UNEDITED TRANSCRIPT

THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON REGISTRATION OF OVERSEAS-TRAINED MEDICAL PRACTITIONERS MET IN THE CONFERENCE ROOM, GOVERNMENT OFFICES, 68 ROOKE MALL, DEVONPORT ON THURSDAY 16 APRIL 1998.

Mrs MAREE PEARCE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIRMAN (Mr Wilkinson) - Maree, thanks for showing an interest and coming along today and also writing to us in relation to this matter. Can you please, for the sake of the transcript, again state your full name and address and in what capacity you are here before us today.

Mrs PEARCE - My name is Maree Pearce, my address is Dooleys Hill, Latrobe and I appear before you in the capacity of a nurse in the critical care unit at the Mersey Community Hospital, Latrobe.

CHAIRMAN - Please give your evidence in whatever way you think appropriate.

Mrs PEARCE - Thank you. I wish to expand upon my written submission, particularly in relation to the right of the population of north-west Tasmania to have access to the specialist skills of Dr Iastrebov or indeed the next Dr Iastrebov to be in this position.

What is to be gained by facilitating the registration and what is to be lost? I guess that is totally dependent on who and what you are and in this instance where you live. Life's chances are not equal for everyone and the quality of life at any age is dependent on one's access to resources. If you live in Tasmania, and particularly in north-west Tasmania, this concept takes on a whole new meaning.

Th committee of inquiry into medical registration and medical work force of 1987 was established following a recommendation at the Australian Health Ministers' conference in 1985 and found that a particular concern with the rapid increase in the doctor/population ratio; the surge of specialism in the last twenty years and the maldistribution of medical personnel. Although Australia is faced with an over-supply of medical practitioners overall, there is a continuing problem with the provision of adequate and appropriate medical coverage in remote and socially undesirable locations.

Doctors operate in a political sphere cleared for and by them which has considerable consequences for the manner in which healthcare is provided with the result that the most important political consequence of medical dominance is that it prevents the most effective utilisation of health resources in society. Keep this in mind because we are not talking about another time, another country or even another State, we are talking about here and now, we are talking about real people, people who are touched by the circumstances at this moment in time. So who decides what constitutes the most effective utilisation of available resources?

The main feature of the social organisation of healthcare delivery is medical dominance. This should indeed be a grave source of concern for those who do not belong to this privileged group because when you examine the issue of registration in Australia of overseas doctors, the medical community openly practises domination and discrimination in the form of exclusion.

The AMA through the Government voice, expound on the differences in education and training and this politics of skill is organised around the phenonomen of medical dominance with State backing and is enshrined in Medicare. This holier-than-thou attitude only reinforces the Australian situation where social institutions tend to reflect the interests of those who control the economy rather than those who do not.

The AMA seeks to maintain a new monopoly over supply of medical services by seeking to use accreditation rules. The blatant abuse of the rules of fair play in the treatment of Dr Iastrebov and other anaesthetist positions should be cause for great sadness in our society.

The analogy for those who do not understand would be to allow an engineer to come to Australia to fill a post not wanted or unable to be filled by Australians and then to allow him to work in that role but pay him as the office boy and discard his services when we either tire or no longer desire his services. This is not an exaggeration and we should hang our heads in shame at this appalling treatment. What greedy peoples we are, have we learned nothing in the last 200 years. We still seek to fell tall poppies and we still seek to control by intimidation and exclusion. It is the right of every consumer to expert medical care and not merely the provision of basic medical care; it is our right to have such care and it is the responsibility of our elected representatives to make sure we are not denied the opportunity to access such services.

The AMA have a formidable representation as a pressure group and have had for most of this century but let us not forget that they are a union. Indeed the Whitlam Government alleged that the AMA was arguably the most powerful trade union in Australia.

The AMA has the support of barely 50 per cent of registered doctors in this country with almost 50 per cent of their own profession failing to identify with their agenda making their power disproportionate to their membership as is their political influence. By refusing to challenge their authority on any matter we therefore give our tacit approval for the continuation of what is surely blatant greed and prejudice. Politics is more than an elector group of parliamentary representatives at local State or Federal level, it can be presented as a contest over meanings, the aim of which is to gain legitimacy.

Recognition of the legitimacy of Dr Iastrobov's qualifications and abilities is currently opposed by the might of the AMA as the current situation appears to be desired by these medical monopolists. Perhaps the benefits both financially and in social status in the current healthcare system are responsible for the apparent and selfish resistance to proposed changes. In the real world however, their perceived loss is nothing in comparison to what the general public stand to lose. No Australian doctor wanted this posting and you can be assured that the AMA would not allow the current discrepancy in qualifications and pay structure to be inflicted upon its members. Indeed no sector of the Australian work force would allow one of its own to be treated in such a deplorable manner; shades of racial discrimination I sometimes think.

Medical practitioners, as a profession, are self controlling and do not take direction nor are they subject to evaluation by any other health occupation. The medical profession has also achieved State patronage which has bestowed upon them the control of the health system in the form of delegated authority. The future of the availability of first class healthcare to all Australians depends on whether this State will deinstitutionalise cosmopolitan medicine from it privileged position. Let not those with a misjudged sense of self worth deprive our community of a specialist now or in the future. His services have resulted in lives saved that most certainly would otherwise have been lost.

I again ask you to have the courage and insight to harness the talent that is offered to you; to not discriminate or exclude on the basis of nationality and your conceived notions of inequity of education. Australian standards are not the only ones in the world worthy of recognition.

We are the suppliers of healthcare for this generation; let not history show that we have been guilty of failing to provide when the means were readily available. Expert doctors are not commodities you can pick up at a local convenience store and they deserve better treatment from what we in Australia currently extend.

Sometime in your life you may hear a voice sing and know that something is different. You may not be a singer but you know what you are hearing is special, you get goose bumps at the sheer quality of talent and know that you have been lucky to be where you are at that moment in time.

This reflects where we are at the moment. We see many, many doctors but only rarely do you meet a practitioner who you instinctively know is special. We have a very fragile grip on that person and we are asking you to help us establish a better grasp.

CHAIRMAN - Thanks for that, very good, and I liked your simile at the end as well.

In relation to a question I would like you to answer, it goes like this: do you believe that members of parliament have the expertise to grant registration to, not just Dr Iastrebov but any overseas doctor or any specialist?

Mrs PEARCE - I believe that members of parliament have the ability to canvass an adequate variety of societies, people who are qualified to make that judgment.

CHAIRMAN - And then they act on the conversations that they have had and the answers that they have been given by the experts.

Mrs PEARCE - In conjunction with the best interests of the people.

CHAIRMAN - Yes. What do you say - and it is not my question really it was a question that Paul Harriss was going to put tomorrow and I think it is a good one - whether members of parliament should be able to, for instance, say to Dr Iastrebov in a couple of years' time, 'Look we don't believe you are now competent enough to be a specialist in anaesthesia'. He then may come back and say, 'What right have you to say that because you haven't got the expertise in the area, what do you know?'.

Mrs PEARCE - I believe that that is probably a failing of the medical system to allow itself to be examined and to allow itself to have outside participation in the setting of their standards. Any doctor who agreed to be registered in Australia should be subject to the standards that are applied here. At the moment those standards are very fuzzy around the edges and as I said the medical community as a whole is very much self-governing and accepts no criticism and books no argument in the terms of what they are qualified to do and not to do. Within this medical world they do not even always act in their own best interests. I do not need to tell you about the hundreds of cases of incompetence that happen every year and this is not just in specialist services but it certainly does happen and that is a problem with regulation of the bodies overall and there seemingly inability to self-regulate themselves.

CHAIRMAN - Should there be a different system when people are getting overseas doctors to areas of need. At the outset what may be an answer was put forward approximately an hour or so ago when a lady stated, 'Well, it would be best if that person first went to a teaching hospital, was then under the gaze and eyes of their peers. After that six months if those peers deemed them to be appropriate, they then go to the area of need that they said they would come out to in the first place'. Do you think that is a good option? It seems to me if I can just preface that by saying that overseas doctors come out, it would seem, on the strength of a CV and perhaps a reference.

Mrs PEARCE - It is very difficult to answer the first part of the question, the overseas doctors filling the posts. A post should be advertised and the best doctor for that post should fill that post regardless of his origin.

CHAIRMAN - I have no argument with that.

Mrs PEARCE - We do not have a glut of specialist doctors in Australia, we just do not. As to the second part, I do not really know what to say.

Mr SQUIBB - I guess there are two alternatives in that situation. One is a suggestion put forward by the Chairman where the overseas doctor goes first of all to a teaching hospital such as the Royal Hobart for six months and then gets allocated to the area of need which in the example we are using is Mersey.

On the other hand, I suppose the other alternative is for the doctor to come directly to the area of need and then to actually be supervised or evaluated by a fellow of the particular college while he or she continues to work in that hospital in the area of need. I guess they are the only two alternatives that seem to have been addressed.

Mrs PEARCE - Competent practitioners do not seem to have a problem with their practices being assessed, they do not. As to the six months in a teaching hospital, I do not know because it would be very difficult to create a role for them in that position whereby what they had as qualifications were not belittled. You must remember that in the case of many of these doctors they are far more qualified than the doctors who would be assessing them.

Mr SQUIBB - Exactly. Competent doctors may not have a problem with their competency being assessed, the problem is the system does not allow for it to be done that way.

Mrs PEARCE - No.

Mr SQUIBB - What some witnesses are suggesting to us is that rather than overseas doctors who have already been through years of training and exams, rather than them having to resit all that sort of business, that they be allowed to be assessed after they have arrived in Australia and it is a matter of whether it is done at a centralised teaching hospital or whether it is done on the job in the hospital where they are going to work.

Mrs PEARCE - You have to then separate it into different levels because what we call the resident medical officers that we get who are base level doctors heading on towards becoming perhaps GPs, that is the level at which their qualifications are at. We see many of those pass exams when their practical practise is on occasions grossly negligent and I mean grossly negligent and there is not one among us who work in a hospital who could not give you examples.

Mr SQUIBB - So are you suggesting that perhaps there ought to be - whilst each assessment should be carried out on its merit - what you are suggesting is that there probably should be two systems, one for specialists and one for RMOs?

Mrs PEARCE - Yes.

CHAIRMAN - What we have heard from one doctor was that at some places around the world you can pay money to find out what the questions are going to be for your exams -

Mrs PEARCE - I have no doubt you can, I have no doubt.

CHAIRMAN - and what we have to make sure of is the standard of medical care is of the highest quality. What I am trying to look at myself is how you can make sure that the person who comes out as the overseas-trained doctor is of a required standard because it is unfair, as far as I consider, for a person to come out as a specialist for two years, act as a specialist - using Dr Iastrebov as an example - and then after two years a person to say, 'Look, you're not a specialist any more'. That is unfair and it would seem to me to be fairer at the outset to have that training in the first three months, six months, however long it might be, and then the person goes into that area of need; that to me would be a fairer scenario than the scenario that we have now.

Mrs PEARCE - Yes, you are talking three and six months when the reality is that that shorter time span is not even an option, is it? At the moment specialists are treated with much less regard.

CHAIRMAN - But that is what we are looking at.

Mrs PEARCE - In what is possible.

CHAIRMAN - We are looking at making recommendations.

Mr SQUIBB - A witness suggested that.

Mrs PEARCE - Again I am very much concerned that you are not separating them into two levels, the specialists are absolutely different kettles of fish to your basic registered medical officers. Your specialists tend not to have their qualifications in their place of origin perhaps, maybe they did their basic training there and they have done extended training in other parts of the world, whereas your residents typically come with their only training in the hospital in which they train. It would have to be a very distinct difference between the two in fairness to the years and years and years that these people have already done.

CHAIRMAN - There seems to be a problem with the rural areas and some regional areas - I say that because of Mr Squibb. But the problem is that people are not having the medical care that they deserve and doctors do not want to come to those areas, for whatever reason. Therefore the only people who will come are the overseas doctors. Do you think it is unfair for the overseas doctor to come and say - which has been said in the past, and I am not saying Dr Iastrebov will do this at all - but Dr Kehilia on the west coast became emotional and said he was going to stay, he wanted to make his life on the west coast, he had been there for *x* amount of years, he had done this and done that and he definitely would not leave. As soon as he got full registration you had to chase him to the airport. That seems unfair on the community as well.

Mrs PEARCE - The prospect of registration is not always what keeps a doctor in a community. In a lot of cases it is perceived by medical people that in a small rural area you have limited access to resources - and I am talking medical technology-type resources. A lot of people's happiness to stay in one position comes from what they are able to work with. If you walked into the Mersey and you could not get medical treatment for a simple condition, that makes the public person feel bad but it also frustrates the doctors and the staff because this is a common thing that has been treated in the world for 50 years and we cannot do it because we do not have the equipment, the technology, the money, or whatever.

If you supply them with equipment that is needed to carry out expert care they tend to become more possessive of that area, knowing that they have the access to it, knowing that they are going to have the skills to use it whether they come with them or whether they are trained. So they tend to have more job satisfaction, and job satisfaction to good doctors - I should not say 'good doctors' because that is a fairy term - but job satisfaction to a lot of doctors involves more than money. Money is important, let us not be silly about it, but it involves being able to have good staff, it involves being able to have good back up, it involves being able to work for an employer who has an interest in more than the overall operation.

I think that is a relatively important point when you are considering rural areas. Rural areas traditionally ship out patients who are difficult or hard or who they cannot help, so the doctors there have a lot of frustrating aspects because they cannot do anything about it and they cannot see an end to it. These patients are always going to have to be shipped out because the hospital is not going to supply us with this piece of equipment, for whatever reason.

CHAIRMAN - If the doctor remained, though - for example's sake with the Mersey General Hospital - the Mersey would have, we were told, around about $100 000 a year more each year to put into facilities, to put into machinery and so on. Therefore it would be unfair, I think, for the doctor to suddenly turn around - if he gets full registration - because of mutual recognition he can therefore practise anywhere in Australia. It would be unfair of the doctor to immediately leave after all the money that was expended.

Mr SQUIBB - Unfair on the hospital.

CHAIRMAN - Unfair on the hospital - and the community, not just the hospital.

Mrs PEARCE - That really does scare us. The possibility of losing him, full stop, really does scare us, but the possibility of losing him when he gains full registration of course scares us, and rightfully so.

CHAIRMAN - So in fairness to everybody concerned - taking into account that the doctors who come from overseas know the ground rules when they come - or if not they should be told those ground rules

- should it also be a condition of registration that they remain in the area of need for a period of time, whether it be three or five years, or whatever?

Mrs PEARCE - I personally think so, and I know that is not perhaps a very popular opinion. If that is the only way we can access those resources then we should use that or alternatively say to them, 'In the five years that you're here, three of them must be spent in an area of need'. Not necessarily a remote area but an area of need.

Mr SQUIBB - If you have that system that will extend the provisional registration rather than full registration, which then means that the overseas-trained doctor is restricted to that area of need for five or ten years, or whatever it may be, and if he wishes at the end of that time to get full registration and move elsewhere, there is no reason why he or she in that period of time cannot undertake the pathway that has been recommended by the college. If we could take an anaesthetist, for instance, it is a matter of doing a study and the exam.

Mrs PEARCE - I disagree. I do not think you can do the study and the exam after you have done the provisional registration stint. You cannot suddenly say to somebody, 'You're good enough to practise -

Mr SQUIBB - No, I am not. What I think is being suggested is that an overseas-trained doctor has the option, if they do not wish to do the study, to remain at a hospital of need virtually for as long as they like but will probably never ever on that basis gain full registration. If they wanted to gain full registration, they would then have to go through the same process as an Australasian-trained doctor.

Mrs PEARCE - Are you talking just exams, or residency and exams?

Mr SQUIBB - No, the exams. The same process that an Australian doctor has to go through. That varies between specialist colleges of course. In some cases, and I think we have been somewhat shocked - or I have - at the inconsistencies that occur -

CHAIRMAN - That's hard to do to shock you.

Laughter.

Mr SQUIBB - Yes, perhaps that was a little bit harsh a word; perhaps I was already aware of some of the instances. But it was interesting to learn that the processes that are used differ between colleges. Yesterday we heard evidence on oath where, in a particular specialist college, a specialist was granted full registration purely on the assessment of his peers. We have been told in the case of an anaesthetist, for instance, that the only way an overseas-trained doctor can be granted full registration is if they do sit the exams, but we also heard under evidence yesterday that that same college - the College of Anaesthetists - has granted full registration to an anaesthetist who has not gone down that pathway. So there are a lot of inconsistencies which we have unearthed during the hearings.

Mrs PEARCE - And the scary part of that is that they decide for themselves and are subject to rules by nobody. It is very much an inequality.

Mr SQUIBB - Yes. And I am not sure that we as a State parliament can do much to change a lot of that because a lot of it is set by the colleges at a national level. What we need to do - and we are not necessarily talking about legislation which will provide for individual registration of specialists - is look at recommending to the Parliament a system which will provide a degree of flexibility to enable overseas-trained doctors, who obviously are competent in the specialty that they have come here for, to be able to remain in those areas of need without each year facing the risk of losing their jobs. From my point of view that is the bottom line and I would hope we can get to it at the end of this inquiry.

What we are asking the witnesses is if they could make some suggestions as to how that may be done and what special needs we need to take into consideration. Obviously if we are going to provide full registration - and our interest of course is to ensure that those areas of need are able to obtain and retain the specialists they need. Under mutual recognition of course, once full registration is granted you run the risk of losing that particular specialist. I do not know whether you have any comments you would like to make which may help us in arriving at that bottom line.

Mrs PEARCE - It is out of my depth, I am afraid.

CHAIRMAN - One of the areas, as you know - and I read here from Bob Walch's letter. It says:

'The Tasmanian Medical Practitioners Registration Act 1966 provides inter alia for the Medical Council of Tasmania to register persons to practise when the council considers that -

(a) to be in the public interest'.

Obviously in areas of need, public interest seems to be there should be medical practitioners and competent medical practitioners in those areas of need for the public interest. It goes on:

(b) in order to practise in a declared area of need'.

Again, that is safeguarded. It goes on:

'Provided such persons have approved qualifications and experience'.

It would seem to me that what the council therefore says is, 'The qualifications, not as a result of any law but as a result of convention, should be that we sit these examinations'.

> **Mr SQUIBB** - Mr Chairman, for the record could I just correct you. That was Dr Catchlove.
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> **CHAIRMAN -** Catchlove - I am sorry.

With respect, you are obviously an intelligent person. Are there any ways that you could see the system improved, such as, as you know registration is normally for two years; that should be increased for a period of time? If so, how should it be increased?

Mrs PEARCE - Are you talking temporary registration?

CHAIRMAN - Yes.

Mrs PEARCE - I do not think you can give somebody temporary registration and then say, 'Oh, we take that away'. That is discrimination. If they are good enough to practise, they are jolly well good enough to practise and have full registration.

CHAIRMAN - So you are saying there should not be any temporary registration at all. If somebody comes in from overseas, they should immediately have full registration so long as there are conditions on it?

Mrs PEARCE - Yes. If the colleges are going to wish to exclude people on the basis of country of origin or country of training, then this should be done up front. If you are going to want to assess those skills then do it up front. It is no good allowing them to practise for two years and then say, 'Oh gee, we might need to have a look at what you know and what you don't know'. It is too late because you have already played with too many lives by that stage.

CHAIRMAN - Forget about the temporary, what about the conditions? What should they be?

Mrs PEARCE - I still do agree with the condition. If people come into the country to an area of need - specifically to come to that area of need - then I think they do have an obligation to remain in that area of need for a certain period of time. Whether that is two, three, four or five years, I do not know. I do believe if they knowingly come to the country to fill a remote or rural position, that there is an obligation to the country they come into to stay there for that length of time. Provided their qualifications are as they say they are - and I again say that this should be done before they start work, you cannot do it two years later - then I think it is just blatant discrimination to pull that registration away from them.

Mr SQUIBB - I take from that that you are supporting the concept that was put forward by an earlier witness this afternoon that there ought to be stricter screening up front - before the first day of work.

Mrs PEARCE - Stricter screening or, I fail to see why Australia does not interact with other nations and get a standard on their qualifications anyway. Why do we consider that our qualifications are superior to everybody else's? They are not, and we see this all the time. You compare standards of different doctors in Australia. Okay, so we get some real poor doctors from overseas, but we have some very poor ones in Australia too. Ours are not the only standards and I think there should be a level of recognition. Other countries have their own professional bodies too; are they so different in their standards of training that we need to judge what they say is adequate?

CHAIRMAN - It seems to me that part of the council's view is also that they have to protect that there are jobs available for Australian-trained students when they leave training and go into the work force. What do you say about that?

Mrs PEARCE - Again you need to distinguish between specialist services and resident medical officers. If Australia was able to fill their remote services by their own doctors, they would never have need to admit foreign doctors. The very fact that the majority of the doctors - in our hospital, anyway - are from other countries, indicates that Australia is not fulfilling that need, nor do they show any sign in the future of being able to fill that need from their own resources at all.

Mr SQUIBB - Can I ask: do you believe that Australia has an obligation to protect these jobs for Australian-trained doctors, bearing in mind that most other aspects of the Australian economy and community are open to global competition?

Mrs PEARCE - I believe that Australia has the responsibility to provide the best health care it can for the people regardless of where that health care comes from, absolutely regardless. If the best doctor for the job is English, French, German, what does it matter? If they are the best doctor then they should fill that need. The workplace is an open market, jobs are a sellable commodity. If the Australians are competitive within that marketplace then they are going to be able to get the jobs they want. Every other one of us has to compete on the open market in terms of jobs spaces; what should give us a privileged position from which they do not have to? This is a profession that is very self-ruling.

Mr SQUIBB - I can relate to that last comment, we do it every six years.

Laughter.

CHAIRMAN - Thanks, Maree, very much. It was a very good presentation. Thanks for your interest and for coming along and talking to us today.

THE WITNESS WITHDREW