BUNDABERG HOSPITAL COMMISSION OF INQURIY

STATEMENT OF DR KEITH DAVID MCNEIL

1. I, **Keith David McNeil,** Head of Transplant Services c/- The Prince Charles Hospital ("TPCH") in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

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

3. Briefly my background is as follows. I graduated in 1981. I completed specialist training in respiratory medicine in 1991. I subsequently trained for two years at Papworth Hospital in Cambridge UK, sub-specializing in cardiopulmonary transplantation, and pulmonary vascular disease. I returned to Brisbane in 1995 and started the lung transplant program at TPCH. I was head hunted back to Papworth in 1996 to run the medical side of their transplant unit, which I did for the next five years. Towards the end of 2001, I returned to Brisbane to run transplant services at the TPCH. I am currently Head of Transplant Services at TPCH which is a full time staff specialist position. Attached and marked **KDM1** is a copy of my CV which sets out further details of my qualifications and experience.

Purpose of statement

4. This statement addresses some of the issues raised in the recently published "discussion papers", and in particular discussion paper No. 6 which focuses on workforce issues concerning the roles of visiting medical officers (VMO's) and full time medical staff (FTMS).

5. This statement also takes note of the workforce issues raised in the Health Workforce paper No. 1 – "Medical Workforce" - issued in June 2005 by the Premier's office. The conclusions of this paper were that there are serious shortfalls in the medical workforce, predicted to worsen over the coming decade and beyond. It is taken as given that a viable and sustainable medical workforce is required for the health system to function effectively, and that this workforce is seriously undermanned.

Different geography requires different solutions

6. Geographical considerations in Queensland influence workforce planning, levels of service and management structures. It is self evident that the issues confronting rural and remote medical services are in many cases very different from those confronting the large teaching hospitals in Brisbane. Thus a "one size fits all" approach will be ineffective in dealing with individual / local issues.

7. The current difficulty of attracting staff to regional centres is well recognized, particularly in specialist areas of practice. The advantages of living in Brisbane are obvious, especially when considered in the light of the vast earning potential of specialist private practice in SE Queensland compared with a full time salaried practice anywhere in Queensland. In non-metropolitan areas, the balance between full time and VMO specialist staff will often be dictated simply by who is available. In metropolitan areas, the academic interests of many specialists will attract individuals to full-time staff positions.

Different specialities require different solutions

8. Different specialties require different solutions with regard to the utilisation of the services of VMO's. VMO's have chosen to work in the public and private systems to differing degrees. A VMO's priority is to provide clinical service to their private patients, and in my experience they will usually have less flexibility than full time staff to be reactive and responsive to the needs of

public patients, particularly when these needs are unplanned (as often happens in emergency situations and after hours). VMO's work extremely well in specialities where things can (mostly) run according to plan, such as in elective orthopaedics and general surgery, or medical clinics (i.e. non-acute services) where defined sessions can be worked with the chances of those sessions running significantly over time minimal. In specialties such as transplantation however, operations are usually conducted in the middle of the night. In this sort of unpredictable situation, it is difficult for VMO's to be available, as they would find it difficult to be able to provide services to private patients the following day (given that safety concerns would mandate a period of rest following the overnight work). Thus in many clinical areas, the capacity of VMO's to be flexible is limited. Another example where VMO's seem to work well is in anaethestics, where VMO's do the relatively straightforward lists and the full timers do the more complex work which requires more time, and is more unpredictable in terms of a defined finishing time. In my experience, the ideal situation in a (major) hospital would be to have a mix of full-timers and VMO's, with the proportions of each depending on the specialty and geographical issues involved. In that way there is a balanced workforce that is able to provide an efficient scheduled service, as well as retaining capacity to react to emergencies and other unpredictable clinical situations.

VMO's standard of service

9. I disagree with the suggestion that the level of service provided by VMO's is of a higher standard than full-timers. In the major teaching hospitals in Brisbane, many of the higher academically qualified, experienced and specialised doctors are full-timers. As well as providing clinical services to patients, doctors in full time practice conduct research, provide the bulk of the education and training of junior medical staff and bring in research funding. In addition, full time staff are responsible for the majority of the administrative and clinical governance duties necessary to keep the system running efficiently and effectively. In my experience, VMO's do not tend to be able to perform these additional activities because of their private commitments.

10. Full-time medical staff are a diverse group. They include staff specialists, junior doctors and senior medical officers, who may or may not have specialist qualifications. VMO's however are almost exclusively specialists, and thus it is not appropriate to compare them without qualification to FTMS in general.

Training, education and supervision

11. Training and education takes considerable effort, and when directly supervising as well, it all takes a lot of time. If the proposed "VMO model" were to be adopted by Queensland Health, the question arises as to who will do all the training and teaching of medical students, junior doctors and specialist registrars. Increased pressures would be placed on the senior full-time doctors to provide this training and education. This increased pressure could potentially be more easily absorbed in the larger teaching hospitals in the metropolitan centres but it would be nigh on impossible to address this issue in the smaller regional centres.

12. Training and education remain significant issues here and now, with inadequate resourcing for this vital activity in most areas. One option to overcome some of the difficulties in this area would be to network the training and education services out of major Brisbane hospitals. The infrastructure of the major hospitals could be used to provide services in outlying areas. Once a viable and productive service has been established it is more likely to attract trainees from regional areas. These registrars would then be more likely to return to the regional area and the service as a whole would become self-sustaining.

13. Training and education do impact significantly on the efficiency of providing a clinical service. However, if you do not put the time into these endeavours there will be no medical workforce in either the public or private sectors. There is an inevitable trade off between clinical training, teaching and education, and the efficiency of providing high quality clinical services.

VMO's productivity

14. I am not sure there is any evidence to say that VMO's are more productive or efficient than FTMS. VMO's are often very experienced and qualified and work well within the system but the same also applies to full-timers. Simply because VMO's work efficiently in their private practices does not mean they are more productive or efficient than full-time staff. Indeed, one might argue that in some cases, public medical practice offers a relief from the stress of private endeavours, particularly if a public unit is well resourced with an experienced resident and registrar staff.

Workforce makeup in different hospitals

15. Any hospital needs to make the best use of whatever resources are available, and in terms of specialist staff this includes both VMO's and full-time staff. As well as providing services for patients in both a public and private capacity, a hospital needs to ensure a sustainable after-hours roster that includes covering for staff whilst other staff are on leave. Usually a minimum roster of one-in-four is required to give the flexibility to have a sustainable service when leave is taken into account. Not every clinical unit however, has four specialists available.

16. Large teaching hospitals will inherently have more flexibility in workforce makeup due to the higher numbers of staff. In teaching hospitals it is generally easier to find a balance between providing a 9.00am to 5.00pm service that is suited to VMO's, and services in specialties that are not so suited to VMO's. Teaching hospitals often have sub-specialty services where only a limited number of suitably trained clinicians will be available.

17. Regional hospitals such as Bundaberg, Rockhampton, Townsville and Mackay have a different service focus to teaching hospitals. They have to provide a general service to meet most of the needs of most people in the community at whatever time of day or night. In these areas they generally need a skill-mix that is flexible and reactive to whatever comes through the front door. One

doctor will inevitably be unable to meet all the needs of all patients so more flexibility is necessary in terms of the makeup of the medical workforce.

18. Although the VMO's priority is running their private practice, it would of course be possible to build a service around them. However there would be a significant cost to the system. Theatre times would have to be flexible and reactive to when the VMO is available, including early mornings, late afternoons and weekends. Staffing the theatre, ward and reception to cover this can be very costly (any out of hours / weekend work incurs significant staff overtime). The VMO's are also unlikely to want to make a large contribution to the after hours roster as it will likely impact on their private work the following day.

19. Similarly, it would also be possible to build a service around full-time staff. In some ways this has the potential to improve efficiency in theatre rostering and thus minimise cost overruns. In most cases therefore, wherever it is possible, I would consider it important to have a mix of VMO's and full time staff, with that mix depending on the particular clinical service involved and the availability of both types of staff group.

20. One issue raised is how to get VMO's back in the public system and maintain their involvement. The answer is simply to accommodate their needs and requirements being mindful that their priority is to run a private practice. However, this must be balanced with the budget available and the needs of other staff groups (particularly junior medical and nursing staff).

21. The thoracic department at TPCH is run fantastically well. There are three dedicated VMO's, two part-time specialists, and 7 full-time staff specialists, the latter group doing the vast majority of the research, teaching, education and provision of super-specialty services. The department runs on budget, has submitted numerous successful business cases for new service developments, and has received a number of prestigious NHMRC research grants. One reason for this success is the right mix of VMO's and full-time staff combined

with the vision of the director who has always placed the public patients at the forefront of our service priorities.

Budget compliance

22. The budget has become a priority in hospitals. Specialists are constantly reminded about running to their budgets. When the budget is the bottom-line it puts enormous pressure on a system which has no real or obvious limit to the demands placed on it by patients. We constantly have to make clinical decisions based on budgetary considerations. This may be one reason some full-timers elect to become VMO's. Another reason for becoming a VMO is the considerable earning potential in most specialties in the private sector.

23. Generally, the public system is about penalties, not rewards. This is the exact opposite to the Commonwealth funded private sector where more work is rewarded. Bearing in mind the constraints of the budget and other resources we need to be able to do the job of providing a safe and high quality patient service. The role of the Health Department (from the Minister down) is to enable clinicians at the bedside to do their jobs to the highest possible standard, not create barriers to hinder and penalties for doing so.

Encouraging full time staff to work in the public system

24. As important as it is to encourage VMO's to participate in the public system, it is equally important for full time staff to be motivated to work in the Queensland public system. The benefits of the public system include access to teaching and research opportunities, and a collegiate workforce. The major negative limiting the public system is that resources are limited. Despite patient demands, and the desire to provide a high quality clinical service, doctors are continually being told by non-clinical staff that resources are unavailable. As a consequence they cannot provide the standard of care deemed appropriate for their patients. This becomes very frustrating. As this and other pressures mount, salaries and remuneration packages in the private sector, interstate and even overseas become more attractive - as in Victoria for

example which in some cases offers twice as much as the Queensland award. WA, SA and Vic have far better remuneration packages than Queensland currently offers.

25. We will inevitably reach a critical point (and it is not far off) where there has been such a drain on suitably qualified staff that there will be no-one to train medical students, junior house staff and training registrars (to think this training and education is achievable in any widespread and sustainable way in the private sector is naïve).

26. There is also an issue of age demographics – there are key departments relying on a certain generation of full time staff who are all close to retirement age. Workforce reform therefore needs to be looked at urgently. However, any amount of up-skilling of nursing and allied health professionals will not fill the critical gaps in the medical workforce now and into the future.

Clinician involvement in decision making

27. At TCH there are opportunities for clinician involvement in decision making at the unit, program and district levels. The District Manager is very receptive to problems and feedback. The Medical Advisory Committee (a group of senior clinicians) plays a key role in providing advice to the district executive. The key is that there is mutual respect and understanding of each others positions, between the administrative and clinical staff. In my experience, for a system such as this to be effective the critical issue is the organisations culture and the attitude and behaviours of all those involved.

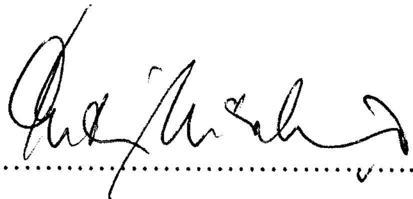
Conclusion

28. Queensland Health is facing a crisis which at the end of the day stems predominantly from a situation of chronic under funding. This has led to a steady drain of highly trained medical and other health professional staff from the public system, placing steadily increasing pressure on those that remain to meet the ever increasing demand.

29. Unless the clinical workforce issues (organisational culture, remuneration etc) are addressed as a matter of the utmost urgency, the prospects of the system meeting community expectations now and in the future are dismal.

30. Underpinning most (if not all) of these issues, is the untenable situation where health policy is seemingly determined on the basis of political expediency and the so-called "Courier Mail Test". Until our politicians stop treating health as a political football, the chances of getting the much needed (essential) long term solutions (as opposed to those aimed squarely at the next election) are equally as dismal.

Signed at Brisbane on 22 August 2005.

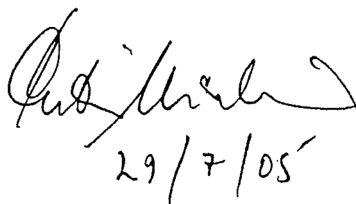


Keith David McNeil
Head of Transplant Services
The Prince Charles Hospital

KDM 1

CURRICULUM VITAE

Name:	Keith David **McNeil**
Date of Birth:	28 July 1957
Nationality:	Australian
Address:	Lot 4 Samford Road Samford QLD 4520 Brisbane Australia
Marital Status:	Married - 3 children
Education:	1. MBBS 1976-1981 2. FRACP Part I 1989 Part II January 1992 3. Medical School, University of Queensland
Learned Societies:	Royal Australian College of Physicians Thoracic Society of Australia and New Zealand Thoracic Society of Queensland Royal Society of Medicine European Society for Heart and Lung Transplantation International Society for Heart and Lung Transplantation - **2003** Director



Previous Appointments:

1.	Jan 1982 - Dec 1982	**Intern** Mater Misericordiae Hospital, Brisbane
2.	Jan 1983 - Dec 1983	**Junior House Officer** Mater Hospital, Brisbane.
3.	Jan 1984 - Dec 1986	**Royal Australian Army Medical Corp** Regimental Medical Officer 2nd/4th Battalion Officer Commanding Medical Company 2nd Field Ambulance Medical Officer 1 Commando Special Warfare Unit
4.	Jan 1987 - Dec 1987	**Senior House Officer/Registrar** Mater Hospital, Brisbane
5.	Jan 1988 - Dec 1988	**Medical Registrar** The Prince Charles Hospital, Brisbane.
6.	Jan 1989 - Dec 1989	**Medical Registrar** Mater Hospital, Brisbane
7.	Jan 1990 - Dec 1992	**Advanced Trainee / Senior Registrar in Thoracic Medicine** The Prince Charles Hospital, Brisbane
8.	Jan 1993 - Apr 1994	**Locum thoracic physician** The Prince Charles Hospital
9.	Jun 1993 - Nov 1994	**Senior Transplant Fellow** Papworth Hospital, Cambridge, England.
10.	Dec 94 - Aug 96	**Consultant Physician,** The Prince Charles Hospital, Brisbane. **Clinical Senior Lecturer** University of Queensland **Visiting Specialist** Division of Specialised Health Services, Queensland Health
11.	Aug 96 - Nov 01	**Consultant Transplant Physician** **Consultant Respiratory Physician** **Director, Pulmonary Vascular Disease Unit** Papworth / Addenbrookes Hospitals, Cambridge
Present Position since Nov 2001		**Head of Transplantation and Pulmonary Vascular Disease** **Consultant Respiratory Physician** The Prince Charles Hospital, Brisbane **Associate Professor of Medicine** University of Queensland

Publications:

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Program Committee Chairman:

- International Society for Heart-Lung Transplantation (ISHLT). Annual Scientific Meeting, San Francisco 1999.
- ISHLT Vancouver 2001

Invited Speaker (2003 - 2005)

2003

International Society for Heart Lung Transplantation (ISHLT) Scientific Meeting	Vienna	• *Satellite Symposium: Pulmonary Hypertension*
Pulmonary Hypertension Scientific Symposium	Budapest	• *Advances in the Understanding of Endothelin Receptor Antagonism (ERA)*
Thoracic Organ Failure Symposium and Australian Society of Cardio Thoracic Surgeons Annual Scientific Meeting	Noosa	• *Current Trends in Donor Management*
8th CAST	Malaysia	• *Update of Immunosuppression for Thoracic Transplantation Updates in* • *Management of Pulmonary Hypertension?*
Shanghai Respiratory Symposia	Shanghai, China	• *Endothelin and Current Management of Pulmonary Arterial Hypertension.*

2004

Thoracic Society of Australia and New Zealand Scientific Meeting (TSANZ)	Sydney	• *Quality of life in PAH.* • *Difficult cases of Pulmonary Hypertension.*
Scientific Symposium	Monte Carlo	• *Quality of life in Pulmonary Arterial Hypertension.*
Scientific Symposium	New York	• *Quality of Life in PAH - what patient's care about.*
XX International Congress Transplantation	Vienna	• *Invited plenary lecture Thoracic Organ Allocation and Distribution in South East Asia*
Asian iPEC Meeting	Hong Kong	• *Facilitator 2 day workshop on practical problems in management of patient with Pulmonary Hypertension.*

2005

8th CAST	Singapore	• *The Right Heart* • *ERA – An evidence based approach for PAH Management*

		and CTEPH.
The European Society for Heart Lung Transplantation	Wengen	• *Tricks of the Trade – A proposed guide to management of Lung Transplant Patients.*
Endothelian Receptor Antagonism (ERA) Bridging Scientific Innovation to Clinical benefits	Seville, Spain	• *PAH from the Physicians Perspective.*