STATEMENT BY DR DAVID MOLLOY FOR THE COMMISSION OF INQUIRY INTO BUNDABERG HOSPITAL

Date: 29 May 2005

Preamble

This Statement is meant to accompany the initial submission to the Bundaberg Hospital Inquiry submitted by AMA Queensland.

1. My name is Dr David Molloy and I am President of AMA Queensland. I have been President since January 2004 when I took over due to the early resignation of the preceding President Dr Ingrid Tall. My position at that time was President Elect.

   I am a specialist obstetrician and gynaecologist registered in the States of Queensland, New South Wales and Victoria. I am in private practice in Wickham Terrace working predominantly with the Queensland Fertility Group. I work in specialty gynaecology, particularly surgery and assisted reproduction. I also have a small private obstetric practice which delivers predominantly at the Wesley Hospital.

   A CV is attached with this statement.

2. The AMA in Queensland is a branch of the AMA under the national organisation the Australian Medical Association. I refer the Commission to Section 2 (subsections 2.1.1 – 2.1.3) to understand the nature of the AMA.

3. As President of the Australian Medical Association in Queensland I have an understanding of the involvement of International Medical Graduates (hence forthwith referred to as IMGs) in the Queensland medical workforce. I understand the need for integration of IMGs in the medical workforce at a Federal level and at a Queensland level. Naturally as Queensland President my expertise and involvement has been mostly at a State rather than national level.

International Medical Graduates are an integral part of the medical workforce and perform many valuable functions. It is fair to say that the Queensland hospital system would very likely collapse without the contribution made by IMGs. There are many highly skilled IMGs providing a high quality of medical care both in the private and public sectors in Queensland.

AMA Queensland has for some years however been concerned about uncertainty in the quality of IMGs who may come to work in Queensland. We have been active in this area since 2001 and in our submission to the Inquiry have provided a series of attachments (A-U) which cover our activities in this area.

Of significant import in relation to our concern about the assessment and integration of IMGs into the Queensland workforce is Attachment G (the Lennox Report).

Attention is also drawn to Attachment L, which is a letter to Mr Beattie dated 27 October 2003 from the then President of the AMA, Dr Ingrid Tall. This letter specifically warns Mr Beattie about the problems relating to IMGs (then called OTDs). In the third paragraph AMA believes the problems relating to IMGs in

fact may cause the Government embarrassment, if Queensland services provided by OTDs become the subject of public scrutiny.

4. An understanding of the normal career path for the medical workforce will assist in understanding Dr Patel's subsequent employment in Queensland.

The standard doctor in Queensland has usually attended the University of Queensland but perhaps may have another primary Australian medical degree. The normal career path will then be:

- 1 year of internship leading to full registration
- 1 to 3 years as a Resident Medical Officer (now referred to as House Officer), whilst waiting for a training job to becoming available.
- 4 to 6 years as a training registrar to become a fully qualified specialist or General Practitioner. This time as a registrar is spent mostly in the hospital sector for a specialist, and mostly in private practice for a GP.

Subsequent career pathways are many and varied. However in general terms for (a) the General Practitioner – much of their future work will be in private practice either in the city or in the country. Country General Practitioners may have posts in small country hospitals. Some will be able to admit patients and perform operations or deliver babies within the context of small country hospitals. These privileges rarely apply in regional centres but may in some centres.

(b) Specialists – Commonly many specialists used to work for a couple of years in the public hospital system as full-time junior staff specialists. This had the

advantage of providing further training and sometimes sub-specialisation. They were then frequently moved to private practice, often retaining a relationship with the hospital as a Visiting Medical Officer (VMO). In their junior years they may have had a relieving position as a VMO before receiving a full time appointment onto their hospital staff.

Alternatively many specialists may have chosen a full time career in the public health sector. Although there is a great diversity in career structure, a majority would work providing clinical services in a public hospital. Full time staff positions were generally recognised to be more lowly paid than the private staff but had the advantages of security, defined hours, after hours rosters, teaching, research, and added intellectual challenges due to the diversity of ill patients looked after in the public sector.

5. The pathway of IMGs into the Queensland workforce is more problematic. I draw your attention to Section 6 of the AMA submission to the Inquiry. There are a number of problems in relation to the assessment and introduction of IMGs into the Queensland medical workforce.

The first of these is that there is no "equivalence table" of medical schools. Any basic medical degree from any university in the world, if it can be verified to be a valid degree is accepted as being equivalent to the University of Queensland degree. Entrants to Queensland therefore have no check done on their basic medical competence. It is reasonable to suppose that there will be a significant number of third world countries which are currently supplying doctors to Queensland where there is not degree equivalence between the universities and

the University of Queensland. Despite reforms for the intended placement of IMGs in Queensland announced by the Medical Board and the Minister in parliament, this issue has not been addressed.

GPs may then enter the Queensland workforce into private practice positions provided they are working in an area of need in the Federal government District of Workforce Shortage. A District of Workforce Shortage is a classification held by the Federal Department of Health and the Health Insurance Commission, particularly for the purposes of issuing a provider number to the doctor. Many GPs will work in a cooperative practice in a semi-supervised setting but some will not. These have been of major concern to the AMA in Queensland.

Specialists may enter the Queensland workforce at a variety of levels.

A) In some circumstances a specialist's experience and qualifications may make them eligible for a Fellowship with an Australian medical college. Once this fellowship is awarded the specialist can work in private or public practice with the support of a Medicare provider number. In College terms this is obviously the ideal situation.

B) In Queensland a specialist may begin work as a deemed specialist. This means that their qualifications have been viewed by the AMC (Australian Medical Council), the Medical Board and the relevant College. Although they are not awarded a full fellowship of the College they are deemed to be able to work as a specialist in a restricted capacity under supervision, usually in a public hospital. During the time of their work they are expected to study and

prepare or undergo supervised practice in such a way that they can be awarded a full fellowship of the College and become part of the regular Australian medical specialist workforce. In general terms the deeming process works well and is adhered to. This is also a positive process for quality.

C) Doctors with variable specialist experience and training may be registered into an Area of Need, particularly in regional areas, as Medical Officers. Some with a low level of expertise may be registered as Principal House Officers (PHOs). Others will simply be registered as Senior Medical Officers and will be employed in a variable capacity in the hospital system by Queensland Health.

It is therefore important to understand the differential between someone working as a specialist and someone who is a qualified specialist in the Queensland public health system.

This last category is particularly important in terms of pay rates. The AMA will tender evidence of comparative pay rates in Australia for hospital doctors. These show that Queensland pays the lowest salaries of any State in Australia for hospital based specialists or doctors doing specialist work. The comparative rates are even worse when one realises that Queensland doctors work a 45-hour week versus a 40-hour week in other States.

However, it is in Queensland Health's interests to avoid the deeming process. In this way they get to pay doctors performing specialist work at SMO rates rather

than staff specialist rates. This can save Queensland Health $10,000 - $30,000 per position in salaries. It is unlikely to be a coincidence that the two quality pathways of ensuring standards leading to better employment conditions for the doctors concerned are mostly avoided by Queensland Health.

6. Queensland needs to import doctors because of a local workforce shortage. This workforce shortage has been contributed to by a series of poor decisions by the Federal Government in late 1980s and early 1990s. The Federal Government restricted the number of medical school places and restricted the number of provider numbers.

However Queensland Health is also chronically short of doctors because there is an international shortage of doctors.

Queensland Health is competing in an international market for doctors offering salaries in Australian dollars rather than stronger currencies. This can be seen by the submitted pay rates. It is also the worst payer in Australia.

Queensland Health therefore has a very low purchasing power in the international medical market. In many markets there is a nexus between the price of a product and the quality of the article received.

It is reasonable to argue that Queensland Health also has a poor reputation nationally and probably internationally as an employer. Problems within the Queensland public health system are well known. Many staff doctors regard their management as relevantly poor and reports of bullying are common. Clinical

autonomy has been reduced in the public sector. The core focus moving from clinical care to budget compliance with the administrators. The Queensland Health bureaucracy particularly within the hospitals is seen to be overblown with poor management accountability and poor management expertise. This is a poor environment to try and recruit doctors for the longer term and encourage them to stay in the Queensland public sector.

I am convinced that there are a number of Overseas Trained specialists of high competence in the Queensland Health system who are employed under an Area of Need classification and have moved from countries which often lower personal security for them and their families eg South Africa. I suspect also that many specialists are making second-generation choices in that they work for Queensland Health under relatively poor conditions knowing that their children will grow up as second generation Australians with full and rich choice of careers. We also have doctors who find our conditions of service, hospital and salaries, relatively attractive by third world standards.

It is my view that many of these doctors are effectively the modern version of bonded labour. Their visas and their Medical Board registration are tied to their working in an Area of Need (explained below). Their salaries are relatively poor and they have no bargaining power with their employer. Should they complain to Queensland Health about salaries, conditions or medical standards they will not be able to work anywhere in Australia except in another public sector health system and in another Area of Need. They will not be able to retreat into private practice.

7. IMGs are able to work in Australia predominantly in Areas of Need (State Government classification) or a District of Workforce Shortage (Federal Government classification). Until very recently the Medical Board registered a doctor to work in an Area of Need but there was a reasonable amount of job mobility under the auspices of the sponsoring employer. I understand that the Medical Board is now tightening its registration procedures to a specifically defined job in a specific Area of Need.

8. It is therefore understandable how Dr Patel could have come to have been working in Bundaberg. The likely pathway is that he was recruited for Queensland Health by an employment agency who presented him to the Medical Board. The Medical Board registered him for a Senior Medical Officer position in Bundaberg. Queensland Health did not choose to try to arrange entry for him as a deemed specialist. He entered an area of workforce need as an SMO. In theory at least a Senior Medical Officer should always be responsible to a clinical director of the department. There was no Director of Surgery at Bundaberg Hospital at that time. Within a very short time he seems to have been promoted from an SMO position to Director. At no stage were his surgical qualifications presented to the Royal Australasian College of Surgeons for assessment. Subsequent registration depended upon appropriate references from the hospital.

9. Other factors affecting the supply of specialist services in Queensland. The VMO workforce is a very important workforce in the Queensland public hospital system. It is the AMA's view that there has been a deliberate reduction in the VMO workforce in recent years. I draw your attention to Section 10 of the AMA Queensland submission to the Inquiry.

We believe that Queensland Health has a deliberate policy of doing away with VMOs wherever it can and employing full time staff specialists.

We believe Queensland Health's view of VMOs is that they are:

- Industrially independent
- More resistant to management extremes such as bullying
- Productive at levels usually seen in the private sector and therefore more expensive

Queensland Health's decision to replace as many VMOs as possible with full time staff specialists has been a major and significant contributor to workforce shortage and service shortages in Queensland public hospitals. This has been further exasperated by a reduction in service standards in Queensland public hospitals. Put simply, doctors do not want to work in bad systems. Doctors are therefore leaving of their own volition as they do not want to be associated with a substandard and frustrating system. This in turn creates further workforce shortages, a further reduction in standards and the loss of well trained nurses and doctors.

The impact of Queensland Health's policies has been particularly severe in regional areas. Many regional and major provincial cities had a good relationship between the public hospital and the private sector workforce. Often the entire surgical services at the hospital were provided by VMOs, often complemented perhaps by only one staff surgeon. There is no doubt in my mind that Queensland Health has had a deliberate policy of driving these doctors away from the

hospitals. They have therefore placed themselves in a position of having to employ staff specialists. As discussed earlier in this statement the prices that Queensland Health are prepared to pay for staff specialists is poor by national standards and terrible by international standards. We therefore have a workforce shortage and a drop in standards. Dr Patel was part of this scenario.

I draw your attention to other sections of the AMA submission in relation to IMGs.

10. AMA Queensland believes that the problems at Bundaberg Hospital would not have happened in a more robust health system which had better resources and better management. We believe that the Queensland Health system is:

A) Globally under-resourced. The Productivity Commission figures show that we spend $200 per head less per year than the national average. This is a spending shortfall on a recurrent basis of $700 million per year. The impact of this year after year on the total quality of the system is huge.

B) That there is inefficient use of resources by Queensland Health. The overall management of Queensland Health is poor. Management layers are excessive. There are large groups of bureaucrats whose purposes seem ill defined. Project officers abound. It is AMA Queensland's view that significant budgetary savings could be made with the introduction of a more accountable streamlined management process. Significant savings could occur. There are large numbers of generic projects in Queensland Health which seem in our view to serve no useful purpose.

C) Lack of accountability in management is interfering with decision-making. The large number of layers of management make negotiations with management time consuming and inefficient. Accountability for decision-making allows management to defer a decision. Doctors who are requesting a clinical decision often have no knowledge of where a decision is made.

D) Management is often described as difficult and bullying. There is little doubt that the culture of management has become very poor in Queensland Health. Part of the management culture has been of budget compliance rather than recognising the core business of patient care. We believe that the emphasis on budget compliance has placed a number of well meaning managers under significant stress to strengthen the bullying culture. AMA Queensland can present cases whereby it has had to act on behalf of its doctors in relation to bullying by Queensland Health management.

E) Productivity issues must be addressed. Strong arguments could be made for the introduction of a fee-for-service model for medical and para-medical groups within Queensland Health to improve productivity.

F) Workforce issues are a significant concern. We believe that many of the workforce shortages are of Queensland Health's own making, as it has made a significant number of poor workforce decisions.

However it would be possible to incentise Queensland Health to provide a better career structure for staff specialists. This would involve pay improvements at least to the level of the rest of Australia. Increased time allowed for teaching and

research would also make work more attractive and raise the overall quality in the system. I believe there is a perception amongst medical practitioners that their commitment to the hospital system and years of experience are not treated seriously by some administrators. Respect for the medical workforce would do much to achieve a stable happy productive long-term medical workforce in my view. Change in the management structure to allow doctors to be in charge of the clinical care of their patients and accountable for their medicines rather than decision-making being made by non-medical bureaucrats would also do much to incentise the system.

At VMO level the major issue is respect and working in a good clinical system. Doctors find it hard to emotionally cope with working at a high quality private hospital and then for three or six hours a week working in a demonstrably poor system where the management is incompetent. It eventually gets to a point where it is simply too tedious and not worth the trouble.

Additional issues that would attract VMOs do include better pay rates and better conditions. Minor conditions are important for VMOs such as parking. If it takes 30 minutes to travel from your rooms at Wickham Terrace to the ward at Royal Brisbane Hospital then you are less likely to make a contribution to the public hospital system. Many VMOs are senior specialists either in their city or region and often in their Colleges. I believe many feel their efforts to assist the hospital system are not regarded appropriately. The tenets for good employment of any worker at any level are respect and good manners. This is often lacking in Queensland public hospitals. AMA currently has examples of VMO positions being filled by full time staff specialists.

AMA Queensland has made a strong submission in terms of our recommendations under Section 13. We will be working with the Forster Review to try and help provide a system where those recommendations can come into force.

The bottom line for solving our workforce problems however in Queensland public hospitals is the strengthening of the medical system and the provision of high quality care for patients. Put simply doctors will work in good systems, but doctors will leave bad systems.

Dr David Molloy
Dictated: 29/5/05
Typed: 30/5/05