Special Commission of Inquiry into Healthcare Funding

Statement of Dr Robert Davies

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Inquiry**) as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role. The statement also responds to matters raised in the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the Director of Emergency Medicine at Tweed Valley Hospital (**TVH**), Northern New South Wales Local Health District (**NNSWLHD**) and I have been in this role since 2011 (previously, The Tweed Hospital). This is a network position overseeing the Emergency Departments (**EDs**) of TVH, Murwillumbah District Hospital (**MDH**), and Byron Central Hospital (**BCH**). In my role, I lead a team of approximately 100 medical staff.

4. I was previously the Deputy Director of the Emergency Medicine for five years. I have been the Vice Chair, and subsequently co-Chair of TVH's Medical Staff Council (**MSC**) between 2010 and 2023. I was heavily involved in the development of the TVH as a result of my role with the TVH MSC. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0539.0001**).

B. ED PRESENTATIONS

5. At TVH, MDH and BCH, we provide treatment to approximately 100,000 ED presentations annually.

6. TVH ED opened in May 2024 and is expected see around 60,000 presentations per annum. Approximately 20% of ED presentations to TVH are currently from Queensland, a figure which has declined over the years.

7. BCH ED has seen a steady increase in presentations over the past 6 years from approximately 17,000 in FY2017 to 23,000 in FY2024.

8. MDH ED has had a more dramatic increase from 17,000 presentations in FY2022 to over 20,000 presentations in FY2024. MDH now frequently receives over 70 presentations per day as opposed to 50 presentations per day last year. This is a result of the loss of rural status when its Modified Monash Model (**MMM**) classification changed to MM1 under MMM 2019, and subsequent reduction in local General Practitioners as rural loading and incentives were no longer available, and also due to the population increase post-Covid. As a result of this increase in presentation numbers, we have had to increase our staffing levels in the ED from 5 to 7 doctors per day.

C. WORKFORCE

9. TVH ED has 76 full time equivalent (**FTE**) medical staff. This year we have required 2 to 3 FTE of locums, which has been avoided in prior years, as a result of the deficit of Junior Medical Officers (**JMOs**), discussed further below.

10. BCH ED has 15 FTE medical staff, of which from September 2023 6 FTE are locums.

11. MDH ED currently has 14 FTE, of which 6 FTE are currently being filled by locums.

(i) Medical Students

12. TVH supports medical students in years 3 to 4 (clinical years) from Bond University and Griffith University, located in Queensland. Whilst these universities are geographically close to TVH, once the students finish their training, most of them accept positions in south east Queensland.

(ii) Interns – Post Graduate Year (PGY) 1

13. BCH and MDH are not accredited to take JMOs – Postgraduate Year (**PGY**) 1 and PGY2.

14. There has been a major shortfall of interns (PGY1) recruited for TVH in 2024, with 14 positions unfilled.

15. A challenge for recruiting interns at TVH is the following:

    a. an overall reduction in supply of interns;

b. as interstate applicants, Queensland medical graduates (where the medical students we clinically train have studied) are prioritised lower than NSW graduates; and

c. more favourable pay conditions in Queensland.

d. NSW Medical Graduates applying for a rural or regional intern position have to complete a 4000 word essay. Applications for metro hospitals requires ticking a box.

16. For the 2025 intern year, TVH currently has all its positions filled.

(ii) International Medical Graduates (IMGs)

17. IMGs are doctors whose medical qualifications were obtained from a medical school outside of Australia. IMGs are generally classified as RMOs (PGY2) or Senior RMOS (PGY3+) (**SRMOs**). They must obtain non-specialist general registration to practice medicine in Australia by the competent authority pathway or through the standard pathway.

18. Five countries are recognised as competent authority pathways in Australia: the United Kingdom, Canada, the USA, Ireland, and New Zealand. If a candidate holds a medical degree from one of those five countries, then they are required by the Australian Health Practitioner Regulation Agency (**AHPRA**) to undertake 12 months supervised training in Australia. Upon completion of that training they can apply for general registration.

19. IMGs who became medically qualified in countries other than the five referred to above are required to undertake the standard pathway to obtain general registration. The IMG must pass the Australian Medical Council (**AMC**) Computer Adaptive Test (**CAT**) Multiple Choice Question (**MCQ**) exam, secure a position with an AMC accredited authority and complete at least 12 months of supervised practice at the AHPRA approved placement, and pass the AMC clinical exam to receive an AMC certificate. The AMC exam has a 20% pass rate. It is not uncommon for doctors to take a number of years and repeated attempts to pass the AMC exam. Based on my experience the AMC exam, which is an eight-hour virtual exam which costs each applicant more than $4,000 per attempt, is not a reliable indicator of clinical competence or capacity to undertake the role of a doctor in an ED.

20. Further, in my clinical experience, I have perceived that for doctors who have not been medically trained in English, starting work in the Australian system places an immense cognitive load on them as they try to translate back and forth from English to their native language. They have to then learn to think in medical English, as well as learn the Australian medical system whilst also trying to integrate into a new facility and position. This creates great inefficiency at work and an enormous amount of stress for the doctor. As a result, I observe that IMGs who are medically trained in a language other than English generally require at least 6 to 12 months of intensive supervision before they can become efficient and therefore productive in an ED.

21. The supervision requirements for IMGs undertaking the standard pathway is onerous and can have a detrimental impact on the quality of care we can provide patients if the supervision and the IMG are not adequately supported. Standard pathway IMGs typically start with AHPRA-imposed requirements for level 1 supervision. This means all patients must be reviewed by the supervisor. Typically, this requires the supervisor to start afresh with the patient and go over all the details. The supervisor will then need to instruct the IMG in what needs to be done and the reasons why. It is usually far quicker for the supervisor to see the patient from the start without the IMG. Thus, involvement of the IMG reduces the efficiency of the ED rather than aiding. As the IMG gains experience in the system and familiarity with medical English they require less instruction and become more efficient in processing information, eventually reaching the point where they become a net gain to the system. This typically occurs around the six month mark for IMGs in the ED which is accepted as an area of high supervision. Outside of the ED this process may take longer with less direct guidance.

22. The current funding system treats standard pathway doctors in the same way as PGY1 and PGY2 JMOs. Accordingly, there is no recognition of the resource expenditure involved in taking on standard pathway doctors who have not been medically trained in English. IMGs are placed into the same medical positions as PGY1 and PGY2 JMOs. The result of this is reduced efficiency, increased risk of errors, and increased levels of supervision. This puts strain on other doctors especially Registrars and Consultants who have overall responsibility for patient care.

23. A solution to this problem would be to employ IMGs undertaking the AMC standard pathway for 6 months supernumerary to assist them learn the medical system and language before undertaking 12 months of supervised practice. In a similar way some countries, for example, New Zealand offers a pre-intern year. Larger metropolitan

hospitals could provide 'pre-internship IMG training' allowing IMGs to then apply for vacant RMO positions. This would make it safer for IMGs to take up positions in rural and regional hospitals. Larger regional hospitals could do the same with support. This means additional FTE funding for such supernumerary places.

24. Recruitment of IMGs reduces our reliance on locums. Locums come at a cost and their effectiveness and efficiency are variable and generally less than doctors at similar levels.

25. NNSWLHD is also in the process of establishing the Workplace Based Assessment (**WBA**) pathway for IMGs undertaking the standard pathway. This pathway would replace the requirement of having these IMGs undertake the second clinical exam. This year, Lismore Base Hospital implemented the WBA pathway, with six IMGs undertaking the pathway. At TVH we are intending to establish 2 WBA positions in 2025.

26. Establishing the WBA pathway will be attractive to IMGs because of the low pass rate of the second AMC exam, whereas the WBA is a continuous assessment pathway. I understand that hospitals that offer a WBA have waitlist for their programs, and offering the WBA pathway will make NNSWLHD more competitive in recruiting IMGs.

(iii) Resident Medical Officers (RMOs) – PGY2

27. Last year, TVH lost ten PGY2 doctors who accepted positions at facilities operated by Queensland Health because of more favourable incentives in Queensland. For example, a $10,000 sign on bonus, a further $10,000 if they complete the entire contract term, and higher overall salary.

28. These vacancies were attempted to be filled with IMGs. Due to delays associated with recruitment, the IMGs could not be recruited in time for the start of the new medical year in February 2024. Accordingly, locums were engaged to fill the gaps.

29. A further challenge is that the NSW JMO recruitment campaign, coordinated by NSW Health -, operates later than all other states. Importantly for NNSWLHD, it is around six weeks behind Queensland, meaning we cannot compete for JMOs who have already accepted jobs in Queensland.

30. A practical solution would be to align NSW's statewide recruitment of JMOs with other states, so that NSW can compete for interstate JMOs. This is particularly important for border regions but also for the whole state.

31. An earlier NSW JMO campaign would also better support the onboarding of IMGs whose visa and AHPRA requirements make onboarding a protracted affair thus delaying the start of these doctors commencing work and resulting in increased use of locums.

(iv) PGY3+, unaccredited / accredited vocational training

32. For the 2024 medical year we needed to recruit 26 SRMO (PGY3+) positions. These were subsequently filled with 16 IMG standard pathway doctors because there was a shortage of Australian and Competent Authority pathway applicants.

33. Our Registrar/Trainee positions were filled by unaccredited and/or PGY4 junior Registrars. Our trainees come almost exclusively home grown from our SRMO ranks, and are mostly UK trained IMGs.

34. Some specialty training programs are integrated into Queensland while others are from NSW. We are deficient in accredited positions. We get circumscribed numbers from training networks but not enough to fill the workload. For example, in Orthopaedics we currently have one accredited and six unaccredited positions. In Medicine, we have 8 accredited and 4 unaccredited positions.

35. However, in anaesthetics, all TVH Trainee positions are filled by accredited trainees rotating to TVH from south east Queensland.

(v) Senior medical staff

36. The TVH ED has a strong culture of supervision, and we were the best performing regional ED in 2022 to 2023. We have won the Australasian College for Emergency Medicine Fellowship prize three times in the last six years.

37. The TVH ED is staffed by Visiting Medical Officers (**VMOs**) and there are no Staff Specialists despite positions being advertised as either VMO or Staff Specialist positions.

38. There has been a continued exodus of newly recruited Staff Specialists because of the inadequate Award remuneration and conditions in NSW compared to Queensland.

D. ACCESS TO TERTIARY SERVICES

39. Tertiary services for NNSWLHD patients are almost exclusively sought from Queensland hospitals, who are increasingly reluctant to take NSW patients. I am aware Gold Coast University Hospital (**GCUH**) switchboard has standing orders not to transfer calls from

NSW doctors to certain specialities. I understand GCUH's capacity issues lie behind that policy. we have had spinal injury patients refused care and were told by specialists at Princess Alexandra Hospital to send these patients to Sydney for tertiary services.

40. Up until 2020, we had a Cross-Border Committee which saw our executives and some clinicians meet with their Gold Coast counterparts every 3 months. During those Committee meetings, members would discuss problems and pathways for patients with the mutual goal of ensuring patient flow between facilities. This Committee is now starting up again, which is a positive step to building relationships and managing patient flow for patients requiring tertiary care.

41. Another solution is to increase funding for TVH to develop its tertiary services. For example, interventional cardiology, interventional radiology, and vascular surgery. This will also have the effect of helping to retain junior doctors due to the associated increased availability of training.

Dr Robert Davies

Witness: BEVERLY HOWELL-THOMAS

16/9/2024

Date

16/9/2024

Date