I am a one session RHH VMO, in the Hyperbaric Unit I was a staff specialist for 20 years in the ED (1984-2001). but in all my years this is the worst crisis yet, with Save The Royal,(when the Field govt tried to reallocate 10 million to the NW in the 1990s) we helped change the government, and had about 10 good years to follow. They learned that we were underfunded for what we did.
I think that there is no enthusiasm for a similar campaign, as there is an air of apprehensive despondency about.
The displacement of CEOs Rayment/Pervan seen as symptomatic of an out of touch government .

The DHHS/Govt should be meeting with senior clinicians/AMA and come to a clinical consensus about where to apply the knife.. We need an Oregon style utilitarian debate, about what is marginal, and what is core. Decisions to cut elective surgery, reduce MAPU, or close the stroke unit are just too easy for the bureaucrats, as they represent cost centers
Whereas ICU admissions (many with poor outlook) Psych ward (too many personality disordered patients admitted for insurance against suicide) Paediatrics (social behavioural issues) frail elderly (admit is a default option) Renal failure (age seems no longer a discriminator) Mammography screening (useless, and harmful in low risk women) Cardiac stents, (marginal over med/lifestyle changes), see latest Cochrane reports on the latter two.....all need attention, harder to do, but better value than the cuts proposed. Elective surgery and Stroke management are highly effective interventions, in terms of quality of life delivered.
The hospital badly needs academic leadership, we need to become an academic medical center, with UTAS health faculty and DHHS combined,(Change the name to University Medical Center, with 3 state-wide campuses) with one board, so appointments, credentialing, research admin all combined with State-wide clinical networks, so clinicians work out the best practices, with the board looking after the patients/community interest. (Arthur Cobbold, the medical dean, was chairman of RHH board in the 1980s)
Every clinician teaches, and every academic so qualified has clinical responsibility. . Look at the great international health centres,(Stanford/Yale/Oxford/MD Anderson) Uni and Med center are one unit.
UTAS participates in a range of joint management institutions, IMAS IASOS CORE) and participating is a health institution can only make it more relevant and enrich the clinical culture with research and teaching.
Tasmania urgently needs a unified health record, so patient information follows the patient, rather than each service having its own system. This is cheaper (less hunting, lost records and duplication) safer (we all work from the same basic info, drug lists, allergies are propinquitous), and avoids repetetive history taking.

If the current crisis is not solved, with clinicians on board, and accreditation for education and training is lost, then we will be reliant on second tier staff (many for offshore and expensive locums), VMOs will drift away to private practice, Staff specialists will be attracted interstate, nurses will go offshore, and it will take a decade to rebuild, Quality and safety will suffer. Consider what happens in developing countries with a failure of democracy (military or autocratic governments) , professional leave in droves, some end in Australia. .
Finally, we all acknowledge that we can only have what we can pay for, yet in a Federation, we share the nations resources, with and even standard expected across the nation, with cross subsidy. With the riches pouring from the soil at preset, the above situation is intolerable. The Federal government has a responsibility to all Australians.
B Walpole