PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE USE OF VISITING MEDICAL PRACTITIONERS IN THE WA PUBLIC HOSPITAL SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT THE GROUP ROOM, THE REGIONAL HOSPITAL, ALBANY
THURSDAY, 22 NOVEMBER 2001

THIRD SESSION

Members

Mr D'Orazio (Chairman)
Mr House (Deputy Chairman)
Mr Bradshaw
Mr Dean
Mr Whitely

HOLMES, MR ALISTAIR,
examined:

The CHAIRMAN: Welcome. The committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the details of witness form?

Mr Holmes: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

Mr Holmes: Yes, I do.

The CHAIRMAN: Have you received and read the information for witnesses briefing sheet regarding giving evidence before a parliamentary committee?

Mr Holmes: Yes.

The CHAIRMAN: Please state the capacity in which you appear before the committee.

Mr Holmes: I am a surgeon at the Albany Regional Hospital.

The CHAIRMAN: Have you made a written submission?

Mr Holmes: I have.

The CHAIRMAN: Do you have any amendments to it?

Mr Holmes: I may expand on it a bit.

The CHAIRMAN: Is it your wish that we incorporate your submission in the transcript of evidence?

Mr Holmes: Yes.

The CHAIRMAN: Do you want to add to your statement?

Mr Holmes: I do not know whether the committee is interested in sessional payments.

The CHAIRMAN: Absolutely.

Mr Holmes: I pointed out that, from my point of view, which is why I am here, sessional payments to rural specialists are not tenable. They may be okay in other situations. I am speaking only for myself. The reason is that the expenses involved in running a practice are substantial; whereas that may not apply to someone who does a session in a teaching hospital in the city but who derives his income from his private practice. In Albany, there are essentially no private hospitals; that is the big difference.

The CHAIRMAN: Do you have private rooms out of the hospital?

Mr Holmes: Yes, that is the crux of the matter. My expenses are all private expenses involved in having rooms such as rent, secretaries, etc.

The CHAIRMAN: Is there no income from that?

Mr Holmes: There is a very small income from seeing people there, but probably 80 per cent of my income derives from operating on public patients in the public hospital, which would be the opposite to someone in a teaching hospital whose income largely derives from their private hospital income.

The CHAIRMAN: Is there no private hospital here?

Mr Holmes: There is no private hospital. There are a few private patients in Albany obviously, but it is a very small percentage.

The CHAIRMAN: Do you see many private patients? Statistically, 30 per cent or so are privately insured. You are saying there is a very small number of private patients. Is that because of the gap between private insurance and the fees charged, or is it that people choose to be public patients?

Mr Holmes: I do not think 30 per cent of patients in Albany are private patients. I do not know what is the percentage, but it used to be more like 16 per cent. People who have private cover often choose to go to a private hospital in Perth. If they are paying a lot of money for their private insurance, they will choose the up-market comforts of a private hospital. They may also have taken out their private cover so they do not have to come to the local hospital. It may be a matter of privacy or whatever if they choose to go to Perth privately rather than come to a private room in the local hospital. I cannot tell you exactly what my percentage of private patients is. It is more like perhaps 10 per cent. It is a very small number. I do not know that I fully understand what you are asking in your second question. Some people who have private insurance will opt not to use it for relatively minor operations on the ground that they often have excess to pay, not so much the gap. They may have a policy that is discounted if they do not use it, but if they do use it they must pay the first $500.

The CHAIRMAN: How extensive is that? This morning is the first time we have heard about that.

Mr Holmes: I cannot answer directly, but I know it happens frequently. A patient may say that rather than paying $500 out of his pocket he only wants a relatively minor operation, which he knows he can have done next week as a public patient in Albany. They do not use the private cover they have because they want to keep it for a major operation at a teaching hospital.

The CHAIRMAN: When you see patients in your rooms, you obviously see them as they come to you then you refer them here to the hospital to have their operation. Is there a component of salary for your offices as well as the fee for service?

Mr Holmes: Yes. I get a consulting fee.

The CHAIRMAN: That is not part of that. As was indicated to the committee, many of the charges under the fee schedule for surgeons are for the whole process from start to finish.

Mr Holmes: No, if I see them in my rooms, I get a consulting fee paid separately. That is part of my income, which is nothing to do with the hospital. When they have an operation in the hospital, there is a schedule fee for the operation, which almost always covers the whole of the post-operative care. I might see them every day for a week, but that is all part of that one fee for the operation.

The CHAIRMAN: Do you think the fee-for-service arrangement is an incentive to work in the community like this? It was pointed out to the committee yesterday that having salaried surgeons causes a drop in productivity. For example, they will see six patients on a fee-for-service basis, but, if they are going to get paid for four hours, they are more likely to choose to see two patients.

Mr Holmes: I think we should have fee for service in the teaching hospitals. It would be much more efficient. It would be my income, so, if I were going to be paid for six cases rather than two, of course I would do six. I like not having a waiting list, as occurs here.

The CHAIRMAN: I am glad you said that, because we asked that same question of the hospital and we were told that there are waiting lists. Are you saying the hospital does not have a waiting list?

Mr Holmes: There are no waiting lists for general surgery. I am booked up next week, but after next week nobody is waiting. There is a waiting list for orthopaedics and plastic surgery. We do

not have a resident surgeon. However, we have two surgeons here plus a GP surgeon. None of us has any waiting lists.

The CHAIRMAN: Are you on call? Are you the only surgeon here in town?

Mr Holmes: No, there are three surgeons.

The CHAIRMAN: Are they all specialists?

Mr Holmes: No. Dr Lubich is a GP surgeon.

The CHAIRMAN: Are you on call as a surgeon for the hospital and outpatients?

Mr Holmes: I used to be. I am not at the moment.

The CHAIRMAN: Do you not do after-hour call-outs?

Mr Holmes: Not any more.

The CHAIRMAN: Why is that?

Mr Holmes: I had a disagreement with Mr Symes almost 12 months ago. As members know, a new contract was brought out and we were offered a one per cent pay rise if we did not sign the contract, which was supposed to reimburse us. I felt that was a very derisory increase in pay. No rise has been awarded for about five years; in fact, my income was decreasing relatively. I have been here 18 years. Having been on call for 17 years, I got very upset and said I would not do it any more because I was not being paid for it. So I am no longer on call.

Mr BRADSHAW: Was there no allowance for consumer price index or anything in the previous contract?

Mr Holmes: I am not sure I can answer that exactly. The schedule increased from time to time. It was never linked to the CPI to my knowledge.

Mr BRADSHAW: Were there increases over that five years?

Mr Holmes: Not, none at all.

Mr BRADSHAW: I thought you said you did get one.

The CHAIRMAN: What about the 1996 agreement that obviously everybody has been working on?

Mr Holmes: That had not increased for five years. When the hospital said it would increase it, it was by one per cent. I felt very upset about it. It was like a slap in the face. As I said, I have been here a long time. The three of us provided cover 24 hours a day, seven days a week - Christmas day, the works - for nothing, and I thought it was not on.

The CHAIRMAN: The agreement you are talking about is a generalised agreement, as was the one in 1996. It covered the whole of the State, so it did not pick up circumstances such as yours. You were the only surgeon and had been on call all the time. That previous agreement applied across the board. Numerous people have said that it was not appropriate for their circumstances, whether it was one of the hospitals in Perth where there can be six knee reconstructions and a hip replacement in a row. There are economies of scale. The surgeon does not have to come back. He is still paid the same fee and vice versa. In your case, it would be only one procedure for the same amount of money. That is all worked into the formula. Are you suggesting to me now that it is better to have an arrangement at each hospital negotiated directly with the surgeon at the location rather than to have a generalised agreement, which is what has been in place?

Mr Holmes: Originally, the idea was that we could negotiate an agreement, which would take into account those factors. As a surgeon, I would often be on call and no-one would call me. I might be on call for four days in a row over a weekend and, if nobody was sick or needed an operation, I

earned no income. However, I would have to stay at home, not go out fishing or whatever, without any recompense. I did that for 17 years and I felt it was a bit unfair.

Mr WHITELY: Since that arrangement lapsed, has your level of surgery changed at the hospital?

Mr Holmes: No, not really.

Mr WHITELY: How do you get the patients to operate on? Do you refer them to the hospital and then operate on them yourself, or do you get referrals from others? Are you continuing to get referrals?

Mr Holmes: All my patients are referred from GPs.

Mr WHITELY: Has that pattern changed since you have been not been on call?

Mr Holmes: No, not at all. I do not get called in the middle of the night any more because everyone knows I am not on call. If there is an emergency in the middle of the night, I am told in the morning. To my knowledge, only one person was flown to Perth because I was not available.

The CHAIRMAN: I do not want to talk about your figures, but we have them. In the 12 months since you stopped being on call, your fees have increased by five per cent. Does that mean you are not doing emergency calls any more, but you are doing more work during the day?

Mr Holmes: Yes, I think that is true. I have also been doing more complicated operations, and they attract a higher fee.

The CHAIRMAN: Why all of a sudden this year, since you stopped being on call, are you doing more complicated surgery?

Mr Holmes: I think it is coincidence. I cannot say there is any particular reason for that.

Mr DEAN: If someone first appears as a private patient, there is potentially a gap in the fees paid. I heard some mutterings that the hospital is paying that gap. Is that true?

Mr Holmes: Are you referring to private patients?

Mr DEAN: Yes.

Mr Holmes: I would not think the hospital had anything to do with it. I am not great on how my billing works, but I would say that if it were a private patient my account would go to him without the hospital being involved.

Mr DEAN: I agree, but I heard that the hospital was paying that gap. That is fine if it is not your area of expertise.

Mr Holmes: I have never heard of that.

The CHAIRMAN: Are you suggesting that there should be two fee scales, one for country rural specialists and one for metropolitan specialists?

Mr Holmes: No, but some consideration could be given to the particular problems we face in the country. For example, doctors do much time on call, which is often not paid. It was suggested I be paid a retainer, but that has gone by the board. It would have involved being paid something for being on call and, if I were called in, I would not receive both the retainer and the fee. If the retained was $300 and I earned $300 from taking out someone’s appendix, I would not receive $600, just the $300. If I stayed at home and twiddled my thumbs, I would get the $300 for staying at home.

The CHAIRMAN: Under the current arrangements, are you as busy as you could be; in other words, is your week full?

Mr Holmes: Not at all. I do all the work that is referred to me, which takes up about three and a half days a week. I cannot do any more work, because there is no more work available. There is no waiting list. The work is all done, and that is it.

Mr BRADSHAW: Should we not be sending some people from Perth?

The CHAIRMAN: That comment was made yesterday. Kalgoorlie has the same problem with spare capacity.

Mr DEAN: Just going back to the retainment issue; would you accept that as a viable alternative?

Mr Holmes: Yes, I think so.

The CHAIRMAN: Would you consider a salaried doctor's position?

Mr Holmes: No.

The CHAIRMAN: Why not?

Mr Holmes: It would not pay me enough.

The CHAIRMAN: Your private practice represents 10 or 15 per cent of your work. With all your overheads and so on, you would appear to be far better off on a salaried officer's rate than your current rates, would you not - not that I want to tell you what others are generating?

Mr Holmes: When you say "salaried", would you include having a suite of rooms in the hospital with a secretary, receptionist and typist?

The CHAIRMAN: Absolutely.

Mr Holmes: I would not have any private expenses?

The CHAIRMAN: You would not have any of those on-costs.

Mr Holmes: I would have to look at that and see.

The CHAIRMAN: Even if you worked at 40 per cent of the current rates for on-call specialists, which it has been indicated would cost the hospital somewhere between $300 000 and $400 000 a year, from the numbers in front of me, it would appear to be more favourable to you to have a salaried officer's position, in which you would be on call and only do what is needed for the hospital, especially as you are not doing any call-outs anyway. You may be against it on principle, but that is different from what the numbers show.

Mr Holmes: If I were a salaried surgeon here, what would happen to the private people?

The CHAIRMAN: If they represent only 10 per cent of your work, obviously you could come to some arrangement with the hospital.

Mr Holmes: I will have to give that some consideration.

The CHAIRMAN: It is just that your income is relatively low in comparison with what some surgeons are getting from the VMP service.

Mr Holmes: That is the problem. My expenses are probably the same; in other words, they are paying the same for a secretary, the rent and rates and so on.

Mr BRADSHAW: Do you work in your surgery on your own or do you have other doctors with you?

Mr Holmes: I am on my own.

Mr BRADSHAW: What sort of staff do you have, if it is not a rude question?

Mr Holmes: I have one full-time receptionist-secretary.

The CHAIRMAN: That is interesting. Yesterday we heard that someone had four full-time staff.

Mr Holmes: Some guy!

The CHAIRMAN: His office expenses are double the amount you are currently taking out of the system. That is the comparison. The specialist was saying that even though the brain surgeon at Royal Perth Hospital is on $130 000, that equates to $350 000 to $400 000 with all the on costs.

Mr Holmes: I take your point.

The CHAIRMAN: In your case it would seem much more acceptable to be in a salaried officer's position, maybe from both perspectives.

Mr DEAN: Do you have any peer pressure from other surgeons because of your refusal to do on-call work?

Mr Holmes: No, not at all.

Mr DEAN: They have accepted your decision. Have they thought about it as well?

Mr Holmes: Yes. I think the feeling is widespread, not merely for specialists, but more particularly so. The general practitioners have been very supportive as well, because they are still referring patients to me, just as before and maybe even more so. They think that I have taken a bit of a stand on this. They realise that being on call as a general practitioner is quite different from being on call as a specialist. A general practitioner on call on a Sunday will be flat out. The have a roster system, so one general practitioner might be covering six or whatever. They will be flat out, and making quite a lot of money, which obviously means that a general practitioner does not mind being on call because he has made, say, $1 000. As I said before, if I am on call I might not make a penny. That is the nature of things.

The CHAIRMAN: Has the hospital worked with you to try to get some more private patients into the system and look at ways of, not so much getting rid of the gap, but taking it out of the equation? It would be in your interest as well as that of the hospital, because it would take the funding out of the private system and put it back into the public system. If a private patient comes to this hospital, the State Government must pay the costs, and the private funds get away without paying what legitimately should have been their expense. Has there been any discussion about that?

Mr Holmes: Not to my knowledge, no. The hospital in general has tried to encourage private patients by making private rooms more satisfactory, but I do not think that has actually achieved anything. A private room in Albany Regional Hospital is nothing like a private room at Mount Hospital.

The CHAIRMAN: I was thinking not so much of a private room. One of the usual problems is that the patient is faced with the gap. The State must pay the whole amount anyway, not just the gap. If a compromise could be reached so that the gap could be reduced, more private patients in the system would take the pressure off public funds, would they not?

Mr Holmes: You asked the same sort of question before. I am not aware of that at all.

Mr HOUSE: Did I correctly hear that you work three and half days a week?

Mr Holmes: Yes.

Mr HOUSE: Has that been since you went off call?

Mr Holmes: No, it has been ever since I have been here.

Mr HOUSE: That is very unusual in the sense that most people in your position who have appeared before the committee are so loaded up that they are complaining about the hours and the intrusion into their private lives, and the obvious stress and that things that go with that, which we all accept. That was the evidence from Kalgoorlie for example. I am just a bit surprised at your position, that is all.

The CHAIRMAN: In Geraldton we were told the surgeon worked 80 hours week.

Mr Holmes: Is he very slow?

The CHAIRMAN: If you have a look a the salary he gets, you would not think so.

Mr Holmes: I think it is merely a question of the workload. I have two operating sessions here a week, which are full most of the time. They are never overfull. Very seldom do I have to ask for

an extra session or an extra bit of time because I have a patient who cannot wait. It happens very occasionally because if someone needs urgent attention, other people can wait for a week and then be operated on anyway.

Mr DEAN: How many operating theatres are there here?

Mr Holmes: There are two.

The CHAIRMAN: Would it be feasible to have a roster system? You are working three and a half days a week. It there were a salaried officer, the Department of Health must benefit by being able to switch someone to where there is a demand and they cannot get someone. A couple of hospitals have pressure on them.

Mr Holmes: I like living here.

The CHAIRMAN: I know, but is it feasible to do, say, one day a week somewhere else?

Mr Holmes: I would not really think so, because of the travel and post-operative care. Generally, it is not a good idea to fly in, fly out. A number of people here, as you know, fly in. We like them to stay for a couple of days post operation. That usually works in quite well. They will operate one day, and have couple of days seeing patients, or a Saturday or something like that. They will make sure that everybody is okay and then go back to Perth. We are not very happy with people who fly in in the morning and then fly out at night, and just leave everybody for someone else to look after.

Mr WHITELY: If you were to have a salaried position, do you think you would do three and a half days work in five days?

Mr Holmes: Yes. There is no more work to be done. When the work is done I go home.

Mr WHITELY: Would you work slower?

Mr Holmes: I could not work slower, because that would hold up the theatres and so on.

The CHAIRMAN: It is unusual that there is spare capacity.

Mr Holmes: One of the things that has perhaps made a slight difference is that over the time I have been here, the hospital has had an increasing number of visiting specialists. We now have a fair range. Some of those specialists to some extent have taken work away from me. As you say, my income has gone up, but the number of cases has probably gone down slightly.

Mr DEAN: There are three surgeons here, are there not, as opposed to the position in Kalgoorlie and Geraldton? You are one of a team of three, are you not?

Mr Holmes: Yes. There are two full-time surgeons, and then there is Dr Lubich who is a general practitioner-surgeon.

Mr DEAN: Are there any other general practitioner-surgeons?

Mr Holmes: No. The are two and a half surgeons, as it were. The point is that Dr Lubich is extremely good, but he does not do major surgery. He does a slightly lower level of surgery, which everyone is happy with.

Mr DEAN: Who is the other surgeon?

Mr Holmes: John Treanor.

The CHAIRMAN: Does he also have a reduced workload?

Mr Holmes: Yes.

The CHAIRMAN: Is he not full time?

Mr Holmes: He would do almost exactly the same as I do. I do not know what his income is, but he has two sessions a week and roughly the same workload.

Mr DEAN: He does about 20 per cent less work.

Mr WHITELY: One of the problems that other country locations seem to have is that they cannot attract surgeons, because people do not want to live there. Albany is a little different, because you have said that you want to live here. I imagine that it does not have the same difficulty in attracting people. Is that true?

Mr Holmes: Yes. I think it really has a problem if there is one surgeon. We used to have one orthopaedic surgeon. He was on call every night of the week. We used to have a gynaecologist - an obstetrics and gynaecology specialist. The same thing happened. He was on call all the time. Both of those people have now gone to Perth. I know one of them does not do any on-call work in Perth. His life has change hugely.

Mr WHITELY: It is almost as if a town has to be big enough to have two surgeons, otherwise there is a conflict with lifestyle. The other factor is that there is minimal private work.

The CHAIRMAN: What does Dr Lindsay do?

Mr Holmes: He is a physician.

The CHAIRMAN: Does he perform any surgery?

Mr Holmes: He performs many endoscopies. He is a world-class endoscopist. He does gastroscopies and colonoscopies. That is his procedural role. The rest of the time he is a physician. He looks after people who have suffered strokes or heart attacks. It is a medical role.

The CHAIRMAN: Does he do that at the hospital?

Mr Holmes: Yes.

Mr HOUSE: What percentage of your patients come from the arc around Kojonup, Gnowangerup and Jerramungup?

Mr Holmes: I do not know the figure, but it is significant.

Mr HOUSE: Obviously the patient assisted travel scheme is directing many of the people who go to those doctors towards Perth.

Mr Holmes: Yes.

Mr HOUSE: If there is capacity in Albany, part of the solution to both the problems would be to direct more of that patient load this way.

The CHAIRMAN: Turn the PATS patients to Albany rather than Perth.

Mr Holmes: I cannot answer the question. I have a number of patients from Gnowangerup, Ravensthorpe, Denmark, Walpole and Mt Barker. I have no idea how many do not come.

Mr HOUSE: That is the unknown quantity. One thing this committee must do is visit a couple of those small towns and ask those questions. Denmark and Mt Barker are a natural catchment for Albany.

Mr Holmes: Yes.

Mr HOUSE: Gnowangerup, Nyabing and perhaps Lake Grace are half and half, depending in which side of town they live.

Mr Holmes: I get very few patients from Kojonup; perhaps two or three a year. Obviously I get nothing from farther north than that. I cannot answer the question.

Mr WHITELY: Obviously, you have excess capacity. Does the hospital have excess capacity or are the theatres and beds always full?

Mr Holmes: Pretty much so.

Mr WHITELY: That would be a constraint.

Mr Holmes: The beds are almost always full.

The CHAIRMAN: Are they necessarily always full?

Mr DEAN: There are 16 old people in there.

The CHAIRMAN: I understand that. Forget the aged persons occupying beds they should not be occupying.

Mr Holmes: Normally the hospital is full almost all the time. There are constant pressures on the hospital. We have a special nurse who comes around and asks whether we can send a patient home because there is someone waiting at the front door.

The CHAIRMAN: Is that medically driven? Do you leave a person in a bed for an extra day, such as in Royal Perth Hospital and Sir Charles Gairdner Hospital? Do you do a procedure and send the person home the next day? Do you keep them in hospital because there is not the pressure that there is in some other hospitals?

Mr Holmes: There might be a slight bias if you can see there are a few extra beds and an elderly lady from Gnowangerup can get home only by her son's coming to get her. There are social factors that we are lucky enough to be able sometimes to accommodate. Some of these people will not go home in the evening. A procedure that would be a day case in Perth cannot be a day case here if a patient has to drive 200 kilometres. Some refuse to drive at night because there are kangaroos on the road. We could kick them out and tell them to go to a motel, but as a rule we do not do that. We let them stay until the morning because we do not need the bed that night.

Mr WHITELY: Apart from that, is it fair to say that there are capacity constraints at the hospital?

Mr Holmes: It is fair to say there is very little spare bed capacity. There is a slight excess capacity in the theatres when both theatres are running. At the moment, one is closed.

The CHAIRMAN: Why is it closed?

Mr Holmes: The hospital is putting in special airconditioning.

The CHAIRMAN: Is that being done because it is needed?

Mr Holmes: Yes.

The CHAIRMAN: How has that affected surgery?

Mr Holmes: It has affected some of the visiting specialists who have had some of their lists reduced. It has not affected me. I think I lost one list in six weeks.

Mr HOUSE: The point Martin made about attracting an orthopaedic surgeon or a gynaecologist was that he would have all the work and therefore become the opposite to you; that is, totally overloaded and overworked, which would affect the rest of his life. Is there another issue in the chicken and egg sense of the availability of hospital beds? Would a gynaecologist or orthopaedic specialist coming here say he would not have enough hospital availability to do the job?

Mr Holmes: I do not believe so. We currently have two visiting gynaecologists who come down alternate fortnights. They would not be invited to continue if we had a resident gynaecologist. In that sense we would be swapping one for the other. The other constraint would be that there is no private income. An orthopaedic surgeon in Perth makes a lot of money in private practice. If one came here, he would get the schedule fee for the public hospital system. Given that there is a shortage of orthopaedic surgeons - they can go wherever they like - not many would choose to come to Albany where they would not get that extra private income.

The CHAIRMAN: In some hospitals, for example, Kalgoorlie Regional Hospital, the orthopaedic load is huge. The income generated at a private country hospital is huge.

Mr DEAN: There is no private hospital there.

The CHAIRMAN: We are talking about private work.

Mr DEAN: Are you talking about private work or a private hospital?

Mr Holmes: I was talking about private hospital income.

Mr DEAN: That is different from private work.

The CHAIRMAN: Even so, the total salary package for private work in Kalgoorlie is huge.

Mr Holmes: Kalgoorlie may be different from Albany, but I think it has a lot of trauma.

The CHAIRMAN: One doctor said he is working 68 hours a week and he cannot give up.

Mr HOUSE: Kalgoorlie does have a lot more trauma cases. That evidence was given that it was clearly because of the mining industry.

Mr Holmes: It has mining trauma, car accident trauma and so on. Here we have an older population. Certainly it gets fractured necks, femurs and so on, but we have very little trauma of the mining type, thank goodness.

The CHAIRMAN: Some of the specialists we spoke to in Kalgoorlie, for example, suggested that it is a great idea to have salaried resident registrars in the outpatient emergency department who then transfer on the work. Here you have the exact opposite with VMPs and nursing staff. Do you think that system works well or should salaried staff be available at any time when someone walks into the hospital?

Mr Holmes: I prefer the Albany situation. The reason in my experience is that general practitioners here are very much more competent than most of the salaried junior officers who tend to be employed in casualty departments. I was a locum in Kalgoorlie years ago when junior officers rang me and asked me to put some stitches in a finger because they did not know how to do it. It was awful. About 90 per cent of the GPs here are extremely competent and can deal with all sorts of minor injuries, fractures and so on. They do not call me at all. The public is therefore getting a far better deal from having experienced GPs who have been here for 20 years. They can deal with just about anything that comes in the door.

Mr WHITELY: What happens when someone presents with a heart attack? Are the accident and emergency nurses highly skilled to deal appropriately with that situation?

Mr Holmes: That is outside my expertise.

The CHAIRMAN: The question was whether they would turn up. At least you know there is a doctor there; whereas nurses must ring doctor A, B or C and it can be some time before the doctor arrives. Is that the best way to go with acute care?

Mr Holmes: Some of the sisters here are better than many of the junior doctors who might be in other places.

The CHAIRMAN: That answers that question!

Mr Holmes: Essentially we have very well trained nurses. Some of them have done triage courses and special postgraduate courses. They are extremely competent.

The CHAIRMAN: You are suggesting that no changes should be made to this service and that everything is absolutely spot on?

Mr Holmes: Absolutely.

The CHAIRMAN: Do you want to say anything else about what happens here?

Mr Holmes: No, we have pretty much covered everything.

The CHAIRMAN: Thank you very much for your evidence. If you wish to add anything, please send it to the committee.