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QUEENSLAND HEALTH

BUNDABERG HEALTH SERVICE DISTRICT

POSITION DESCRIPTION

POSITION TITLE	Director of Medical Services
VACANCY REFERENCE NO.	BB99/11/7
LOCATION	Bundaberg District Health Service
CLASSIFICATION LEVEL	MS9
REPORTS TO	District Manager
AWARD	Senior Medical Officer's & Resident Medical Officer's Award - State
REVIEW DATE	November 1999

PURPOSE OF POSITION

The Director of Medical Services is the accountable officer for the delivery of medical care within Bundaberg District Health Service. As such the position is responsible for ensuring the highest professional and ethical standards are observed by all medical staff.

The Director of Medical Services will drive the strategic direction of patient care and the development of multi-disciplinary models of care and will oversee the credentialling and privileging of medical staff.

ORGANISATIONAL ENVIRONMENT

Reporting Relationship

The position is located at Bundaberg Base Hospital and is directly responsible to the District Manager.

Relationship Between the Position and the Supervisor

The position operates with a significant level of independence. Continual consultation would occur with the District Manager, Bundaberg District Health Service and other executives within the District's facilities and agencies.

Staff Reporting to the Position

Medical Directors, Senior Medical Officers, and all Allied Health Department Heads within the Bundaberg Base Hospital report to this position.

Professional support is provided to Medical Superintendents at Childers and Gin Gin Hospitals and Mt Perry Community Health Centre.

PRIMARY DUTIES AND RESPONSIBILITES

Contribute to the planning process of clinical services for the Bundaberg District in conjunction with the Hospital Executive, District Executive and the District Manager.

Coordinate clinical services within the Bundaberg Base Hospital and throughout the District and be involved in the integration of services across the District.

Ensure those services provided are of the highest standard given the resources available and in accordance with statutory requirements.

Provide advice to the District Manager regarding Medical and Allied Health Professional resourcing and appropriate Models of Care.

Communicate with other staff in the Hospital on matters of mutual interest relating to patient care.

Oversee the establishment and maintenance of medical quality improvement programs and to participate in relevant internal and external quality assurance exercises as required.

Manage the Private Practice Scheme for full time medical staff of the District.

Ensure that the recruitment, appointment and employment of medical and professional staff is consistent with legislation and award provisions.

Coordinate junior medical staff recruitment, appointment, performance review and disciplinary processes including the annual selection of registrars and residents.

Manage counter disaster planning and control at District Health Service level.

Provide leadership/management to the District Research & Ethics Committee.

Monitor and oversee management, budgeting and expenditure of cost centres accountable to this position.

Ensure there is a strategic approach to the development of contemporary human resource practices and policies including workplace health and safety, equal employment opportunity, anti-discrimination, ethical behaviour and commitment to their implementation.

Qualifications and Experience

Essential

Eligible for registration as a Medical Practitioner in Queensland.

Preference will be given to candidates that either have, or have substantially completed, FRACMA or other post-graduate management training.

Proven ability to efficiently, effectively and equitably manage the medical services of a health organisation.

Desirable

Well developed interpersonal skills, including communication, negotiation, organisational and time management skills.

Demonstrated sound theoretical knowledge, practical skills and ethical behaviour required of a medical practitioner.

Experience in working in a multi-disciplinary environment

COMMITTEE RESPONSIBILITIES

Chair the following Committees

- Research & Ethics Committee
- Senior Medical Advisory Committee

Participate on the following District Committees

- District Consultative Forum
- District Health Council
- District Executive
- Patient Records Committee
- Credentials and Privileges Committee
- Pharmacy Committee
- Casemix & Clinical Costing Committee

ADDITIONAL INFORMATION

Queensland Health is a "smoke free" employer. Smoking is not permitted in any Queensland Health facility except where specifically defined.

Queensland Health has an Equity Management philosophy.

The Bundaberg District Health Service requires all employees to adopt appropriate and recognised measures to minimise the risk of infection and workplace injury to themselves, other staff and clients and to adhere to the Districts Infection Control Policy Manual and Workplace Health and Safety policies and practices.

A Bundaberg District Health Service *Confidential Agreement* is to be signed upon appointment.

Applicants must address each selection criterion

SELECTION CRITERIA

SC1
Possession of Queensland Registered or Registrable medical qualifications is mandatory

SC2
Demonstrated skills and ability or capacity to acquire skills in medical administration suitable for the management of a complex Health Service.

SC3
Demonstrated ability to provide leadership in a dynamic, changing environment, within a multidisciplinary context containing diverse professional and service delivery groups.

SC4
Demonstrated advanced level of communication, negotiation, consultation and interpersonal skills.

SC5
Substantial knowledge and proven ability in strategic planning and management for the provision of clinical programs and services consistent with the responsibilities of the position.

SC6
Sound knowledge at a strategic level of human resource management issues, including workplace health and safety, equal employment opportunity, anti-discrimination, ethical behaviour and demonstrated commitment to their implementation.

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EXECUTIVE SERVICES

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FORM 7

Queensland Government
Queensland Health

CREDENTIALLING AND APPOINTMENT PROCEDURES FOR MEDICAL PRACTITIONERS BUNDABERG HEALTH SERVICE DISTRICT

A. GENERAL COMMENTS

The Queensland Health Policy Document on the Credentialling, Clinical Privileges and Appointment Procedures for Medical Practitioners is attached. This document outlines broad and, in some cases specific, procedures to be followed with respect to the credentialling and appointment of medical practitioners.

In essence, Queensland Health Policy:

- Firstly, states that doctors appointed to Queensland Hospitals must formally hold an appointment irrespective of whether they are treating public and/or private category patients.
- Secondly, states that prior to appointment the credentials of applicants must be verified and appropriate privileges should be recommended (after appointment, the document allows the mechanism for clinicians to vary their approved clinical procedures).
- Thirdly, outlines the formal appointments mechanism which follows the PSMC Guidelines for appointment of all staff to District Health Services.
- Fourthly, the new appointment procedures apply to all new appointments after the date of introduction of this new policy (ie all existing appointments retain original appointment entitlements – unless they apply for an upgrade position. Changes in credential status for all new and existing staff must however, be updated as appropriate.

While broad principles must be followed, some flexibility for Health Districts is possible, given the varied nature of each of the 39 Districts of the State. It is the purpose of this document to outline the specific requirements for the Bundaberg Health Service District. The sections and paragraphs referred to in the following District policy which should be read in conjunction with Queensland Health policy.

B. CREDENTIALLING PROCEDURES

Section 1

Purpose of the Credentials and Clinical Privilege Process

Where the Section reads "Regional Health Authorities" amend by inserting "Health Districts".

Section 2

General Principles and Definitions

Paragraph 2.7 Governing Body. The Deputy Director General (Health), Queensland Health is now the Governing Body, however the District Manager of Bundaberg Health Service District has been delegated authority for credentialling the granting of clinical privileges and the authority to appoint medical officers.

Paragraph 2.8 Written Procedures – delete "all Regional Health Authorities or other - ....."

Section 3

Credential and Clinical Privileges Committees

No variation.

Section 4

Role and Function of Credential and Clinical Privileges Committee

No variation.

Section 5

Membership of Credential and Clinical Privilege Committees

5.1 Dot point two -- delete "Regional" and insert "District".

Other Principles Supported:

It is appropriate to have a credential and appointments mechanism which serves all Health Care Facilities in this District.

BUNDABERG DISTRICT CREDENTIALLING AND CLINICAL PRIVILEGES COMMITTEE (C & CP Committee)

Membership – Permanent

- Medical Superintendent, Bundaberg Base Hospital (or nominated delegate during periods of leave) – this is the District Manager's nominated medical practitioner. To be Chairman.
- Chair of Medical Staff Advisory Committee – Bundaberg Base Hospital

Membership – Variable

- Relevant learned College representative or a representative of AMA or RDAQ for rural hospital.
- Medical Superintendent of Gin Gin or Childers Hospitals if positions being considered at one of these hospitals. (If any of these positions are being filled they will be replaced by the District Manager's medical representative).
- University representative (for conjoint clinical appointments at Bundaberg Base Hospital).
- Clinical Director of Specialty Department (if appropriate staff or visiting positions are being considered at Bundaberg Base Hospital – but not needed if the Senior Staff representative is also the Clinical Director of Specialty Division).
- Other representative/s as appropriate.

A quorum for the C & CP Committee must be a minimum of three, with at least one representative from the permanent and variable groups. The permanent representative must be the District Manager's nominated medical practitioner. The relevant Learned College representative must be within the quorum. The maximum composition for the C & CP Committee will be seven. The Chairman of the C & CP Committee is to be the Medical Superintendent of the Bundaberg Base Hospital. Medical Administration of Bundaberg Base Hospital is to provide the secretariat. If the duly appointed Chairman is absent for a meeting, one of the other permanent members is to be appointed Acting Chairman. The Chairman of any C & CP Committee meeting may hold the proxy vote/comments of an authorised panel member who formally apologises for his absence.

At the conclusion of each C & CP Committee meeting, it is the responsibility of the Chairman to ensure that relevant details are formally recorded in a Minute Book and that the details are available to the Medical Appointments Committee.

When a candidate for appointment is being considered, or where a variation of clinical privileges for an existing staff member is being sought, the following information in relation to each candidate is to be recorded:

- Basic registration status with the Medical Board of Queensland.
- Specialty status (if any) recorded with the Medical Board of Queensland.
- Professional standing of the candidate within the medical fraternity.
- Specific privileges which are granted.
- Any privileges which are not granted
- Any privileges which are qualified, eg temporary supervision.

Section 6

Guidelines for Credential and Clinical Privileges Committees

General principles Supported:

It is required that documented specific clinical privileges awarded to any duly appointed clinician should be kept not only in the main Secretariat but also in the hospital to which the clinician is appointed.

6.1 Dot point nine – delete "Regional Director" and insert "District Manager".

Section 7

Duration of Clinical Privileges

General Principles Supported.

Clinical Privileges for full time and visiting staff will be reviewed every 3 years and in both cases if an appointee is 65 years or older then credentials will be reviewed annually.

7.3 Temporary Privileges/Locums in the Bundaberg Health Service District. This power has been delegated to the Medical Superintendent of the Bundaberg Base Hospital.

EXECUTIVE SERVICES

In addition to the points noted in the document, alterations to clinical privileges may occur between assessment periods if a clinician or hospital wishes to have privileges reconsidered as noted in section 8. (The exception to the above general rule is in relation to qualified privileges. Qualified privileges must have a specific qualifying period, eg six months under supervision of another clinician).

Section 8

Review of Clinical Privileges

General Principles Supported.

Dot point 3 – delete "Regional Director" and insert "District Manager".

Section 9

Appeals

No variation.

Section 10

Termination of Clinical Privileges

No variation.

Section 11

Implementation of Credentials and Clinical Privileges Process

General Principles Supported.

It is suggested that review of clinical privileges be considered on a common date at three years.

EXECUTIVE SERVICES

Section 12

Specific Criteria for delineation of Clinical Privileges

General agreement.

It should be noted that this section indicates that specialist privileges will generally be those awarded by the relevant learned College, however, care should be taken when

a) specialists wish to undertake clinical activities that either require special certificates or other training/qualifications as required by the relevant learned College or;

b) if a specialist wishes to undertake clinical activities in another specialty or sub-specialty area that is generally regarded as the domain of other specifically trained individuals.

In relation to General Practice, a basic set of clinical procedures is allowable for all duly registered medical practitioners. However, where a general practitioner wishes to undertake additional activities, then specific documentation is required on the application form.

If appropriate, supervised procedures may be considered under Section 12.3.2.

Forms

Seven common forms are to be used throughout the Bundaberg District Health Service. Appendices 1-7.

- Appendix 1

  Form 1 – Application for Clinical Privileges (Specialist)
- Appendix 2

  Form 2 – Application for Clinical Privileges (General Practitioner)
- Appendix 3

  Form 3 – Application for Review of Clinical Privileges
- Appendix 4

  Form 4 – Narrative by Chairman
- Appendix 5

  Form 5 – C & CP Committee Order of Business
- Appendix 6

  Form 6 – Delineation of Clinical Privileges
- Appendix 7

  Form 7 – Advice to Applicants and to C & CP Committee members

EXECUTIVE SERVICES

C. MEDICAL APPOINTMENT PROCEDURES

Section 1

Purpose of the document

Delete "Regional Health Authorities" and insert "District Health Services"

Section 2

General Principles and Definitions

Paragraph 2.1 – where mentioned delegate "Regional Health Authority" and insert "District Health Manager".

Section 3

PSMC Guidelines

No variation.

Section 4

Appointments Process

No variation.

Section 5

Role and Functions of the Appointments Committee

No variation, however it should be noted that it is not required to interview all candidates for a medical position. As for any other hospital position, shortlists may be formulated, particularly if candidates do not have the necessary credentials or do not meet key selection criteria. The Manager of the Bundaberg District Health Service has the delegated authority for the appointment of medical practitioners in this District.

Section 6

Membership of the Appointments Committee

Paragraph 6.2 – delete "Regional Health Authority" and insert "District Manager".

The Bundaberg District Health Service Appointments Committee is to be established to serve all Health Facilities in the Health District.

It should also be noted that generally, PSMC Guidelines do not recommend more than four individuals on an interview panel. This principle should be followed for the majority of positions, however, it is acknowledged that on occasions it will be necessary to have slightly larger panels – up to six members for some positions, eg the Medical Superintendent Bundaberg Base Hospital.

The Committee membership is to be as follows:-

Core (Permanent) Membership

- The District Manager or his nominee.
- Medical Superintendent of the hospital to which the appointment is being made. If this position is being filled, the committee member is to be replaced by a nominee of the District Manager.
- Senior Staff Representative of Bundaberg Base Hospital for that hospital or the Medical Superintendent of Bundaberg Base Hospital for other hospitals.

Variable Membership

- Relevant learned College representative or a representative of AMA or RDAQ for rural hospitals.
- University representative (for conjoint clinical appointments).
- Senior Representative of Gin Gin Hospital, Childers Hospital, Integrated Mental Health Service, Community Health Services as appropriate.

For all senior positions, a minimum of two representatives from the core membership and one external representative must be present.

Generally, recommendations about appointments should be made along the following lines.

Full Time Medical Staff

Although Full Time appointments are generally of a permanent nature, they must include a one year probationary period.

Visiting Medical Staff

Visiting Medical Officers are appointed either for specific periods of time (if so advertised) or on a permanent basis after a one year probationary period.

Section 7

Probationary/Temporary Appointments

No variation. Delete "Regional Health Authority" and insert "District Health Service".

Section 8

Termination of Appointment/Disciplinary Matters

No variation.

Section 9

Appeals

No variation.

Section 10

Application Protocol

No variation.

Section 11

Categories of Medical Practitioner

General Principles supported.

It should be noted, however, that in the case of affiliated practitioners, such positions can only be considered if such practitioners are willing to participate in some form of public patient care that is satisfactory to the District Manager and the Medical Superintendent of the hospital.

Section 12

References

No variation.

EXECUTIVE SERVICES

D. APPOINTMENT OF MEDICAL OFFICERS

Letters of appointment will be issued to medical officers appointed to the Bundaberg District Health Service.

Letters of appointment will clearly outline the following:-

- Terms and conditions of appointment as per relevant industrial awards or determinations.
- Clinical Privileges granted.
- Any special conditions or privileges granted.
- A requirement that the appointed medical officer sign and accept all terms, conditions and privileges granted.

The Human Resources Department will provide all details on appropriate inclusions in letters of appointment and/or prepare letters on behalf of the Chairman of the Appointments Committee.

Any conditions, terms of appointment or privileges proposed to be granted outside of Award conditions or other determinations will require the written approval of the District Manager.

.....

Mr P. Leck
District Manager

EXECUTIVE DIRECTOR
DR P.G. LIVINGSTONE AO

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THE UNIVERSITY OF QUEENSLAND
Medical School, Herston Road
Herston Qld 4006 Australia
Telephone (07) 3365 5047
International +61 7 3365 5047
Facsimile (07) 3365 5032

8 December 1999

Dr John Wakefield
Acting Director of Medical Services
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

Dear Dr ~~Wakefield~~ John

Re: Part-Time Medical Education Officer at Bundaberg Base Hospital – Draft Letter of Agreement

Further to our discussions, please find enclosed a draft Letter of Agreement between the Postgraduate Medical Education Committee (PGMEC)/Queensland Medical Education Centre (QMEC) and Bundaberg Base Hospital, concerning the secondment of a part-time Medical Education Officer to your hospital for the development and maintenance of prevocational medical education initiatives.

A copy of the job description and selection criteria for the position is also enclosed.

We would be grateful if you could peruse this draft Letter of Agreement and advise me of any comments or changes you may have, as soon as possible. We will then proceed to make amendments to the document in light of any changes you may have and forward a finalised Letter of Agreement to the District Manager for signing.

We are planning to advertise the position on Saturday 8 January 2000, in The Courier-Mail and local Bundaberg newspaper. We will be in touch closer to the date to arrange shortlisting and interview procedures.

Yours sincerely

Jennifer Harlen
Project Manager
Prevocational Medical Education Program

File

cc. Mr Peter Leck, District Manager, Bundaberg Base Hospital

EXECUTIVE SERVICES

8 December 1999

Mr Peter Leck
District Manager
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

Dear Mr Leck

LETTER OF AGREEMENT

The following letter records points of agreement between the Postgraduate Medical Education Committee (PGMEC)/Queensland Medical Education Centre (QMEC) and Bundaberg Base Hospital, concerning the secondment of a Medical Education Officer to Bundaberg Base Hospital for the continued development and maintenance of pre-vocational medical education programs within Queensland hospitals:

1. Three original copies of this letter of agreement will be signed by Dr Peter Livingstone, Executive Director of Postgraduate Medical Education Committee (PGMEC), and countersigned by the District Manager of Bundaberg Base Hospital. An original copy will be kept at Bundaberg Base Hospital and two original copies at the University of Queensland.

2. The Medical Education Officer position will funded by the PGMEC/QMEC from the commencement of the appointment for the position until 30 June 2000.

3. PGMEC/QMEC will provide the following funding and support for the Medical Education Officer position:

   3.1 Part-time (0.5FTE) wages and oncosts for the Medical Education Officer position within the salary range nominated in the attached job description for this position;
   3.2 Costs associated with recruitment for the position excluding any relocation costs if these are involved;
   3.3 **Some** travel and accommodation costs to attend QMEC approved workshops;
   3.4 Provision of computer hardware and software including access to internet and electronic mail (if required).

4. Bundaberg Base Hospital is requested to provide the following onsite support for the Medical Education Officer position:

4.1 Office space at the hospital, desk, chair and secure document storage space;
4.2 Full information technology support;
4.3 Provision of computer hardware and software including access to internet and electronic mail (if required);
4.4 Telephone with STD access and telephone costs;
4.5 Access to a photocopier, fax machine and associated costs;
4.6 Postage costs and stationery supplies costs;
4.7 Travel and accommodation costs if required (it is recommended that one national conference per year be funded by Bundaberg Base Hospital – preferably the National Forum on Prevocational Medical Education);
4.8 Provision of a car parking space/car parking facilities.

5. The position description and selection criteria for the Medical Education Officer position at Bundaberg Base Hospital has been supplied to you. A finalised copy of this information is attached to this Letter of Agreement.

6. QMEC will advertise the position, respond to enquiries and forward the position description and selection criteria to potential applicants.

7. A joint appointment committee will be formed, comprising up to two representatives from QMEC and up to two representatives from Bundaberg Base Hospital to shortlist and interview candidates and select the successful candidate for the position.

8. The appointment of the Medical Education Officer [illegible] all terms of agreement will be from commencement [illegible] 30 June 2006 with a [illegible] month probationary period for the incumbent [illegible] commencement of the appointment. At the conclusion of the probation period there will be a meeting with appropriate hospital staff, the MEO and QMEC representatives to review the performance of the MEO and development of the position. Continuation of the position will be dependent upon the incumbent's performance and continued funding from Queensland Health.

9. Both QMEC/PGMEC and Bundaberg Base Hospital will endeavour to ensure that a fair balance of working hours are spent meeting commitments for both parties to this agreement, and that the incumbent has an acceptable workload in meeting both parties' requirements for the position. If necessary, a more detailed duty statement for the position will be developed by the joint appointment committee.

10. The Medical Education Officer is employed to assist Bundaberg Base Hospital in developing educational initiatives for junior doctor training and contributing to the statewide and national development of a general clinical education program. Duties for the Medical Education Officer at Bundaberg Base Hospital will primarily address the needs of junior doctor training.

11. At the commencement of the appointment, QMEC will provide orientation and a resource kit for the Medical Education Officer.

12. Bundaberg Base Hospital is requested to provide the Medical Education Officer with a hospital orientation program (for non-medical personnel), and to provide the incumbent with hospital ID card/s appropriate for the position.

EXECUTIVE SERVICES

13. The Medical Education Officer will report to the Director of Clinical Training at Bundaberg Base Hospital and is also responsible to the Project Manager for Prevocational Education Programs at QMEC.

14. In addition to the funding of the Medical Education Officer position for the development of pre-vocational medical education initiatives and hospital-based initiatives, QMEC will also provide Bundaberg Base Hospital with documents produced from the research conducted for this program.

QMEC looks forward to a productive relationship with Bundaberg Base Hospital in developing and implementing initiatives for junior doctor training and education.

Joint Signatures to this Letter of Agreement:

Dr Peter Livingstone	**Mr Peter Beck**
EXECUTIVE DIRECTOR	**DISTRICT MANAGER**
Postgraduate Medical Education Committee	**Bundaberg Base Hospital**
Date:	Date:

cc. Dr John Wakefield, Acting Director of Medical Services/Director of Clinical Training, Bundaberg Base Hospital

GRADUATE SCHOOL OF MEDICINE
QUEENSLAND MEDICAL EDUCATION CENTRE

POSITION DESCRIPTION AND SELECTION CRITERIA

POSITION:	**Medical Education Officer** Queensland Medical Education Centre (QMEC) Graduate School of Medicine
LOCATION:	**Based at Bundaberg Base Hospital** Bourbong Street Bundaberg Qld 4670
CLASSIFICATION:	**Research Officer (Level A)** Part-Time (0.5FTE) until 30 June 2000
SALARY:	In the range of $39,628-$45,911 per annum (pro-rata) Depending on qualifications and experience
TERM OF EMPLOYMENT:	Continuation of the position after 30 June 2000 is dependent on the availability of further funding

1.0 BACKGROUND INFORMATION:

Since 1996, full-time and part-time Medical Education Officers have been employed to provide educational and organisational assistance to hospitals in developing initiatives to improve teaching and learning strategies, assessment and evaluation for junior doctor training in public hospitals. The first two postgraduate years represent the crucial transition from university graduation through to increasingly independent medical practice. These years also provide a broad generalist base of prevocational training before medical officers commence specialist vocational training including general practice training.

At present, a total of 16 Medical Education Officers have been appointed to 17 hospitals throughout Queensland. A Project Manager and other support staff are based at QMEC in the Mayne Medical School at Herston. This staffing arrangement has allowed an effective working network to be developed between Medical Education Officers at different hospitals, the Postgraduate Medical Education Committee and QMEC staff.

2.0 POSITION DESCRIPTION:

The Medical Education Officer will be employed by QMEC to conduct educational activities for the development of an integrated two-year clinical training program for postgraduate years 1 and 2 (PGY1 and PGY2) in Queensland public hospitals for the Queensland Postgraduate Medical Education Committee.

The Medical Education Officer will be responsible to the Project Manager at QMEC and will also report to the Director of Clinical Training at the hospital. This position will be funded until 30 June 2000 with the possibility of extension subject to the availability of funding.

3.0 RESPONSIBILITIES

The Medical Education Officer will be required to:

3.1 recognise and respond to the educational needs of medical staff in PGY1 and PGY2 by:

- 3.1.1 the establishment of and/or maintenance of the ongoing process of development, implementation and evaluation of educational programs within the hospital;
- 3.1.2 contributing to the promotion, development, trialing and evaluation of educational resource material;
- 3.1.3 supporting an assessment framework that ensures effective formative and summative assessment with regular feedback;
- 3.1.4 assisting and directing PGY1 and 2 in career path and planning;
- 3.1.5 actively participating on the General Clinical Training Committee (or equivalent committee);

3.2 establish cooperative and productive working relationships with hospital and QMEC staff;

3.3 contribute to process evaluations and the preparation of program reports for QMEC and the hospital;

3.4 attend orientation and program development workshops in Brisbane;

3.5 perform other duties in consultation with the DCT as approved by the Project Manager, QMEC.

SELECTION CRITERIA:

1. Possession of tertiary qualifications in an education or health discipline. Possession of, or progress towards, a higher degree would be an advantage.

2. Experience in education and training program development, implementation and evaluation, in the fields of health, education and/or research, is required. Knowledge of the health care system in Queensland would be an advantage.

3. Excellent organisational, consultation and communication skills (both written and verbal).

4. Ability to work effectively both independently and as a member of a multi-disciplinary team.

5. Ability to generate enthusiasm, a resourceful and resilient personality, and an approachable and tactful manner.

6. Proficiency in the use of a word processing package, preferably Microsoft Word. Experience with using e-mail and/or online databases would be an advantage.

Further information regarding this position can be obtained from Mrs Jennifer Harlen on (07) 3365 5053 or e-mail *j.harlen@mailbox.uq.edu.au*.

Applications, with curriculum vitae and the names and contact details of three referees, citing position title and reference number, and addressing all selection criteria, should be forwarded to:

Mrs Jennifer Harlen
Project Manager, Prevocational Medical Education Program
Queensland Medical Education Centre
Level 3, Mayne Medical School
Herston Road
HERSTON QLD 4006

CLOSING DATE FOR APPLICATIONS: 21 January 2000.

Applicants are requested to submit three copies of their application (preferably 1 copy not bound).

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BUNDABERG HEALTH SERVICE DISTRICT RURAL CLINICAL SCHOOL PRELIMINARY PROPOSAL FOR 3RD YEAR GMC MEDICAL STUDENTS

Prepared by

Dr John Wakefield
MB CHB FRACGP FACRRM Grad.Cert.Management
Director of Medical Services
Bundaberg Base Hospital

4 April 2001

1 Introduction

In mid March 2001, the Bundaberg District Health Service was approached by representatives from the Board of Studies of the fledgling Rural Clinical School at Rockhampton. The representatives were Dr Denise Powell; interim Chair of the Board of Studies Rural Clinical School and Dr John Price; University of Queensland Medical School.

Drs Powell and Price indicated that resources had been allocated by the Commonwealth of Australia to implement the planned Rural Medical School in Rockhampton It was envisaged that within three years, 25% of all GMC students would spend the final 2 years of undergraduate training in the rural/provincial sector. Whilst the School would be based in Rockhampton, Bundaberg was likely to be a significant strategic partner in the provision of training opportunities for the students.

It was noted that the time-frame for developing and implementing the Rural Clinical School was very short and that preparation needed to commence immediately. To this end, the District has prepared a preliminary proposal for the consideration of the Board of Studies.

2 District Profile

Bundaberg Health Service District services a population of approximately 80,000. The District covers Bundaberg City and surrounding coastal towns from Woodgate in the South to Agnes Water in the North. It also covers the towns of Gin Gin, Childers and Mt Perry. There are Hospitals at Bundaberg, Gin Gin and Childers and a Community Health Centre at Mt Perry.

Bundaberg Base Hospital campus is a 140 bed facility which provides secondary level services to the Bundaberg District and North Burnett. The Hospital provides medical, surgical, vascular surgical, paediatrics, emergency, intensive care, coronary care, renal, orthopaedics, obstetrics and gynaecology, medical oncology, radiology, rehabilitation, allied health, integrated mental health services. It has established links within the Queensland Health Central Zone for tertiary services, mainly with the Prince Charles and Royal Brisbane Hospitals.

Community Health Services provided by the District include Community Mental Health, Alcohol and Drug, Child Health, BreastScreen, Palliative Care, Oral Health, HACC Services, Sexual Health and Indigenous Health.

3 Educational Environment

The District continues to develop as a centre for undergraduate, and post-graduate medical training. This is evidenced by the following:

- Preceptorship of 3rd year GMC students during their Rural Terms.
- Accreditation by the Post Graduate Medical Education Committee for pre-vocational training of interns and PGY2 doctors.
- Accreditation by the Colleges of Surgery, Psychiatry, Obstetrics and Gynaecology, for specialist training.
- Accreditation by the Royal Australian College of General Practitioners for GP Training.
- Formation of a General Clinical Education Committee.

The Hospital has an active continuing medical education program encompassing all the clinical departments This includes weekly surgical, medical, obstetric and gynaecology, radiology, paediatric rounds, intern training, emergency sessions. The District also participates in video-conferencing with peer facilities and tertiary referral centres.

The Education Infrastructure has been improved in the recent Redevelopment, with the addition of a Tutorial Room adjacent to the clinical areas. However, the library facilities and District Education Centre are located away from the main clinical area, and require resources to properly equip, manage and relocate to a more suitable and accessible site.

As in many provincial hospitals, service delivery priorities have eroded the available resources from education infrastructure (both physical and human). Despite this, the enthusiasm of the medical teachers and the wealth of learning opportunities for students continues to generate positive feedback from current students. However, it is imperative that the infrastructure, receive sufficient resources to support enhanced learning opportunities for students.

4 Proposed Model of Training for 3rd Year GMC Students

4.1 Terms

The 3rd Year Terms are in the following areas:

- Surgery
- Psychiatry
- Medicine
- Rural
- General Practice

4.2 Allocation

Early suggestions are that Bundaberg could support 8 to 10 students for a full year at Bundaberg This would include rotations in the above attachments with 2 students attached to each area at any one time. It would be appropriate to commence this process with 4 to 5 students.

4.3 Partnerships

The Division of General Practice and the Bundaberg Health Service District currently provide placements for 3/4 3rd Year students during their rural attachment. This has proved a valuable experience for students and has been quite successful to date. It is anticipated that this partnership be strengthened in the future

The involvement of the private specialist sector in the formal training of undergraduates has not been discussed to date. Further consultation would be required before this possibility were to be considered.

4.4 Model

The model currently being considered would be that the District would undertake to provide a comprehensive experience for the 'Bundaberg' GMC 3rd Year Cohort.

Students would be allocated in conjunction with Rockhampton, and would be received at commencement with an appropriate orientation, to include the Division of General Practice, Health Service District, and other key stakeholders in the community. A student coordinator would need to be appointed to provide all the necessary support and coordination functions required

The Rural Clinical School would need to provide/negotiate a core curriculum and basic Service Agreement for sign-off with the District and Division of GP's and also with the individual clinical teachers in the facilities. This provides a clear understanding of the responsibilities of individuals and the organisations in respect of the requirements of the students. It would also specifically deal with the issues of financial reporting, indemnity/insurance, assessment processes, conflict resolution etc etc.

An appropriate educational infrastructure is to be developed to support the students and clinical teachers in their endeavours This is to include access to appropriate professional education support, administration support, learning resources and physical infrastructure.

The students should ideally be accomodated at the Bundaberg Base Hospital. Due to limited accomodation, this is currently not feasible for the suggested number of students. This is a fundamental issue for the students and will require resolution.

Appropriate support would be provided from the Rural Clinical School for the clinical teachers. This could include access to all facilities and access to the UQ Library.

Appropriate recognition of the services of clinicians in teaching should be afforded by way of honorary university appointments.

5 Resources

The resources required for the Bundaberg Health Service District to adequately provide a comprehensive 3rd Year GMC curriculum for 8 to 10 students will be considerable.

It is not possible in the short time frame provided, to give a detailed account of the capital and recurrent resources required to implement this Proposal. However, the following provides a guide as a starting point and should stimulate further discussion and a more detailed business case

5.1 Student Education Coordinator

A half time position is recommended for a person with a background in education. This role would be very similar to the medical education officer for post graduate training support. This person would provide support to both the students and the teachers and would ensure an approach consistent with contemporary learning theory and based on evidence Costing is to include basic office set-up plus networked/internet ready PC, laser printer, scanner and phone and some professional development allocation. Air conditioning unit should be costed in setup.

Recurrent:		
0.5 FTE PO3 plus 20% on costs		$32058 pa
Professional Development		$1500 pa
Computer maintenance contract		$1250 pa
	TOTAL	**$34808**
Capital:		
Office furniture		$1000
PC & Printer		$4000
Scanner		$400
Phone		$150
Airconditioner		$1500
	TOTAL	**$7050**

5.2 Administration Officer Support

A half time position is recommended for an admin support officer at a level of AO2. This would be to provide support for the Education Coordinator and Clinical Teachers, and would also provide assistance with the library and educational resources management. This is to include basic office set-up including PC, phone and recurrent stationery supplies.

Recurrent:		
0.5 FTE AO2 plus 20% on costs		$20,219 pa
Consumables		$2000
Computer maintenance		$1250
	TOTAL	**$22969 pa**
Capital:		
Office furniture		$1000
PC		$2000
Phone		$150
Airconditioner		$1500
	TOTAL	**$4650**

5.3 Library and Educational Resources

There is a need to enhance the facilities at Bundaberg to ensure that students do not miss out on the learning opportunities of their metropolitan peers. Although electronic access to information will assist, there is still a need for basic texts in the relevant core clinical areas. These should be available to the students in the library

In addition, the students and teachers require access to a range of educational resources which currently do not exist in Medical Education, Bundaberg. These include laptop computer and projector, and a range of educational models such as IV arms, suture practice kits, vaginal and rectal examination models etc.

There is a need for 2 computers to be purchased for the use of students in a specific location. These are for preparation of presentations, access of internet and clinicians knowledge network etc. In addition, a laser printer is required. A basic office set-up is required for this training room to accommodate the students. Air conditioning unit may be required

Recurrent:		
Consumables		$1500
Computer maintenance/internet access		$3600
	TOTAL	**$5100 pa**
Capital:		
2 PC's & Printer		$6000
Airconditioner		$1500
Office furniture		$1000
Laptop computer		$4000
Projector		$8000
Educational Aids		$15000
Core Texts		$10000
	TOTAL	**$45500**

5.4 Clinical Teachers Sessions

It is difficult to identify exactly what additional time is required of clinicians providing teaching to students. Obviously teaching will be formal sessions, ward rounds and clinics, and operating theatre.

The clinicians at Bundaberg Base Hospital are currently faced with high workloads compared with their metropolitan colleagues, due to the absence of experienced registrars and senior registrars, the onerous on-call commitments and the limited number of staff in each discipline. It is not feasible to expect that teaching can occur, to an acceptable standard, unless sufficient time is provided for preparation and delivery of an appropriate program.

The concept allows for specific sessions to be funded by the Rural Clinical School in order that service delivery is not affected by the impact of teaching. This would allow the District the flexibility of funding sessional replacements for full-time and visiting staff involved in teaching

It is estimated that this will require 6 sessions per week of funded time at the contract VMO rate for 44 weeks per year.

Recurrent:
Six x 3 hour sessions per week @ $133.91 per hour (VMO contract rate) 44 weeks per annum
TOTAL $106056 pa

5.5 Accomodation

As already indicated, the District is not in a position to provide accomodation to all the estimated 8-10 students here full-time. It is suggested that the Rural Clinical School consider whether accomodation assistance is provided to students to enable them to access the private rental market.

It is anticipated that lack of suitable free/cheap accomodation for students will be a significant barrier to uptake of this opportunity

6 Summary

This Proposal should form the basis of further discussion with the Rural Clinical School regarding the resources required to enable Bundaberg to adequately support 8-10 3rd year students for the full year.

It should be noted that this Proposal was put together in a very short time frame, and is based upon limited preliminary meetings with University and Queensland Health representatives. Appropriate and full consultation has not yet occurred. Furthermore, the Proposal has been based upon a superficial assessment of perceived support and infrastructure requirements of clinical teachers and students. No specific formula has been used (or appears to exist) in the development of the document.

7 People

The team currently progressing this process at the Bundaberg Health Service District are:

Dr John Wakefield — Director of Medical Services
Email — john-wakefield@health.qld.gov.au

Dr Peter Miach — Director of Medicine
Email — peter-miach@health.qld.gov.au

Dr Kees Nydam — Director of Clinical Training
Email — kees-nydam@health qld gov au

JGW-E

Review of

Resident Medical Officer

Rostering

Bundaberg Base Hospital

Dr Mark Mattiussi

Executive Director of Medical Services

(Redcliffe Caboolture Health Service District)

Background

Dr John Wakefield, Director of Medical Services, Bundaberg Base Hospital requested a review of aspects of the Resident Medical Officer Rostering to ensure efficient and effective service provision The scope of the review included the following

- Emergency Department fixed roster arrangements including the number and level of resident medical staff
- After-hours and weekend resident medical officer cover for the Bundaberg Base Hospital
- Appropriateness of numbers and level of resident medical officers attached to the clinical units of surgery, orthopaedics, medicine, O&G, paediatrics, anaesthetics/ICU and mental health.
- Arrangements for relief at Gin Gin and Childers hospitals.

Methodology

A site visit was conducted from the evening of the 6th June to the afternoon of the 7th June 2001. All Unit Medical Directors and Resident Medical Officer staff were offered the opportunity to meet with the writer though, only one Unit Director and a significant proportion of the Resident Medical Officer workforce availed themselves of that opportunity. Meetings were subsequently arranged with the following staff to obtain relevant information:

- District Manager
- Director Medical Services
- ESO to the Director Medical Services
- Acting Director Emergency Department
- Director of Surgery
- Director of Anaesthetics/ICU
- Director of Mental Health
- Resident Medical Officers (a majority of staff attended a Lunch Time Forum)

Copies of rosters, financial and activity reports were perused to gain a detailed understanding of the issues surrounding Resident Medical Officer allocation and rostering at Bundaberg Hospital.

Current Situation

An analysis of the current Senior and Resident Medical Officer allocation was undertaken. These findings are summarised and presented in Table 1 below The Resident Medical Officer on call and relieving arrangements were also reviewed The after-hours cover at Bundaberg Hospital is provided by the Emergency Department staff and three ward Principal House or Junior House Officers. The Emergency Department staff, including the sole Junior House Officer on night shift, only cover the ward calls if they are not busy so the ward calls are regularly covered by the on call ward staff.

Table 1: Medical Officer Allocation

Department	Senior MO	VMO	PHO/Reg	SHO/JHO/Int
Emergency	1.3		3	5 (+ 2 relievers)
Medicine	1.6	0.4	3	2
Ortho	1	0.3	1	1
Surgery	2	0.2	2	2
O&G	1	(provide call only)	1	2
Paediatrics	1	0.2	1	1
Anaes/ICU	4	0.5	1	1
Mental Health (acute unit)	1		1	1

The ward cover and new admissions reviews are provided by three ward based Resident Medical Officers who cover the facility in the following combination of disciplines:

- Medicine, Mental Health, ICU
- Surgery, Orthopaedics
- O&G, Paediatrics

The Anaesthetic Department first on call is covered by a combination of the Senior Medical Officers, Visiting Medical Officer and Principal House Officer who all work on a rotating roster.

Country relieving for Gin Gin and Childers Hospitals is provided by the Bundaberg Hospital Resident Medical Officer staff who are usually drawn from ward based terms. The relief for these Medical Superintendents is provided on the basis of a weekend off per fortnight. Bundaberg Hospital provides a medical officer each and every weekend to either Gin Gin or Childers and the required days off for these Resident Medical Officers are absorbed into the ward roster from which they are drawn The relief for Gin Gin Hospital is provided from 6pm Friday until 6pm Sunday whilst Childers Hospital relief is from 8am Saturday until 7am Monday morning The resident medical officers are paid as Principal House Officers for a rostered shift for the period 8am to 12 midday on each day of the weekend and held on remote call for the rest of the period. Recalls are paid as per the Senior Medical officers and Resident Medical Officers Award at Principal House Officer rates.

Possible Strategies

In order to discuss the possible strategies each area is dealt with separately though it is realised that many of these are interdependent The first area for discussion is the Emergency Department.

Emergency Department

The Bundaberg Hospital Emergency Department averages approximately 2,500 attendances per month. The vast majority of patients being categorised as National Triage Scale Category 4 or 5 (approximately 80%) Waiting times for these patients are within Queensland Health benchmarks for Emergency Departments and the percentages of patients who are admitted/transferred are within acceptable benchmark limits supporting appropriate triage categorisation. Reviewing the staffing of the Emergency Department against this activity indicates that the level of Resident

Medical Officers is reasonable though consideration towards more senior on site cover on the night shift is recommended. The addition of a Principal House Officer on the night shift roster (and therefore an increase in establishment of one Principal House Officer) will provide increased supervision for the night Junior House Officer and improved capacity for ward call cover from the Emergency Department. The cost of this improved Emergency Department cover could be off set by changes to current ward cover arrangement and this aspect is discussed further in the individual department sections below. Further, the additional medical officer on night duty will facilitate meal relief and will support roster changes to allow a 10-hour night shift commencing at 2130 hrs and finishing at 0830 hrs, with a one hour meal break, or 0800 hrs allowing for a half hour meal break. Hand over to the oncoming admitting teams and the morning shift can be commenced at 0800 or 0830 hrs allowing improved day and afternoon coverage. It is also recommended that consideration be given to an evening shift being rostered on the day before commencement of the night shifts as this is in line with safe-hours rostering It is recognised that this would entail further changes to the Emergency Department roster to accommodate teaching that would possibly need to be undertaken on Thursday rather than Wednesday, as is currently the case.

Another area of potential benefit in the Emergency Department, though technically outside of the scope of this review, is the methodology of care provision to some of the Triage Category 4 & 5 patients A recent Policy and Procedure Paper undertaken by the Health Funding and Systems Development Unit, Queensland Health described a mechanism whereby National Triage Scale Category 4 and 5 patients could treated as private patients. If these patients voluntarily elected to be seen as private patients in a Primary Care Clinic that is operating within the private clinic guidelines they could be billed under Medicare. As 80% of attendances to the Emergency Department are Triage Category 4 & 5, this has the potential to provide a revenue stream for Bundaberg Hospital. There is the possibility that the Emergency Department consulting rooms adjacent to the current waiting room could be utilised for this purpose though it is recognised that workforce issues and direct competition with the private sector might make this impracticable.

Medical Unit

The medical officer allocation of this unit seems reasonable The Medical Unit Principal House Officers currently provide cover to the medical, intensive care and mental health units after hours. Discussions with the Resident Medical Officer staff indicates that in their opinion this cover could be rationalised as they feel they are not necessarily adding value after hours, particularly as a number of the recalls to duty are for ward call type issues. It is recommended that the current after-hours medical cover duties be reviewed with a view to incorporating these into the function of the proposed night Principal House Officer located in the Emergency Department. Operationally this would entail the Emergency Department Principal House Officer covering the wards as first senior call for all medical issues and accepting responsibility for most overnight admissions. The Medical Unit Principal House Officers will provide cover to the wards during normal business hours Monday to Friday and up until the Emergency Department night shift Principal House Officer commences duty Saturday and Sunday. This will eliminate any fatigue pay/leave concerns for the Medical Unit Depending upon the level of medical cover in the Emergency Department and the amount of work generated from the wards the evenings could also be covered by the Emergency Department staff. Accurate costing for the reduction in recall and fatigue will need to be undertaken though it is the impression of the writer that the savings achieved from the reduction in these will be sufficient to offset any additional cost incurred in providing the additional Emergency Department cover.

Surgical and Orthopaedic Unit

The allocation of medical officers to these units seems reasonable. Concerns were raised regarding the skill level of the Principal House Officer staff but it is recognised that Bundaberg Hospital is constrained by the availability of skilled staff. The surgical and orthopaedic Principal House Officers provide the after-hours cover for surgery and orthopaedics by a rotating one in three proximate on call roster. It is recommended that this be reviewed in conjunction with improved senior cover in the Emergency Department as it is envisaged that the requirement for a proximate call

surgical Principal House Officer will be vastly reduced if not rendered obsolete. It is recommended that the Principal House Officers be placed on remote call and only recalled for patients deemed to require surgical intervention. The surgical and orthopaedic Principal House Officers will need to provide some daytime and possibly weekend ward cover for patient ward rounds, new admissions and discharges. It is recommended that the Emergency Department staff, in the first instance, conduct all other after-hours ward call and initial patient reviews.

Obstetric and Gynaecology Unit

The allocation of medical officers to these units appears to be primarily based on the requirement for after-hours cover being one Principal House Officer and two Junior House Officers. Each of these staff provides cover for Obstetrics and Gynaecology and Paediatrics on a one in three after-hours proximate call rotation. This oncall arrangement seems reasonable, though during the daytime it is questionable whether the workload requires the attendance of three staff. It is recommended that, with due consideration to skill level, the roster be adjusted towards an evening shift which then provides midnight till dawn oncall cover for these areas. Further, depending on the workload of the Emergency Department staff they, and in particular the Principal House Officer, could provide first call for the Paediatric Unit reducing the requirement to recall to Obstetrics and Gynaecology staff further offsetting the cost of the additional Emergency Department Principal House Officer.

Paediatric Unit

The allocation of medical officers to this unit seems reasonable though the provision of the Junior House Officer to this unit in the summer months may be more for teaching than service provision. Caution should be exercised in removing this position during the summer months though, as this is likely the only position that can provide sick leave and other relief at very short notice should the need arise. The after-hours paediatric cover options have already been discussed in detail in the sections above.

Mental Health Unit

The allocation of medical officers to this unit also seems reasonable though like paediatrics, the provision of the Junior House Officer to this unit may be more for teaching than service provision. Caution should be exercised in removing this Resident Medical Officer allocation as the move towards a more community based model providing an extended care arrangement may require conversion of this position to a Principal House Officer to provide greater flexibility. It is recommended that the Emergency Department provide the immediate after-hours cover for the inpatient unit though this should be revisited if the above-mentioned changes occur.

Anaesthetic and Intensive Care

Primarily staff specialist and senior medical officer anaesthetists currently provide the Bundaberg Hospital anaesthetic service. Based on this model the allocation of one Principal House Officer for anaesthetics and one Junior House Officer for the Intensive Care Unit is reasonable. The after-hours arrangement for anaesthetics to be covered by a rotating roster including the Staff Specialists/Senior Medical and Principal House Officers though not ideal is the most reasonable considering the model and available staff. The Medical Unit Principal House Officer on proximate call currently provides the first call for the Intensive Care Unit though it is recommended that the proposed night shift Emergency Department Principal House Officer cover this.

Another item warranting consideration, though not specifically within the scope of this review, is the number of staff specialists, senior medical officer and visiting anaesthetists required to cover the allocated operating sessions. The ratio of morning to afternoon sessions where anaesthetic cover is required is significantly biased towards the morning. This is seen particularly within the operating theatre with most mornings requiring four sessions whilst in the afternoon there are one or two and rarely three sessions requiring an anaesthetist. It is acknowledged that the preadmission clinic is also provided in the afternoons and there is also routinely allocated an emergency operating theatre which, based on the information provided, is

severely underutilised It is recommended that the operating theatre schedule be reviewed to provide a more appropriate balance of morning and afternoon session allocation, which will reduce the requirement on anaesthetic services, by an equivalent of approximately one full-time position.

Relief for Gin Gin and Childers Hospitals

The current arrangement for the provision of relief to these two hospitals is significantly negatively impacting the flexibility of rostering within the Bundaberg Hospital The provision of one Resident Medical Officer to Gin Gin or Childers Hospital each weekend limits the frequency of weekends off able to be provided to the Resident Medical Officers. In addition, the methodology of payment and perceived inequity by the Resident Medical Officers provides significant impetus for gaming to improve the income generated from these weekends. Though the current relief arrangement is in accord with IRM 2.7-10, providing two full days off per fortnight, it is recommended that the relief provision to these hospitals be reviewed toward providing one of the following options. Relief provided for 5 days every 5 weeks or 1 week every 6 weeks is possible within in the guidelines described within section 11 of the Award for Medical Superintendents With Right of Private Practice and Medical Officers With Right of Private Practice – Public Hospitals, Queensland as reproduced below

> *"Leave – relief of Employees*
>
> *An employee shall be entitled to the equivalent of one (1) day free from duty in each week upon which duties under the Award are performed.*
>
> *Provided that such time, free from duty, may accumulate up tro five (5) days without the approval of the employee or up to nine (9) days by mutual agreement between the employer and the employee"*

This will allow for income to be generated from the Medical Superintendent relief arrangement in the hospital as well as the private practice. Alternatively, arrangements could be considered toward involving Gin Gin and Childers Hospitals in a relieving circuit for which the Bundaberg Hospital provides a reliever on a regular

basis. This will require an increase in the Resident Medical Officer establishment though for the time spent out of the district appropriate reimbursement of salary and on cost will be provided. During the site visit the Resident Medical Officers expressed their dissatisfaction regarding the current relief arrangements and felt either of the options outlined above would be preferable

Recommendations

Following the review of Resident Medical Officer numbers, allocations and rostering the following recommendations are made. These are:

- Increase the establishment in the Emergency Department to provide a night shift Principal House Officer
- Alter the Emergency Department roster to include a ten hour night shift commencing at 9.30pm and the day staff to commence duties at 8.00am
- Review the business practices within the Emergency Department with a view to capitalising on the ability to treat Triage Category 4&5 patients in a private environment
- Alter the oncall arrangements for the Medical Principal House Officer reducing these as cover will be provided by the Emergency Department night shift Principal House Officer
- Considering appropriate skills modify the rostering of the Obstetrics and Gynaecology Principal and Junior House Officers to include a rostered evening shift
- Consider removing the Paediatric Junior House Officer position over the summer months
- Review the junior medical officer allocation for the Mental Health Unit in conjunction with anticipated service delivery models
- Modify the operating theatre schedule improving the balance between the anaesthetic resources required in the morning and afternoon sessions thereby reducing the demand on anaesthetic services by approximately one full-time position

- Alter the relief arrangements provided to Gin Gin and Childers Hospitals toward providing relief for an entire week rather than the weekends as is currently the practice.

'JGW-F'

PRIVATE PRACTICE FOR FULL-TIME MEDICAL SPECIALIST STAFF BUNDABERG BASE HOSPITAL

REFERENCE BOOKLET AND POLICY

Target Audience:

- All Medical Staff
- Clinic and Admissions Clerical Staff
- Private Practice Clerk
- Nursing Staff

Prepared by:

Dr John Wakefield
Director of Medical Services

Review date: November 2000

CONTENTS:

Introduction:

Full Time Specialist staff are eligible to participate in private practice arrangements as outlined in IRM 2.7-12. This arrangement was introduced in 1995 as part of the "A 4-Point Plan Meeting The Immediate Need" policy to help improve recruitment and retention of specialist staff to the public health system.

The Medical Superintendant is accountable for the management of the Scheme, and providing appropriate administrative support. The individual specialists are responsible for acting in accordance with relevant Policy and Legislation. The relevant documents which should be read in conjunction with this booklet are:

- IRM 2.7-12 "Rights of Private Practice – Full Time Medical Specialist Staff"
- Contracts for Option A and Option B
- Medicare Benefits Schedule Book – Commonwealth Department of Health and Aged Care

QUESTIONS:

Am I eligible to participate in the Private Practice Scheme?

To be eligible, the specialist must be:

- A registered specialist in Queensland.
- Be willing to treat patients privately when they elect to be treated privately by a Staff Specialist.
- Obtain a Provider Number for treatment of private patients.
- Sign a contract for Option A or Option B.

When do I sign the contract and can I change from one Option contract to the other?

- Option A contracts must be signed annually on or before 1 July.
- Option B contracts are for a 1 year period initially but can be extended to 3 years before a new contract is necessary.

- The specialist can change from one Option to the other as of 1 July each year and at no other time.

What is the difference between Option A and Option B?

- Option A Specialists:

  A 45% loading of base salary including Directors Allowance if applicable, is paid. This is paid during any periods of paid leave.

- Option B Specialists:

  The money collected from private patients has administration and facility fees deducted as per the attached Schedule D, and the remainder paid to the Specialist to a ceiling of 50% of the base salary (currently under review Corporately). Above that amount, $1 in every $3 (after deduction of facility and administration fees) of this payment is made to the Specialist, and the remainder is credited to a "Private Practice Study, Education and Research Trust Account." The funds in this account are distributed according to a Committee as per the IRM.

How do I start private practice?

- You must have a provider number and have a signed Option A or B contract. See the Director of Medical Services for this.
- Visit the Private Practice Clerk and provide your Provider Number, and discuss the billing arrangements and Option category.
- Arrange clinic times with Administration and Nursing staff of Clinics.
- Inform local GP's of Private Practice arrangements through the Director of Medical Services.
- Order personalised prescription pads (normal and Authority).
- Order Private Practice Newstart kit from Medicare (includes Medicare Benefits Schedule) phone 132150.
- Contact Private Radiology and Pathology Providers.

What can I charge private patients under my care?

- Eligible Patients:

  Private patients who are eligible under Medicare can be charged up to the Scheduled Fee. Workers Compensation patients and Veterans Affairs patients can be charged up to their scheduled fees. **In the case of Option B Specialists, the Specialist sets the fee. With Option A Specialists, the District Health Service sets the fee** and the Policy suggests that consideration be given to setting these fees such that the patient is not out of pocket for the service. This is to attempt to maximise the number who will chose to be treated privately. This equates to **bulk billing outpatients and charging the**

Scheduled Fee for inpatients. This is the current policy of the Bundaberg Health Service District.

- Ineligible Patients:

  Ineligible patients are patients who are overseas visitors where no reciprocal agreement exists or where no item number exists (e.g. some cosmetic procedures). The fees are determined by the Option B Specialist or by the District Health Service in cases where treatment is provided by an Option A Specialist. The District will set the fee for Option A patients at the Scheduled Fee.

How do I bill patients seen privately?

All patients must be billed by the Hospital Billing Agency. It is important that you maintain good communication with the Private Practice Clerk and the Clinic Administration Staff. The billing arrangements will be as follows:

- Outpatients: The clinic administration staff will bill the patient for the services which you indicate on the form attached to the chart. Do not forget to add tests performed in the clinic such as ECG or spirometry. You must indicate the Medicare Item Number on the form.

- Inpatients: You should provide the Private Practice Clerk with information On a **weekly** basis for all private inpatients under your care. This should be provided on the designated form, and should include patient sticker, dates and details of services provided and Medicare Item Numbers. Ensure that all billable items are indicated to ensure revenue is maximised.

How do I organise any investigations for my private outpatients?

Private Outpatients should access Medicare funded investigations. As the treating Specialist, you should be aware of the following:

- Radiology: Referrals for all radiology should be made on the private form for Bundaberg Medical Imaging. You can endorse the form "hospital" to ensure that the patient is bulk-billed (this is at the discretion of the radiology practice and may change without notice). Patients **should not** be referred to the hospital radiology department.

- Pathology: Referrals should be made on usual pathology referral forms and the ***private*** box should be ticked. Patients should be directed to the Hospital Lab collection area above the Emergency

department. The **specialist name** and **provider number** should be placed on the form.

How do I organise medication for my private outpatients?

The Pharmaceutical Benefits Scheme should be used for private outpatients. The Hospital Pharmacy should not be used for this purpose.

- You will need to organised personalised PBS and Authority prescription pads by contacting the Health Insurance Commission. You must also have a prescriber number which is person specific (not location specific like a provider number).
- Write on PBS prescriptions for all medications listed as general benefit or restricted benefit in the PBS Yellow Book or MIMS. You should write with appropriate pack sizes and number of repeats as indicated in MIMS.
- Items listed as "Authority only" can only be prescribed by telephoning the PBS and providing details including the Authority condition, patient details or Medicare Number, and item. You must have an Authority Prescription Pad to write these.
- There are a limited supply of blank script pads and Authority pads. You should however, get your own supply as soon as possible.

How do I organise investigation and medication for private inpatients?

The situation for private inpatients is complicated by the ability of hospital services to raise accounts for specific services. The following is a suggested process:

- Radiology: Radiology is best provided by the Hospital Radiology Department with a fee being raised. Xray, Ultrasound, CT, and interventional radiology should be requested on a **private** referral form and sent down to **the Hospital Radiology Department.** They will arrange the procedure at the Base and it can be billed by the radiologist. The Hospital bill the radiologist according to *Schedule D* for facility and admin fee.
- Pharmacy: Inpatients should receive medication by prescribing on a standard inpatient script form. On discharge they should receive a standard public discharge script for **5 days** treatment. In essence this is the same as for public patients.
- Pathology: The pathology requests should be written on the usual hospital request form and the ***private*** box should be ticked. It is important to put the **specialist name** and **provider number** and also mark the ***inpatient*** box.

Can the Resident Medical Staff be involved in the care of my private patients?

Resident Medical Staff can be involved in the care of private patients for Option A Specialists. Bundaberg Health Service District also authorises RMO involvement in the care of Option B private patients unless by doing so, this significantly interferes with public duties (eg the RMO has to work overtime to perform duties which would ordinarily be able to be perfomed in normal hours: refer to IRM 2.7-12).

Specialists are advised to indicate to private patients that RMO's will be involved in their care. They should also indicate to the RMO's what their own requirements are for involvement in caring for private patients. Notwithstanding the above, private patients have a right to have their nominated specialist manage their illness.

It is necessary to comply with Health Insurance Commission requirements for billing (see Medicare Benefits Schedule Book). For you to bill the patient, you must perform the service or oversee it eg ECG done by nurse. You cannot bill for a service performed in your absence eg. Urethral catheter performed in your absence by the nurse/RMO.

Can I see private patients during my public clinics?

Option B Specialists according to the IRM 2.7-12 should see private patients in a separate clinic which should be clearly marked as private. Where possible this should be physically separate from the public clinics. There is no such condition placed upon Option A specialists.

In Bundaberg, until further notice, the following should occur:

- Option B Specialists: Clinics should be separate from public clinics and clearly marked "Dr X, Private Practice Clinic". Where possible, the clinic time should be at a time when there are no public clinics as there will be a common waiting room/clinic area.

- Option A Specialists: The Specialist may elect to operate a similar arrangement as for Option B. However, this is not necessary and public and private patients can be mixed. Private patients must be identified from their referral and only billed if seen by the participating specialist.

GENERAL POLICY FOR ADMINISTRATION OF PRIVATE PRACTICE FOR FULL TIME SPECIALISTS:

The Policy is based on the principle that patients have a right of choice in relation to whether they wish to be treated as Public or Private patients within the facilities operated by the Bundaberg Health Service District, where these services are available.

Expected Outcome:

To ensure that:

- Patients are informed of their choices in relation to public and private services available.
- Patients are aware of the implications and consequences of these choices.
- Patients make an informed decision as to which form of service they wish to access.
- Potential for allegations from patients that they were not aware of the options or implications of their choice or they were denied choice in relation to services they received will be minimised and any such cases will be able to be defended by the Health Service.

Background Information and Policies:

There are several general policy matters that are of relevance to the principles of conducting Private Practice Clinics by full-time Specialist Medical Staff in an equitable matter. These matters are drawn from sources including:

- Queensland Health Policy.
- Award conditions
- The Industrial Relations Manual of Queensland Health
- The Australian Health Care Agreement between the Commonwealth and State of Queensland
- The Health Insurance Act 1973
- The Medicare Benefits Schedule (1st November 2000)
- The Code of Ethics

- Patients who are Medicare eligible are entitled to treatment as Public Patients for services available within public hospitals in Queensland.

- Patients have the right to choose whether to be treated as Public or Private Patients for services that are available and covered by Medicare.
- Patients who elect to be treated as Private Patients, have a right of choice of accredited appointed Medical Practitioners.

- Patients who elect to be treated as Public Patients will be treated by an appropriate Medical Officer appointed by the Hospital. There is no right for the patient to demand any particular treating doctor. Public patients are entitled to a second

opinion. If this is not available within the Hospital, the patient is personally responsible for the costs involved in obtaining the second opinion.

- A Public patient has the right to refuse to accept treatment by a particular doctor The Hospital is obliged to provide an alternate practitioner if an appropriately trained and skilled one is employed by the hospital and is available.

- For a Specialist Service to attract a Medicare Rebate, the referral must:

- Be made by a practitioner with a Medicare Provider Number.
- Be for a Service that is included in the Medicare Benefits Schedule.
- Be addressed to the Specialist (except for some diagnostic tests) who provides the service.
- That the Specialist is recognised by the Health Insurance Commission and has a valid Provider Number for that location.
- Be for a patient who is eligible for Medicare Services (i.e. be an Australian resident or be an emergency or acute service for a resident of another country with reciprocal "Medicare" arrangements with Australia.

- Full Time Specialist Medical Officers can choose to exercise a limited right of Private Practice. This is either under Option A or B as specified in the IRM 2.7-12. Certain obligations exist if the Specialist chooses to exercise either Option. These include:

- Participation of Specialists in the Private Practice Scheme must in no way compromise or adversely affect the treatment of public patients.
- All Private Practice performed between 0800 hours and 1800 hours on normal working days must utilise the Health Service Private Billing Agency.
- All Private Practice during these hours and during any on-call period must be performed in premises nominated in the Option A/B Contract with exceptions only as authorised by the Director of Medical Services on an individual (patient) basis.
- All Private Practice performed within premises nominated by the OptionA/B Contract must be billed through the Agency, irrespective of whether on-call or not, during after-hours periods.
- An Option A Specialist has contracted with the District Health Service to treat any Private Patient referred to them, and have authorised the District to bill Medicare in their name and Provider Number.
- Participants are required to identify Private Patients under their care and promptly notify Health Service Private Practice Billing Agency of all applicable item numbers and other relevant information required to process accounts.
- Option A Specialist charges must be agreed to by the Health Service and are not to exceed the Medicare Benefits Scheduled Fee.
- Option B Specialists can set their own fees.
- Fees for non-eligible patients are at the discretion of the Specialist and/or the Health Service.
- Private referrals may be made to a participating Specialist by full-time Senior Medical Officers, Specialists or by General Practitioners. Referrals by House

Officers and Registrars will be permitted only at the expressed wish of the patient, and this should be documented in the referral and the clinical notes.

Valid Referrals:

For a referral to be legitimate, the following information is required:

- A 'referral' is a request to a particular Specialist or a Consultant Physician for investigation, opinion, treatment and/or management of a condition or problem of a patient **or** for the performance of a specific examination(s) or test(s).

Subject to the exceptions below, for a valid "referral" to take place:

1. The referring practitioner must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the Specialist.
2. The instrument of referral must be in writing by way of a letter or note to a specialist and must be signed and dated by the referring practitioner; and
3. The Specialist to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

Exceptions to the requirements are that:

- The above does not apply to an examination of a patient by a specialist anaesthetist in preparation for the administration of an anaesthetic (Item No. 17603).
- Sub paragraphs **1.** and **2.** Do not apply to:

  A referral generated within a hospital, in respect of a privately admitted patient for a service within that hospital, where the hospital records provide evidence of a referral (including the referring practitioners signature): or

  An emergency situation where the referring practitioner or the specialist was of the opinion that the service be rendered as quickly as possible. (For these purposes, an emergency is a situation where the patient is treated by the medical practitioner within 30 minutes of presentation).

- A referral for a procedure is not a referral for a consultation. Unless the referral for the procedure(s) or test(s) also requests a consultation and fulfils all the criteria above, it cannot be utilised as a referral for a consultation.

- A referral for a consultation does allow for certain procedures or investigations to be performed by the consultant. As an example a referral for a consultation by a Specialist Physician allows that physician to determine that an Echocardiogram is necessary and to perform and charged for that Echocardiogram. The account must be endorsed "SD" to denote the test was self-determined.

Private Referrals:

- A referral to an Option A or Option B Specialist will be considered a private referral if the referral is:

- Made in such a manner that it complies with all the requirements outlined above, or;
- The patient is non-eligible under Medicare.

Ambulatory Patients:

- No appointments will be made without receipt of a valid private referral.

- After a valid referral is received and it is assessed as a private referral, it will be assigned to the private practice clinic for an appointment to be made.

- Upon making an appointment, the clerk will:

- Notify the patient of the appointment details as per the proforma letter and/or telephone as appropriate;
- Notify the patient that it is to a Private Practice Clinic and that a fee will be levied. The fee is to be nominated in so much as the patient is to be informed that the service will be bulk-billed with no patient contribution required for the service (Option A) **or** that there will be a necessary patient contribution (Option B depending on individual Specialist practice).
- Notify the patient that referral to a Private Practice Clinic will result in them being seen by the nominated Specialist whilst a Public Clinic will entail any Medical Officer appointed by the Hospital seeing them.
- Notify the patient that if they do not wish to be seen as a Private Patient then they need to request that their referral be endorsed "public" and follow the procedure for Public Clinic bookings.
- Place the referral in the correspondence section of the Medical Record or in an appropriate folder until the appointment time.

- At the time of attendance for appointment, details of the referral (date, date of referral, referring doctor, provider number or address of referring doctor and period of referral) will be entered into the patients clinical notes for all services other than Radiological Examinations. For Radiological Examinations, the details will be entered into the register in that Department.

- Notes will be made in the clinical record of the patient in relation to the details of the consultation and/or procedure(s) or test(s) by the consultant to whom the patient was referred.

- The Specialist will complete the form as attached to this Policy with the patient details, referral details and services provided (and Item Numbers), and furnish the

completed forms to the Private Practice Billing Agency within 1 (one) month of provision of the service.

Admissions:

- Patients are to be processed as per the procedure and protocols for admission to Hospital.

- It should be noted that in order for patients to be admitted privately, they must "elect" to be private. This is regardless of their insurance status (Only exception is "Ineligible" patients).

- Significant revenue is lost by failure to identify patients eligible for private in-patient treatment. These include:

- Workers Compensation patients (most workplace injuries).
- Veterans Affairs (any gold card holder).
- Armed Forced personnel.
- Privately insured patients.

REVIEW OF RESIDENT MEDICAL STAFF ROSTERING

BUNDABERG BASE HOSPITAL

INTRODUCTION

Dr John Wakefield, Director of Medical Services, Bundaberg Base Hospital has requested that a review of aspects of resident medical staff rostering occur to ensure that this service is efficient and effective.

Bundaberg Base Hospital is a 140 bed, Level 4 provincial facility providing a broad range of secondary level services to a community of 88,000 residents.

Resident medical staff are recruited and allocated terms centrally by the office of the Director of Medical Services. Residents are required to provide weekend and ad-hoc relief for rural medical superintendants in Gin Gin and Childers.

OBJECTIVE

The objective of the review is to examine the rostering of resident medical staff, to ensure that this service efficiently and effectively meets the needs of the Hospital.

SCOPE

The review should address the following aspects of resident medical staff rostering –

- Emergency Department fixed roster arrangements including number and level of resident medical staff
- After-hours and weekend resident medical officer cover for the Bundaberg Base Hospital
- Appropriateness of numbers and level of resident medical officers attached to the clinical units of surgery, orthopaedics, medicine, O&G, paediatrics, anaesthetics/ICU, mental health
- Arrangements for relief at Gin Gin and Childers hospitals

METHODOLOGY

The Reviewer will examine any documentation pertinent to the scope of the review. This will include, but is not limited to:

- Budget and expenditure reports
- DSS reports relating to the above expenditure
- Rosters
- Term allocations
- Activity data

It is also anticipated that the Reviewer will meet with certain key individuals during the visit. This will include the Departmental Directors and the Director of Medical Services. A meeting will also be arranged with the resident medical officers.

RESOURCES

The reviewer will be –

Dr Mark Mattiussi Executive Director of Medical Services
Redcliffe/Caboolture Health Service District

Administrative support will be provided by the office of the Director of Medical Services and Business Manager Medical Services.

TIMEFRAME

There will be a site visit on 7 June to Bundaberg Base Hospital.

REPORTING ARRANGEMENTS

A written report detailing findings and any recommendations will be provided to Dr John Wakefield within a timeframe to be negotiated.

Dr John Wakefield
Director of Medical Services
Bundaberg Base Hospital

Dr Mark Mattiussi
Executive Director Medical Services
Redcliffe/Caboolture Health Service

21/7/99 'JGWG'

#1 Friday pm 4pm
Charles went to book case.
Registrar · Richard) PHO's ½ hr
· Wendy) stuffy around
16
45 min 1525 - 1730 Jenny told him
· advised ring consultant
→ Jenny Church contacted him 1.30 TUPP
he came in
Charles hung around until he came
Jen paged – "over in 10 mins" – came + sorted.

#2 Jenny Monday.
· Richard on all weekend
· 42 RIF pain — 7.30 pm. busy appt.

· P. Anderson asked Richard + Wendy to do case +
if problems – call Dr Kingston. ? could have
been done earlier P. Anderson finished MOP's @ 3 o'clock.

* College re guidelines for unsupervised.

BAFS · Wed am 7am — 8am.

· Wed pm

1·30 (2·3).

· irregular op time – before 6am. Thursday when possible

QUEENSLAND HEALTH

OFFICE BUNDABERG BASE HOSPITAL
POSTAL P.O. BOX 34, BUNDABERG, QLD 4670
PHONE (07) 4152 1222
FAX (07) 4150 2099

BUNDABERG DISTRICT HEALTH SERVICE

INCORPORATING - Bundaberg, Gin Gin, Mount Perry and Childers Hospitals and Community Health Services

Department of Anaesthesia

31st August 1999

Dr. John Wakefield,
Acting Director of Medical Services,
Bundaberg Base Hospital,
Bundaberg. 4670.

Dear John,

I am writing to you because of some problems of a rather delicate nature that have impacted on the running of the theatre and endoscopy suites.

On at least three occasions in the last two weeks Dr. P. Anderson has been unavailable for public patients during working hours. On one occasion Dr. Jaysekera was left to finish an endoscopy list on his own. It was clear that Dr. Jaysekera was less than comfortable with the procedures he was left with. On another occasion an urgent case was deferred until 17.30 hours because Dr. Anderson was unavailable until this time. A theatre team and anaesthetist were available from 13.30. The case was performed in the evening with all the impacts that a case out of normal working hours has on the organisation. Finally, a very sick man under the care of Dr. Anderson requiring a laparotomy was booked for theatre for 13.30 hours. Dr. Anderson did not do the case because he was unavailable for the afternoon and he convinced Dr. Nankivell to perform the case for him.

On each of these three occasions it was said that Dr. Anderson was unavailable because he was dealing with private patients at one of the private hospitals in town.

Dr. Anderson, I am sure, is aware of his contractual obligations, however, as these three instances have shown there is an impact on both the organisation and the staff while Dr. Anderson is elsewhere and unavailable.

I am sure you will give this matter your utmost attention.

Yours sincerely,

File

Dr David C Little.
Staff Anaesthetist.

'JGW - H'

QUEENSLAND HEALTH

MEMORANDUM

PRIVATE & CONFIDENTIAL

To: Dr Pitre Anderson, Director of Surgery

From: Dr John Wakefield
Acting Director of Medical Services

Contact No: (07) 4150 2210

Subject: **Private Practice outside of Employment Contract**

Dear Pitre

In the light of several complaints from hospital staff regarding your availability during rostered hours due to private practice commitments off site and outside of the Option A contract, I seek to clarify the terms of your contract.

In discussing this issue I draw your attention to your Option A contract signed and dated by you on 29 April 1999, and the Industrial Relations Policy Manual IRM 2.7-12 which details the rights of private practice of full time medical specialist staff.

These documents clearly state the conditions for private practice arrangements for full-time staff specialists' appointments and also indicate that both the Medical Superintendent and the District Manager are accountable for the appropriate administration of the private practice scheme.

The contract clearly states that the specialist is not to engage in any form of private practice in any location during normal working hours of 0800 to 1800, Monday to Friday, and any rostered overtime/on call. Clearly if this does occur this is in breach of the employment contract, and also potentially has an adverse effect on the appropriate treatment of public patients. In addition to this it disrupts normal theatre utilisation and contributes to increased after hours theatre use.

In the light of this information, I request that you cease any private practice during rostered hours outside of Option A.

I trust you will understand my position and would like to discuss the matter with you in person at the earliest opportunity.

Yours sincerely

John Wakefield

1.9.99

'JGW-I'

QUEENSLAND HEALTH

MEMORANDUM

To: Dr John Wakefield - A/Director of Medical Services

From: Dr Pitre Anderson - Director of Surgery **Contact No:** (07) 4150 2220

Subject: **Private Practice**

Dear John,

I am writing to let you know that I am in the process of rescheduling my Private Clinic so that it will take place after business hours. I don't plan to resign imminently but I will make some proposals to establish a VMO position for me to take up when and if it is arranged. I have had some discussion with Charles and it appears that we need to recruit another staff surgeon to cope with the workload and probably this surgeon should have a vascular interest so he can take over Dr Thiele's activity when he retires. We will need to sit down and talk about these issues in due course.

Kind regards

Pitre Anderson
Director of Surgery

file
cc. District manager

9/09/99

'JGW-J'

QUEENSLAND HEALTH

MEMORANDUM

To: Dr Pitre Anderson, Director of Surgery

Copy to: District Manager

From: Dr John Wakefield
Acting Director of Medical Services

Contact No: (07) 4150 2210

Subject: **Private Practice**

Dear Pitre,

I am happy to sit down and talk about the issues brought up in your memo when I return from holidays. It would be appropriate if your private commitments during work hours outside of Option A could cease within the next two weeks.

Yours sincerely

John Wakefield

10.9.99

'JGW-K'

Queensland Government
Queensland Health

FAXED 3-10pm 28/7/00
Received 2-55pm 28/7/00

MEMORANDUM

To: Elizabeth Piper-Cruikshank, Senior Employment Relations Officer
Organisational Development Branch

Copies to:

From: Dr John Wakefield
Director of Medical Services
Bundaberg Health Service District

Contact No: (07)41502020
Fax No: (07)41502029

Subject: Dr Pitre Anderson, Director of Surgery
Bundaberg Health Service District

File Ref: Click, enter Ref No.

Strictly Confidential

Liz

Please find attached a draft letter to Dr Pitre Anderson.

There are three (3) issues here.

Firstly his continued breach of employment conditions and option A contract, despite verbal and written warnings to cease this private practice.

Evidence Verbal confirmation from Chief Executives of private hospitals, Bundaberg Friendly Society Private Hospital, and Mater Hospital, confirming his operating list schedules at their facility obtained on 27 July 2000.

Secondly, in being off-site when supposed to be available to care for Bundaberg Base Hospital, causing delays in surgery, increased costs to public purse, and delegating responsibility to junior medical staff who are not capable of performing the procedure.

Evidence First hand account from the Clinical Nurse Consultant Theatre, who was scrubbed for the case. Corroborated by staff surgeon who was in theatre at the time. No written statements at this stage by these people. I have not talked to the Principal House Officer, Dr Bryant, as I am not sure whether I can rely on his support.

Thirdly, of removing equipment, without authorisation, for use off-site for private practice.

Evidence Verbal evidence from the Clinical Nurse Consultant Theatre, and Director of Anaesthetics.

Obviously, the main issue here contractually is his continued private practice, and I believe that I have strong evidence of this. The other bits may well be best left out, as to date, no-one is committed to a written and signed allegation.

I await your advice on the appropriate course of action and documentation, and the available sanctions.

Dr John Wakefield
Director of Medical Services
MB CHB FRACGP FRACRRM Grad.Cert.Management

Distmng\anderson1.doc

DRAFT

28 July 2000

Dr Pitre Anderson
Director of Surgery
Bundaberg Health Service District
P O Box 34
BUNDABERG. QLD. 4670

Strictly Confidential

Dear Dr Anderson

As a result of information which has recently been brought to my attention, I seek you written response within twenty-four (24) hours, and ask you to "show cause" why disciplinary action should not be taken by the District.

- Continued breach of employment conditions and Option A contract

  I draw your attention to my letters of 1 September 1999, and 10 September 1999, and associated meetings with myself and Mr Peter Leck, where it was made quite clear that your private practice off-site was in breach of your employment conditions and Option A contract, and additionally, was resulting in extra expense to the District, due to the operative cases being delayed until "after-hours", due to your absence.

  My letter of 10 September 1999 indicated that you were required to cease this activity within two (2) weeks. You did not respond in writing to this letter, but verbally indicated to me that these activities were now being conducted in your "own time". I have recently received information which indicates that you continue to be absent from the hospital in order to perform private practice outside of Option A contract, as follows:

  - Most Wednesday afternoons at Bundaberg Friendly Society Private Hospital.
  - Wednesday mornings until 9.00am at Bundaberg Friendly Society Private Hospital.
  - Some Thursday afternoons at the Mater Hospital
  - Other ad hoc times.

  Despite this you continue to indicate that you are in Bundaberg Base Hospital from 0800 to 1800 Monday to Friday on your time sheet.

There have been several occasions where your absence has caused increased costs to the Health Service by delaying surgery which could have been performed during normal business hours, to "after hours".

Also of significant concern is that whilst off-site, you have instructed your resident staff to perform procedures which they are not dompetent to perform without direct supervision. I refer to an incident relating to 21 July 2000, when you instructed your Principal House Officer, Dr Richard Bryant to perform a laparoscopic appendicectomy on a sixteen (16) year old girl. This procedure commenced at 1525 hours, and in your absence. It was only at 1600 hours that due to concern from nursing and anaesthetic staff and the fact that the resident surgeon clearly was not capable of performing the procedure, that you attended. I have been made aware of the fact that you were performing a procedure that afternoon in a private hospital. Once you attended the Base Hospital at approximately 1630 hours, the procedure eventually was completed at 1730 hours. This procedure therefore took two (2) hours, which is twice as long as average, and posed a serious risk to the patient. Despite this, only three (3) days later on 24 July 2000, you placed a forty-two (42) year old female patient in a similar situation. Despite finishing your minor ops list at 3.00pm, you asked your Principal House Officer Dr Bryant to perform a laparoscopic appendicectomy on this patient, without supervision. Eventually the procedure was performed assisted by the on-call Visiting Medical Officer surgeon and the gynaecologist. Your Principal House Officer had been exhausted after a busy weekend on call, and had passed the case onto the Visiting Medical Officer surgeon on-call.

It has also been brought to my attention that you have removed items of equipment from Bundaberg Base Hospital theatre, without appropriate authorisation, for use by yourself during private surgery off site. I was recently informed that you removed an abdominal retractor, such that it was not available for use on a public patient undergoing major abdominal surgery the following day under a different surgeon.

IRM 2.7.12 July 1995 indicates that "Maintenance of services to public patients is paramount and must not be compromised by private practice arrangements".

IRM 2.7.12 goes on to state "Private practice by participating full-time specialist must be carried out **within the premises** administered by the employing District Health Authority."

Clearly your actions continue to seriously breach your employment conditions and Option A contract in the following ways:

- Unapproved off-site private practice on public time.
- Compromised delivery of care to public patients due to delayed surgery, and allowing residents to perform procedures upon patients without adequate supervision.

I regard this as a very serious matter, and expect a response in writing within twenty-four (24) hours, to show cause why disciplinary action should not be taken by the District.

Yours faithfully

Dr John Wakefield
Director of Medical Services
MB CHB FRACGP FRACRRM Grad.Cert.Management

'JGW-L'

FILE COPY

2 August 2000

Dr Pitre Anderson
Bourbong Street
BUNDABERG 4670

Dear Dr Anderson

I refer to correspondence of 1 September 1999 and your response of 9 September 1999 wherein concerns regarding the level of your private practice commitments were raised and of subsequent agreement reached by both parties. I have recently been made aware of significant breaches of your Option A contract requirements and further allegations of clinical negligence have ben made against you.

The nature of these allegations are as follows

- That you continue to work in a private capacity at a number of private health facilities during your normal rostered hours of duty, despite previous clarification of the terms of your contract that you cease any private practice during rostered hours outside of Option A. Instances of your breaching this contractual obligation on your part include Wednesday morning and afternoon sessions at Bundaberg Friendly Society Private Hospital, and some Thursday afternoon sessions at the Mater Hospital, Bundaberg.

- You have falsified timesheets insofar as claiming payment for periods where you have not been on duty at the public facility but are performing clinical procedures at various private health facilities.

- That an abdominal retractor was removed from the Bundaberg Public Hospital by yourself for use in private surgery offsite without approval, compromising major abdominal surgery scheduled for the following day due to the unavailability of that essential equipment

- That on the 21 July 2000 a Principal House Officer (PHO) was instructed by yourself to perform a laparoscopic appendicectomy which they were not competent to perform without your required supervision. Additionally, that on the 24 July 2000, a further incident involving a forty two year old patient, wherein the PHO was again instructed to perform surgery which they were not competent to perform without your required supervision. During these two incidents, you were absent from your rostered public duties undertaking clinical work at a private health facility.

After giving careful consideration to the nature of these allegations, it appears that you may be liable for disciplinary action pursuant to section 87(1) of the Public Service Act 1996 on the grounds of misconduct for:

- fraudulently claiming payment for hours worked when this was not the case;
- breaching, without reasonable excuse, the Queensland Health Code of Conduct in that you removed equipment from the public health facility and used said official resources, without authority, for other than official purposes and,
- carelessness in the discharge of duties for neglecting to provide the necessary clinical supervision to a junior staff member directed by yourself to perform an operation for which they were not competent, potentially placing the patient/s at serious risk; and

I am required to ascertain whether there is any evidence to either prove or disprove these allegations on the balance of probabilities. Therefore, in accordance with my responsibilities detailed under section 37(2) of the Criminal Justice Act 1989, I am required to report matters which may constitute official misconduct to the Criminal Justice Commission, via the Audit and Operational Review Branch, Queensland Health, for further investigation.

Any investigation into these allegations will be fair and unbiased and conducted in accordance with the principles of natural justice.

You are entitled to, but are not required to, submit a written explanation in response to these allegations. Any such response you wish to make should be submitted to me within fourteen (14) days of the receipt of this letter.

I will advise you of the terms of reference for the conduct of this investigation in due course.

It is my belief the efficient and proper management of the District might be prejudiced if your services continue during the period of the investigation. As a result, I am immediately suspending you from duty pending the outcome of this investigation. Because these are extreme allegations, pursuant to my delegated authority under the Public Service Act 1996, I am considering that your suspension be without pay pending the outcome of the investigation. In accordance with the principles of natural justice, I am giving you the opportunity to show cause why I should not suspend you without pay from 4th August 2000. Please respond in writing within 48 hours of receipt of this letter. If you do not respond within that time, the suspension without pay will occur.

The Employee Assistance Service offers a confidential counselling service to all employees of Queensland Health / Health Service Districts and you may wish to discuss with them you situation. To make an initial appointment, please contact Mr Alan Prince.

Should you have any queries in relation to this process, please do not hesitate to contact Dr John Wakefield.

Yours sincerely

Kate Young
A/District Manager

'JGW-M'

Registrar
Medical Board of Queensland

31 October 2000

RE: Dr. Malcolm Stumer, Bundaberg Base Hospital

PRIVATE AND CONFIDENTIAL
INFORMATION TO INSTRUCT CROWN LAW

Dear Sir,

I wish to inform the Board of my concerns regarding the ability of Dr Malcolm Stumer to practice as a specialist in obstetrics and gynaecology. I seek the assistance of the Board in resolving this matter.

Dr Malcolm Stumer has been employed as staff specialist in obstetrics and gynaecology at Bundaberg Base Hospital since 1992. He was made Clinical Director in 1997 and remained the only consultant in the Family Unit, with a visiting medical officer in gynaecology, Dr Trevor Davies.

I was appointed Director of Medical Services in February 2000, and it was during the early part of 2000, that the District Manager, Mr Peter Leck raised concerns, about the number of medico-legal cases arising out from Dr Stumers practice.

Whilst I was away on leave in June/July 2000, my locum, Dr Jean Collie was approached by the Training Registrar, Dr Bronwen Byrne. As a result of the concerns raised by Dr Byrne, Dr Collie requested a review of the Family Unit at Bundaberg Base Hospital. A major part of the concerns raised by Dr Byrne related to the Dr Stumers practice.

On 6 July 2000, Dr David Little, Staff Anaesthetist at Bundaberg Base Hospital, met with Dr Collie after being involved in two cases where, he believed that, patients were subjected to serious risk of harm due to decisions made by Dr Stumer. Dr Collie requested that Dr Little put his concerns in writing, and I have attached the letter for your consideration.

Between 25 July and 27 July 2000, Dr Don Cave, Director of Obstetrics and Gynaecology Royal Womens Hospital and Ms Coralee Davies Central Zone Management, conducted a review of the Bundaberg Family Unit. No report has yet been provided to me. However, during this period, I met with the Review Team several times. Dr Cave indicated to me during these meetings that he had significant concerns regarding the decision-making capabilities of Dr Stumer, as evidenced by the following: 1) Discussion with medical and nursing colleagues of Dr Stumer who practice under his Direction, or as colleagues 2) Review of medical records 3) Meeting with Dr Stumer, at which time they felt that his thought processes appeared 'odd' with a tendency to jump from one subject to another and difficulty in following a particular line of inquiry.

On the 27 July 2000, I had a meeting with Dr Stumer and his resident medical officer Dr Lisa Copeland after a complaint had been received from Dr Copeland. Dr Stumer had seen a 20-year-old tuberosclerosis sufferer, on large doses of anti-epileptics, in the clinic. The girl was 10 weeks pregnant and had requested a termination of pregnancy. Dr Stumer had consented her and written in the chart that this was to be performed with Prostin insertion. On the day of the admission, Dr Stumer refused to perform this procedure, and put out a hospital-wide memo, that day, indicating that no abortions would be performed in the Bundaberg Base Hospital. The resident was left to look after the patient as Dr Stumer refused to be involved. At the meeting, Dr Stumer explained that he wasn't happy to perform this procedure as he thought that Dr Davies (VMO) would do it. Whilst this did not compromise the safety of the patient, it further raised doubts over the appropriateness of his decision-making.

I subsequently met with Dr Bronwen Byrne. I wished to clarify the information that she had provided to the Review Team and to Dr Collie during my absence. Dr Byrne indicated her general serious concerns over Dr Stumers practice. She highlighted this with two examples: 1) P418 . was 42+ weeks' gestation and was admitted for induction of labour. Several attempts at induction were made with none being successful. Dr Stumer sent her home, and Dr Byrne felt that this put her at risk. 2) P419 was 39 weeks gestation with twins and was delivered by caesarean section with severe pre-eclampsia. She required Intensive Care Unit therapy and was seriously ill. She had been admitted 14 hours previously with pre-eclampsia, and Dr Stumer had allegedly failed to deliver her at this stage. Dr Byrne felt that this put the mother and babies at serious unnecessary risk.

I met with Dr Stumer on 1 August 2000 and discussed with him the nature of the allegations. He denied any problems with his decision-making or his health and was determined to fight any such allegations with vigour.

At this stage, given the seriousness of the concerns raised by Dr Stumers peers and colleagues, a meeting took place on 2 August 2000 with Dr Stumer, Dr Cave, myself, Mr Lindsay Pyne (Central Zone Manager), and Kate Young (Acting District Manager). At this meeting, Dr Stumer agreed to participate in a peer assessment process and signed a letter to this effect However, Dr Cave and myself spent some considerable time discussing the issues with him, and he appeared to have little insight into the allegations raised. He agreed to leave with full pay in order to undertake a peer assessment process which has commenced at Royal Womens Hospital under Professor Khoo and colleagues. This is an eight-week process and a final assessment has been scheduled to be conducted by College Examiners. This is a voluntary program, and is not part of a disciplinary process under the Public Service Act.

I understand that Dr Stumer has now declined to undertake a peer assessment.

I learned subsequently that on 2 August 2000, his last day working in Bundaberg Base Hospital, that P420 . presented with a severe placental abruption. Dr Stumer ordered an ultrasound scan, which delayed delivery by over one hour The senior resident medical officer questioned this delay in the light of the CTG readings, which indicated foetal distress. This was documented in the chart (see attachment). The baby was subsequently born by emergency caesarean section after a severe ante-

partum haemorrhage, and was in cardiac arrest for approximately ten minutes. The child suffered severe brain damage and requires extensive care. The parents have approached the hospital requesting an explanation of the management. The Principal House Officer, Dr Barbara Cloete approached me to alert me to the fact that she had urged Dr Stumer to urgently deliver Mrs M.Z. immediately on presentation. She felt that his explanation of the need for an ultrasound 'to exclude placenta praevia' was irrelevant. Dr Cloete remains distressed by the adverse outcome, which she felt, would not have occurred if he had acted as indicated.

Other cases brought to my attention by the Family Unit staff which illustrate potential decision-making difficulties include the following:

P421 a 27 year old lady who presented with rising beta HCG without any evidence of intrauterine pregnancy. Dr Byrne was concerned about the possibility of metastatic gestational trophoblastic disease. She ordered a CT scan of the chest and abdomen, but Dr Stumer wanted to send her home and allegedly did not appear to recognise the potential diagnosis. The CT scan was performed and revealed metastatic disease in the chest. She required urgent transfer to Brisbane for chemotherapy and management by the gynaecology oncology team. Sending her home and losing her to follow-up could have had serious consequences for the patient.

P422 is a 44 year old lady who was found in February 1999 tohave adenocarcinoma in situ of the cervix. This was diagnosed from a cervical biopsy, and the disease involved the margins of the specimen. Despite being seen several times under Dr Stumers care, she did not have a hysterectomy until June 2000. This was a delay of 17 months. The report from the final histology indicated "extensive carcinoma in situ in the endocervical region". He allegedly placed the woman at serious risk by not acting on the initial biopsy results and performing early hysterectomy, in a woman of this age.

P423. is a 28 year old lady who presented to the Family Unit in June 1997 in labour. She was noted to have evidence of fetal distress at 1800 hours that day, as evidenced by a flat unreactive CTG trace. Dr Stumer was called and did not intervene. At 2200 hours, he was again called, as the CTG remained flat and unreactive. He ordered an emergency caesarean section at 2245 hours. This took placed at 2330 hours by which time the baby was stillborn and was unable to be resuscitated. There was evidence of severe chorioamnionitis at the operation. It is alleged that intervention at the first sign of severe fetal distress may have saved the baby.

P424. is a 46 year old lady seen in gynaecology clinic by Dr Stumer on 19 April 1999. She was having some dysmenorrhea and occasional menorrhagia. The GP had ordered an ultrasound, which demonstrated some mild fibroids. She was pre-menopausal. Dr Stumer booked the lady for a hysteroscopy and D&C. This confirmed the ultrasound findings. Dr Stumer then booked her for total abdominal hysterectomy. There was no mention in the notes that the lady was morbidly obese at 100kg, being 5'6" in height or of the increased risk factors associated with surgery in this case. The registrar also commented in the notes that no hormonal management of the lady had been attempted as first line. The operation took place and was associated with serious complications of wound dehiscence and small bowel fistula requiring

several further operations and a stay in hospital from 25 February to 5 May 2000. The patient complained about Dr Stumer, but subsequently withdrew. It is alleged that this case was inappropriately managed.

P425 is a 40 year old lady that delivered a still born baby in February 1995. She was seen in ante-natal clinic over a period of three months and noted to have increasing clinical evidence of severe growth retardation. When seen by Dr Stumer on 25 January 1995, the gestational age was noted to be 36 weeks. The uterine size at this stage was consistent with a 26 week foetus. Dr Stumer indicates in the records that he would "cease shared care, and repeat ultrasound scan in a week or two". P425 presented on 2 February with reduced foetal movements and was diagnosed with intra-uterine fetal death. Dr Stumer records in the notes: "I told parents I feel responsible as I did not admit on 25/1/95 for daily CTG's. Baby may have survived if a caesarean section were performed." This case was the subject of a preliminary litigation process which was not finalised.

In summary, information from several sources indicates that serious doubt exists as to the ability of Dr Malcolm Stumer to safely discharge his duties as a specialist obstetrician and gynaecologist. I request that the Board consider this matter and advise accordingly.

I must point out that to date, all the matters raised are allegations only. There has been no formal investigation or inquiry to address the allegations. It has always been my intention, and that of the District Health Service to ensure that the principles of 'natural justice' are applied and Dr Stumer is treated appropriately and with respect.

Yours faithfully,

Dr John Wakefield
MB CHB FRACGP FACRRM Grad. Cert. Management (QUT)
Director of Medical Services
Bundaberg Health Service District