# Regional Medical Specialists Association of Australia

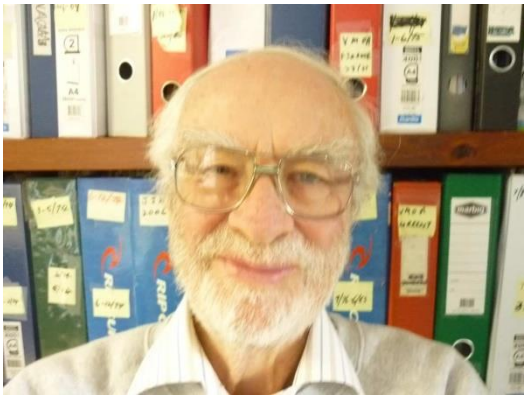
**Inaugural General Meeting**
**Hyatt hotel, Canberra and Calvary John James Hospital**
**April 6th and 7th 2018**

**Abstracts**
**7th April 2018**

## Building and running a non-profit private hospital by private medical practitioners

**Dr. Peter Hughes, Urologist, Canberra**

In November 1965 the Board of the only hospital in the ACT, Canberra Community Hospital, announced that it proposed to gradually replace the Honorary Medical Officers with salaried specialists.



I called a meeting of private medical practitioners, general practitioners and specialists, which meeting resolved that we needed a private hospital in Canberra and would try to have one built. The group approached the Little Company of Mary nuns who had the lease of a block in Barton with the specific purpose of private hospital. The nuns said that they no longer wanted to build a private hospital and were going to build a large public hospital in the suburb of Bruce.

The group approached Dr John Bain, who owned a private hospital in Penrith, just west of Sydney. He advised that private hospitals could be economically viable, if done properly.

The group then approached the National Capital Development Commission who eventually made available a block of land in the suburb of Deakin. Raising the finance proved very difficult. The doctors not only had to make personal loans to the Company but had to each give Joint and Several guarantees of the borrowings. An architect was engaged and the first stage of the hospital was designed, including 24 beds, operating theatre, radiology department and pathology. Tenders from builders were called and the successful tenderer was Buckmans of Wagga Wagga. The building was completed and opened in March 1970.

Occupancy was low initially and we sailed close to the wind financially for a while. Occupancy steadily improved and the surpluses allowed further wings to be gradually added, including more operating theatres, Day Surgery, Obstetrics and Intensive Care, with a total of 130 beds.

In 2006 the doctors' company leased the hospital business to the Little Company of Mary, while retaining ownership of the land and buildings.

In the geographically isolated city of Canberra the John James Hospital was a citadel for private medical practice during the strikes by Visiting Medical Officers in 1984, 1987 and 1993.

# Disputes between governments and the medical profession, 1941-2014

**Dr Peter Hughes, Urologist, Canberra, ACT**

A Labor federal government was elected in October 1941, led by John Curtin, with a long-standing policy that public patients in hospital should be treated only by salaried specialists. In 1944 the government passed a Pharmaceutical Benefits Act which many in the medical profession found objectionable. The Medical Society of Victoria successfully challenged the legislation in the High Court, and the government then prepared a referendum question to allow it to make laws regarding pharmaceutical benefits, and accepted an amendment by Robert Menzies to insert the words "but not so as to authorise any form of civil conscription." That referendum question was passed with the federal election in September 1946, which was won by Labor.

In June 1947 the government passed a new Pharmaceutical Benefits Act which would provide many medications free, but only if prescribed on government forms. Less than 2% of the profession accepted delivery of the government prescription forms and eventually the government had to accept private prescription forms.

The Menzies Coalition government was elected in December 1949, and introduced subsidised private health insurance, and a pharmaceutical benefits scheme which was widely acceptable to the medical profession.

I will deal with the prolonged and successful strike in NSW and the ACT in 1984-85, objecting to amendments to Section 17 of the Health Insurance Act. I will also talk about ACT doctors' strikes in 1987 and 1993, the Mildura VMO contract dispute in 1996, when the Base Hospital and Department of Health brought in overseas doctors to replace doctors refusing to sign a new, unfair contract, and the Queensland doctors dispute in 2014.

d The Hawke Labor government was elected in March 1983, and Neal Blewett PhD was appointed Minister for Health.

In September of that year he introduced into federal parliament the Health Legislation Amendment Bill, which, in Section 17 of the Health Insurance Act, amongst other things, gave to the federal Minister for Health the power to set the wording in VMO contracts in all states.

In February 1984 orthopaedic surgeon Bruce Shepherd, and the President of the NSW branch of the Australian Association of Surgeons, general surgeon Michael Aroney, set up the Council of Procedural Specialists [COPS], and called on VMOs to resign their public hospital appointments. This happened in steadily increasing numbers.

The federal president of the AMA, Dr Lindsay Thompson, told the ACT Branch of the AMA that industrial action was now indicated, so ACT VMOs went on strike, from 14 March, 1984.

The ACT strike consisted of cancelling all elective surgery, but continuing emergency and cancer services. The strike lasted 3 weeks.

In March 1984 the Victorian branch of the AMA called a mass meeting at Camberwell Civic Centre, and about 1200 doctors attended. The meeting resolved to take industrial action, and preparations were made for the strike to start on 5 April. Elective surgery lists were cancelled throughout Victoria.

Unfortunately, the meeting had given to the President of the Victorian Branch of the AMA, Dr Clyde Scaife, the power to call off industrial action if thought appropriate, and this he did, on 4 April. The plan was never revived. Thereafter industrial action continued only in NSW.

The matter was eventually settled in April 1985, when Prime Minister Hawke announced that the government would rescind its amendments to Section 17 of the Health Insurance Act if the doctors withdrew their resignations. Most returned to their hospitals, but Bruce Shepherd didn't.

He went on to be elected federal President of the AMA.

In 1987 anaesthetists in Canberra announced that they wouldn't continue with fee-for-service payments and demanded sessional payment, equal to the NSW 1985 Justice Macken Award. The Federal Minister for Social Security and Health, Brian Howe, refused sessional payment, even though sessions had been offered by Labor governments in 1974 and 1983.

The then current VMO contracts expired on 17 March and thereafter VMOs provided only emergency services to public patients in the 3 public hospitals.

Negotiations involved Labor Federal Cabinet Ministers, and the strike lasted for 8 months, led by orthopaedic surgeon, David McNicol [see slide]. The dispute was settled when VMOs were given the choice of sessional or fee-for-service payment, at reasonable pay rates, with annual indexation.

In March 1993 in the NSW Industrial Relations Commission Justice Hungerford reduced NSW VMO pay rates by $22 per hour. During contract negotiations that year the ACT Health Department sought to reduce VMO pay rates, and to abolish fee-for service contracts.

The contracts ran out in mid-November and VMOs went on strike for a month, led by gynaecologist Grahame Bates. The VMOs returned to work when promised arbitration by Justice Gordon Samuels.

As President of the ACT Branch of the AMA I was roundly abused in the media for refusing to agree that we would necessarily accept all of Justice Samuels's determinations.

He held hearings on three days in March and April, 1994, but didn't produce his Interim award until 8 months later. In that he determined cuts in VMO pay rates even more severe than ACT Health had requested. The Health Department was so embarrassed that it promptly offered a much better contract, but this was rejected by the VMOs. In early November orthopaedic surgeons, followed by urologists, had started to give 90 days' notice of resignation from the public hospitals.

ACT elections were held in February 1995, and a minority Liberal Party government took over.

Fee-for- service contracts were put back on the table, and agreement was reached, with a continuing choice of sessional or fee-for-service contracts, and annual indexation.

## Clinical Governance for Bushies

**Dr. Robert Gray, Anaesthetist, Toowoomba, QLD**


Clinical Governance of specialty practice has traditionally relied heavily on the imprimatur of the learned Specialist Colleges. Self-regulation by our profession continues to be more efficient and more effective than external agency supervision but this must be done with rigour if the process is to be accepted by government and wider society. With increased complexity in Western health care comes more regulation and more accountability. As regional specialists, we maintain a broad practice but participate in increasingly sub-specialised professional structures. General Surgeons in regional areas have been Orthopaedic Surgeons, Urologists and Obstetricians in the past and must still be Colorectal Surgeons, Breast and Endocrine Surgeons and Plastic Surgeons. Anaesthetists in regional areas are occasional Paediatric Anaesthetists, occasional Obstetric Anaesthetists and occasional Intensivists. This practice is contextually appropriate but open to criticism. The missing ingredient in appropriate accreditation of regional specialists is clinical and societal context and our new Society is uniquely positioned to advocate in this domain on our behalf. This paper will ask many more questions than it answers but crucially, will ask our new Association to engage at high level in the clinical and professional governance of regional specialists.

## SPECIAL CHALLENGES ASSOCIATED WITH THE SUPERVISION OF OVERSEAS TRAINED SURGEONS IN REGIONAL AUSTRALIA.

Adrian R. Aitken MBBS, PhD, FRACS.
General Surgeon
'Fitzpatrick House', Sale, Vic 3850
www.fitzpatrickhouse.com.au

The use of imported surgeons and other medical specialists from overseas countries to staff regional hospitals is an all too common strategy that can be seen as a cynical exercise by hospital administrators to fill rosters rather than addressing the real issues that fail to prevent medical specialists including surgeons from moving to regional areas. Many of these hospitals are only an hour or two from a major capital city and are isolated or remote and there are usually local factors that make the hospital unattractive.

Too often hospital administrators including CEOs use 'area of need' as an excuse to recruit indentured specialists from overseas who are required to undertake professional supervision under oversight by Australian specialists rather than recruit locally trained specialists who may know too much and may be outspoken.

The issues of assessment and quality assurance of surgeons and indeed other medical specialists in theory should be easy but supervision, assessment and credentialing of these foreign surgeons is a high stakes activity with huge pressures and stress for both the supervised surgeon and the RACS appointed supervisors.

Surgeons are like diamonds with their true value unable to be properly determined until they are carefully assessed and scrutinised.

Problems with all surgeons and poor standards of surgical practise have headline potential and culminate in expensive and lengthy litigation such as the Jayant Patel Bundaberg experience and diminish the discipline of surgery as a whole.

With that said there are many positives though for supervising that includes collegial fraternity, friendship, exposure to different perspectives and new ideas. The dark-side however includes unwillingness to adapt, recalcitrance, arrogance, intransigence and competitive stress. In the worst situations relationships with supervisors can devolve into threats, intimidation and vexatious notifications to regulating bodies. Difficulties can spill over and create third party problems and blow back on the supervising surgeon which can fracture the relationship between the supervising surgeon and the health service and it should be remembered that surgeons are employees of the health service, not independent service providers. This uneven power imbalance puts the supervising surgeon and employee of a health service at grave risk because there are no special workplace protections.

Given the increased reliance and demand for IMG surgeons because of inadequate planning and administration, supervision and assessment should move from a peripheral college activity performed by volunteer surgeons on a voluntary and ad hoc informal basis to core RACS business.

A range of recommendations will be presented and no doubt a robust discussion will ensue. It is time that the learned professional colleges including the Royal Australian College of Surgeons formulate more robust supervision strategies, enforce core educational and professional standards and address the reasons why the Australian public hospital system in regional areas has become so reliant on locum and imported doctors.

## A PERSPECTIVE ON THE RELATIONSHIP B ETWEEN MEDICAL SPECIALISTS AND REGIONAL PUIBLIC HOSPITALS

Adrian R. Aitken MBBS, PhD, FRACS.
General Surgeon
'Fitzpatrick House', Sale, Vic 3850
www.fitzpatrickhouse.com.au

A healthy and mutually respectful workplace is essential to the delivery of specialist medical care.

The commitment of a medical specialist whether it be specialist physician or surgeon to move to a regional area is arguably a more serious career decision and more difficult than staying put in a metropolitan hospital because it tends to be a one way route and almost impossible to reverse with almost no exit strategies except for other regional locations.

There are few incentives other than lifestyle reasons and increasingly the use of short term contracts and the lack of respect and proper ongoing support from hospital administrators ends up with the specialist being left high and dry, marooned without a contract and treated in a very disposable manner.

Many might justify and argue that short term employment contracts are used throughout the commercial environment and that hospitals should be no different but this is just wrong because the gestation time of medical specialists is long and the acquisition of expertise and the delivery of that expertise to a community can only flourish in a stable supportive workplace.

Hospital administrators might argue that this is what they deliver but the use of management strategies such as revising and offering un-signable contracts including micro-management techniques is really just governance camouflage. The reality is that employed public hospital specialists are treated more like a serf in a feudal system where specialists give over their Medicare billing to the hospital in return to be an employee. The legally of signing over Medicare earnings to the hospital is debatable and the morality of this is problematic and questionable.

The perspective that will shared in this meeting is a personal horror story involving manipulation, coercion, blackmail, threats of physical violence, theft and malfeasance.

In many ways it might be a better solution in the current regional hospital workplace environment for medical specialists including surgeons to stay in metropolitan areas and create a coalition of willing participants to deliver services only on an outreach basis rather than put all their eggs in one basket and end up losing the lot if treated roughly without workplace protections. Another alternative might be for medical specialist including surgeons to rally together and create a block to contract specialist and services to public hospitals and withhold labour to those hospitals behaving and performing poorly.

It is time to formulate a better strategy for medical specialists as a total workforce group ather than accept ad hoc solutions and to learn the lessons of those brave enough to move to regional areas and have unsatisfactory and damaging experiences.

**VMO Contracts, ? Casual Employment.**

**Peter Hughes, Canberra, urology.**

Following strikes by VMOs in Canberra in 1987 and 1993 the pay rates and conditions in ACT VMO contracts were reasonable. From 2003 to 2016 VMO contracts were available for 3 or 7 years. The 3-year contracts stated that during those 3 years the VMO's workload could not be reduced involuntarily. In the 2013 and 2016 contract negotiations and arbitration the security of workload was removed. The relevant clauses of the contract now read :-

"Schedule 2

Setting and varying of workloads

1[b] ii) The Territory will give the VMO at least 3 months' notice (or a lesser

Period if agreed) of its intention to reduce the number of operating

Room lists or sessions allocated to the VMO but may only do so if the

Reduction is directly related to:

1. The VMO's availability;

2. The VMO's past utilisation of their allocated operating room

Lists or sessions for Public Patients;

3. Any changes in the number of specialists operating within the

Specialty;

4. Where applicable, the total waiting list for the specialty and

The proportion of the total specialty waiting list represented by

The VMO's individual waiting list;

5. Any changes in medical or dental technology that has or will

Impact on the requirement for operating room or sessional

Time during the year; and/or

6. The operational needs and service delivery needs of the

Relevant Health Facility or the Territory including the effective management of waiting lists."

This means in effect that that on 3 months' notice the Territory can reduce a VMO's workload to nothing. What is the experience in other Territories and States?