for example.

So when you say you wouldn't pull up the information you wouldn't pull up the original application?-- No.

You would pull up your data-----?-- Yes.

-----in your database. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Mullins. Mr Allen?

MR ALLEN: Just briefly, thank you, Commissioner.

CROSS-EXAMINATION:

COMMISSIONER: Thank you.

MR ALLEN: Dr Huxley, you mentioned in the course of your duties you are involved at a national level in the jurisdictional response to the authorisation of the Royal Australasian College of Surgeons and the ACCCs review of other Medical Board colleges?-- Yes.

What's your involvement in that process?-- I was on the jurisdictional implementation committee for the College of Surgeons Review, and I have also been involved in the review of other Medical Board colleges undertaken by ACCC and AHWOC, so they did the work and then the reports were sent to us for each of the jurisdictional reps to go through.

So you're a jurisdictional rep on what committee, firstly, the first one you mentioned?-- I sit on the Board of Specialist Surgical Training as one of two jurisdictional representatives on that Board.

The Board of Surgical Training is under what-----?-- College of Surgeons. So the College of Surgeons - surgery training is split into two basic, surgical training and advanced or specialist surgical training. So each of those sections of the training has a Board. The Board members of the specialist surgical training board are a representative of each of the sub branches or organisations and then since the authorisation there have been two jurisdictional reps on that board.

Okay. So these-----

COMMISSIONER: Sorry, are you a surgeon?-- No, I'm a jurisdictional representative.

What does that mean?-- Part of the authorisation required

Government input, so Queensland - Queensland Health, Victorian Health input into-----

Oh, this is ACCC stuff?-- Yes.

So what's your function as a representative on this committee?-- My function as a representative is to put forward jurisdictional views on certain issues and also to take issues back to - through my manager to AHWOC or directly to AHWOC, which is the Australian Health Workforce Officials Committee, which is made up of workforce officials from each of the jurisdictions.

Mr Boddice, I would actually be very interested at some stage to get a list of every committee there is in Queensland Health and what they do and who is on them, and so on. This is just mind numbing stuff.

MR BODDICE: I will have that information prepared for you.

COMMISSIONER: Yes. Yes, Mr Allen?

MR ALLEN: Is there some type of public record of what these committees are doing in that context?-- To tell you the truth I'm not aware of the minutes of the Board's being available to the public. I'm not sure the extent of the authorisation. Certainly information regarding training, training numbers - there were a number of things set out under the authorisation that the college of surgeons was to make public.

And how are they made public?-- At this stage I'm not sure that they are available, but if they were available to the public they would be on the College of Surgeons web site.

And you've got some involvement, leaving aside the College of Surgeons, in relation to the ACCC review of other Medical Board colleges?-- Yes.

What is your involvement in that?-- As I said before, I'm one of - the AHWOC and ACCC representatives interviewed all of the other colleges. The ACCC, after they had done the authorisation of the College of Surgeons did not want to go through that big bureaucratic process for every college, so they formed a smaller group to go and get similar information from each of the colleges in a simpler way to determine if there were any specific issues with the other Medical Board colleges.

And is there some type of public record of what has occurred in that regard?-- I believe that the report will be going to the Health Ministers, to AHMA, the Health Ministers' meeting in a matter of months, and after that I imagine the report will be a public report as the reviews that the college of surgeons has done. It is in the process of finalisation.

When you say the public, as in the case of the reviews by the College of Surgeons?-- Part of the authorisation of the College of Surgeons was that they needed to do a review of the accreditation of training posts and also a review of overseas-trained surgeons' assessment, so both of those reports are now finished and are available, I believe.

From where?-- That would be College of Surgeons. I have certainly seen the final version, so I imagine that it would be public document.

I see. Yes, thank you.

COMMISSIONER: Mr Allen. Mr Devlin?

MR DEVLIN: Just a couple of questions about documents.

COMMISSIONER: Of course.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin is my name. I represent the Medical Board of Queensland. You will be pleased to know just a few questions. If we could go to document number 30 in your bundle, please? It is attachment 3, if that helps.

COMMISSIONER: Page 30 in the bundle.

MR DEVLIN: Page 30, yes.

COMMISSIONER: Yes.

MR DEVLIN: Have you got those?-- Yes, thank you.

30 and 31 seem to be the one document?-- Page 30 to page 33 is the Area of Need certification. It is just blown up.

Okay. Can you confirm this for me: that the first - sorry, that the four pages are filled out by the sponsor in Bundaberg-----?-- The-----

-----and sent to you. So the document headed "Queensland Health, application for Area of Need certification", that document through to your signature-----?-- Uh-huh.

-----is filled out, is typed up in Bundaberg?-- I can't

verify that because often - sometimes the hospital will do it. If someone comes through a recruitment agency, the agency may do it.

Can I assist? This is the renewal?-- Yes, the agency may do the renewal.

Can I assist you this way: at the top of the first page is the imprint "18 November '03, 16:27, Executive Services", and there is a fax number?-- It has been faxed from - faxed from that number.

Yes. In fact that fax number is to be found on page 3 under the signature of Dr Keating, fax number 41502029?-- Okay.

So am I right to conclude that somebody in Dr Keating's office appears to have prepared this and sent it to you for your certification as Principal Medical Advisor?-- It appears so.

Yes, which you have done on the 21st of November 2003?-- Yes, 21st, yeah.

Now, Ms Vider drew your attention to the job description originally being that of a Senior Medical Officer. In retrospect, looking at the top of page 2 - and you may not care to comment on this, you may not be able to - but in retrospect, does the description of the job now for renewal, "Director of Surgery - SMO", appear to send something of a mixed message compared to what the original PD was, the original position description of Senior Medical Officer answering to the Director of Surgery? Are you able to comment on that or-----?-- As I said, I would not have referred back to the PD and we frequently-----

COMMISSIONER: Without referring back to the PD, it is meaningless to write "Director of Surgery - SMO", isn't it? That's a meaningless description. It is two different positions. One is Director of Surgery, the other is an SMO?-- It depends on whether you believe that an SMO can be a Director of Surgery.

No, they are two different positions, aren't they?-- I prefer not to answer that.

Two different pay scales?-- The director part of the description means that they get an administrative loading.

Yeah, well, which position were you approving? Was it a director's position or an SMO's position?-- I was approving the SMO's position.

Okay.

MR DEVLIN: Anyway, what we've established by following that trail is that it appears that those originating documents have been prepared in Dr Keating's area, Dr Keating's office and sent down to you for processing?-- Or that they were prepared by the agency, faxed for signature by Dr Keating, and then

faxed by Dr Keating to us, which is not an infrequent occurrence.

That's another possible pathway?-- Yes.

Thank you.

MR DIEHM: Commissioner.

COMMISSIONER: Yes, Mr Diehm.

MR DIEHM: A brief question, if I may, or a few questions.

COMMISSIONER: Of course.

CROSS-EXAMINATION:

MR DIEHM: Dr Huxley, just on one of those last points raised by the Commissioner and Mr Devlin, is it the position within Queensland Health that an SMO may in fact be engaged as a director of a particular department within a hospital?-- As I said before, at Ipswich our director of the emergency department is an SMO.

Do you know for it to have happened in other places, in other positions?-- I imagine that it is not uncommon. For BreastScreen, many of the directors of BreastScreen are SMOs.

And is the structure with respect to position descriptions, it pays such that if a person is an SMO working as a director of a department, that they are simply paid an allowance for the added responsibility, being director of the department?-- Yes, there is an IRM which relates to the director's allowance and it doesn't discriminate between an SMO and a specialist. It is purely for senior medical officers in that it covers both SMOs and specialists. So there is no discrimination that I am aware of.

Thank you. I have nothing further, thank you.

COMMISSIONER: Well, on that last point, if you go back to page 23 - and this is what I think Deputy Commissioner Vider took you to - whatever may have been the position at Ipswich or anywhere else, the position in question here was that of a Senior Medical Officer reporting to a Director of Surgery?-- In this PD, yes.

Yes. Well, that's the only PD there is, isn't it?-- I am not sure. I have seen Dr Patel's personnel file.

Sorry?-- But I can't remember if there is any updates on PD in that file.

I will rephrase that. That is the only PD ever submitted to

your office?-- Yes, definitely.

Mr Boddice?

MR BODDICE: No, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Yes, please, Commissioner.

COMMISSIONER: Thank you.

RE-EXAMINATION:

MR ANDREWS: Doctor, how many persons are there who are delegates of the Minister for declaring an Area of Need?-- Three.

Three. The new forms, I see, make it much easier for those three delegates to determine whether there is an Area of Need, that is the new forms that I understand you authored?-- Yes - well-----

They will show, I see from page 60 of the bundle, there is an attachment A which shows that any of the delegates now when they receive a form will at least know what efforts were made to fill a vacancy and what other medical practitioners there are providing a similar service in the area?-- That's attachment A to the form. At the moment, that's for private practice only. We will be instituting that for public sector as well but at the moment it is for people going into private practice only.

I want you to consider a hypothesis that a regional hospital, such as Bundaberg's, sends you an application form for a declaration of Area of Need. As I understand it from the statute, you and the other two delegates, whichever of you receives the application, are to "consider whether there are insufficient medical practitioners practising in that part of the State to provide the service at a level that meets the needs of the people in that part of the State"?-- That's from the policy, yes.

Indeed, I was quoting from the-----?-- 19-----

From section 135 of the current Act?-- Of the Act.

What are the protocols that you and the other two - do you have protocols to assist you to make that determination?-- Not with respect to the public sector because our data is not good enough.

At the moment, if there is an application made by a regional hospital, is it just simply accepted by you or the other two

delegates?-- We assume that they have gone through the process, particularly senior staff, of actually trying to recruit an Australian - a suitable Australian practitioner.

COMMISSIONER: Is the answer to Mr Andrews' question yes?-- Can you ask the question again?

MR ANDREWS: Do you simply - do you and the other two delegates simply accept each and every application from a regional hospital for an Area of Need position?-- Yes, under the assumption that they have gone through the correct process.

COMMISSIONER: Mr Andrews, will you read that section again? I don't have it in front of me.

MR ANDREWS: Section - you will see it within Ms Huxley's statement on page 5 and it is subsection 3, but the relevant words of it are "if there are insufficient medical practitioners practising in a part of the State to provide the service at a level that meets the needs of people living in the part of the State".

COMMISSIONER: All right. So Dr Huxley, reading those provisions, if we go to the position in relation to surgical requirements at Bundaberg as a case in point, I assume that before you could satisfy yourself that there are insufficient practitioners practising in that part of the State to provide service at a level meeting the needs of the people living in that part of the State, the first thing you would have to do is find out whether there are, for example, private specialists prepared to provide those services as VMOs?-- As I said, we expect that the hospital has tried to fill the vacancy, whether that's with VMOs or with full-timers, through a process of advertising. So assuming that they have advertised and that no-one is available to fill the position to the requirements of the hospital, then that is the assumption that we make when we are processing our Area of Need forms. Is that sufficient, and is that sufficient to go forward with, I very much doubt that.

So the assumption which you make when you exercise your powers as the Minister's delegate is that the hospital needing, for example, a doctor to practise in surgery, will exhaust all of the appropriate avenues, whether advertising for an SMO or advertising for a staff specialist, or looking for a VMO, will do whatever is necessary to fill the position from an Australian doctor before applying for an Area of Need certification?-- Every medical super would prefer to have an Australian trained doctor within their hospital. The extent to which you mean-----

Just answer my question?-- The extent to which you mean exhaust, it has to be within reason.

Within reason?-- So that would be, for example, advertising within the Queensland Health Bulletin and perhaps advertising in the standard surgical journal.

Well, would it be reasonable to ring up the surgeons who are practising in the private sector in that locality and say to them, "We need a surgeon. Are you prepared to do a couple of sessions a week as a VMO?" That would seem reasonable, wouldn't it?-- I would assume that they would need to find probably at least eight sessions, so if they could fill their eight sessions with VMOs, then that would be a solution.

But you would expect them at least to try that?-- That would really have to depend on the medical super and the knowledge of the medical super of their own area. So I would not want to dictate that to them.

All right. When you received a delegation from the Minister to exercise the Minister's powers under section 135, did you understand that the expectation was that you would then apply your mind to the requirements of the section and make a judgment in accordance with the requirements of the section?-- We - I have been undertaking my delegation according to my judgment, yes.

No, answer my question, please?-- Could you please ask the question again?

Yes. When you were appointed as the Minister's delegate to exercise the Minister's powers under section 135 did you understand that you were required to apply your mind to the issues raised by that section?-- Yes.

But you haven't, have you?-- I believe that I have.

Well, in relation to the renewal of Dr Patel's Area of Need certification, you didn't consider whether there was sufficient medical practitioners practising in the State or the part of the State to provide the service?-- As I said, we would not reject a renewal of an application.

So you didn't turn your mind to the provisions of the section, did you?-- If that's your assessment, then that's your assessment. I am sorry, but I can't answer your question.

But you understand this, don't you: that if the Minister had wanted to delegate his power to every manager of every hospital in the State, the Minister could have done that. Instead, the Minister's delegated it to you and two others. You understand that much, don't you?-- Yes.

So the Minister wasn't expecting that the judgment call would be made by every manager of every hospital in the State, the Minister was expecting that you would apply-----?-- Judgment call, and I made the judgment call.

How do you make a judgment call when you don't even turn your mind to the issues raised in the section?-- I am sorry, but I can't answer your question.

Well, is there some misunderstanding on my part about what

subsection 3 raises for you to consider?-- As I said, I understand my delegation, I understand this part of the Act. I have done my job to the best of my ability. If you take issue with that, I am very sorry.

Well, you have never rejected an application by public hospital, have you?-- Not since I have been in my job, no.

And you have never investigated one, have you? You have never-----?-- That is untrue.

Have you ever picked up the phone and said, "How much has this been advertised?"?-- No.

Have you ever picked up the phone and said, "How many doctors are there in the locality who could act as VMOs?"?-- No.

What steps have you taken in any of them to satisfy yourself of the matters set out in subsection 3?-- I satisfy myself by the fact that the workforce shortages are so great that I can only assume that the medical superintendents are doing their job and they are advertising the position. If that is so and they cannot fill the position - and I understand the medical workforce shortages are great in this State - then I sign the form.

Anything arising out of that from anyone? No. Mr Andrews?

MR ANDREWS: Doctor, in considering section 135, which indeed you will see on page 5 of your statement, it occurs to me in looking at subsection 3 that you and the other delegates when considering this question, aren't obliged to consider the cost of medical practitioners in a particular area, but rather it seems that your obligation is only to consider the sufficiency of the numbers of them?-- The costs, no.

No. The reason that this becomes more than hypothetical is that there may be some evidence adduced to the Commission that suggests that in some regional areas there is an opportunity to provide medical services if visiting medical officers are tapped as a resource?-- Mmm.

But that they may be more expensive as a resource than the alternative of engaging an IMG. And on that hypothesis, I wonder is it possible for you and the other delegates, when receiving applications for an Area of Need, to quiz the applicants as to whether there are sufficient VMOs in the area to-----?-- Who are willing to-----

Provide an-----?-- -----participate.

Provide an adequate resource, yes?-- That's possible.

I notice that the form that you use for private hospital placements, which appears at page 60 of your statement, already seems to ask for details that might indeed provide answers to that very question. Is it feasible for you to include a form such as attachment A at page 60 as part of the

forms that any regional public hospital might fill in when applying for the delegates?-- As I said, we will be reviewing the process even further. We have made some changes, there are certainly others to make. That would be one that we would consider. The other thing that I would include is also expecting photocopies of proof of advertising, because writing that you have advertised is not necessarily advertising.

Now, a hypothesis also that might be explored in evidence that I would like you, as one of the Minister's delegates, to advise me on is that a hospital administrator concerned, of course, with budgetary practicalities will find it cheaper to appoint a full-time SMO than to engage visiting medical officers to perform the same services. Now, can you accept that that is a feasible hypothesis?-- It is feasible but, as I said before, if you can provide the services with Australian trained practitioners, then that's always preferable.

COMMISSIONER: And you would expect any competent hospital administrator, therefore, to examine first the option of appointing VMOs to fill a position rather than appointing a foreign trained SMO?-- I would hope so, yes.

You would hope so, yes.

MR ANDREWS: And you would regard it as preferable, because you have assumed that the Australian trained doctors - is it preferable from a clinical point of view, from a standards point of view, or some other basis?-- Preferable from many points of view. If you can get enough Australian-trained doctors engaged within your hospital, whether they are full-time or VMOs, then that enables you to engage training Registrars. So there is a lot of benefits as well as the standards of service delivery. So there is many reasons why you would want to include VMOs in your service.

And are you aware as to whether the good sense of employing VMOs is something reinforced in the trenches out in the regions with the administrators at the hospitals?-- I don't quite understand the question, sorry.

COMMISSIONER: Is the message getting out to the hospitals that it is - the first priority is to get an Australian specialist, even if that means appointing a number of Australian specialists as VMOs rather than having one full-time SMO?-- I think it may sometimes be simpler to have a full-timer, but, again, if you have got VMOs who are willing and able and interested in providing the service and being part of the clinical team of the hospital, then, yes, that would be preferable.

MR ANDREWS: You were taken before to a form that appears in your statement at page 30 to 33. And I would like you to clarify something for me. The last page of the form on page 33 above your signature has two boxes ticked "supported". They would be ticks that you included, wouldn't they?-- Yes.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Dr Huxley, you're excused from further attendance. Thank you for coming today. I apologise that you were put to the inconvenience of waiting. The previous witness went rather longer than was expected?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Whose next, Mr Andrews?

MR ANDREWS: I was rather - I am embarrassed by lack of witnesses at the moment.

COMMISSIONER: Yes, you have run out of witnesses.

MR ANDREWS: May we adjourn for two weeks?

COMMISSIONER: We will adjourn now until 9.30 a.m. on Monday, the 20th of June in Bundaberg. Can I suggest to those at the Bar table who haven't already made travel arrangements and bookings to do so because apparently it is school holidays and there are some complications.

Also, I will say about the facilities in Bundaberg, we chose to use a lecture theatre rather than a courtroom because there was no courtroom large enough. The difficulty with the lecture theatre is that it has fixed seating, so counsel will have, as it were, the front row of the lecture theatre and that's right behind the stage. So you will be able to use the stage as a table or lectern. But it might be useful to get there a bit early to arrange things in a way that will allow you to operate efficiently from the so-called Bar table. Anything else anyone wants to raise before we adjourn for two weeks?

MR ANDREWS: No, thank you.

COMMISSIONER: It is close to 5 o'clock, no wonder. Thank you gentlemen and ladies for your assistance over the past two weeks and we look forward to seeing you in Bundaberg.

THE COMMISSION ADJOURNED AT 4.56 P.M. TILL 9.30 A.M. AT BUNDABERG, MONDAY 20 JUNE 2005