UNEDITED TRANSCRIPT

THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON REGISTRATION OF OVERSEAS-TRAINED MEDICAL PRACTITIONERS MET IN THE CONFERENCE ROOM, GOVERNMENT OFFICES, 168 ROOKE MALL, DEVONPORT ON THURSDAY 16 APRIL 1998.

Mr ROBERT LIONEL WALSH, CHIEF EXECUTIVE OFFICER, MERSEY COMMUNITY HOSPITAL/HEALTH CARE OF AUSTRALIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIRMAN (Mr Wilkinson) - Thank you for coming along. Could you state your full name and address and the capacity in which you are here.

Mr WALSH - Robert Lionel Walsh, 65 Forth Road, Don. I am chief executive officer of the Mersey Community Hospital.

CHAIRMAN - Please give your evidence in any way in which you feel most comfortable. I do not want any further recommendations as far as Dr Iastrebov's expertise is concerned because there has been plenty of glowing reports about him and about his expertise and I certainly have no argument at all with those and I do not believe anybody on the committee has.

What we have noticed over yesterday and the previous time we sat is that it seems to me that some colleges differ in relation to granting specialist accreditation. Orthopaedic surgeons seem to; Dr Hanusiewicz has get here speciality without going through an exam, as I understand it, which seems unfair. Also, people prior to 1992 who came from England as a specialist were immediately recognised in Australia as a specialist. That has changed. What we are looking at are ways of retaining people like Dr Iastrebov, Dr Edwards at Burnie and people like that, within the system with either an extended condition of registration or can you give them full registration, should the Parliament intervene in something they probably do not have the expertise in for full registration, should there be another committee other than the Medical Council. We are looking at those type of things, or any other things that you believe are of assistance to us in coming forward at the end of the day with a number of recommendations which hopefully the Government will look at and look at very closely. That is a summary of where we are at the moment.

Mr WALSH - I do not intend to go over the submission that came in under Dr Catchlove's signature. You do not want me to go through that, or do you?

Mr SQUIBB - I just had a question in relation to that, and that is where you refer to the training provided to the Tasmania Ambulance Service members by your highly-skilled anaesthetist; is that Dr Iastrebov?

Mr WALSH - Yes, it is.

Mr SQUIBB - The government-owned Tasmanian Ambulance Service is quite happy in these cases to receive that -

Mr WALSH - Most assuredly. Geoff, I can fill you in on that. What happened was the ambulance people were going down to Hobart for essentially intubation training, which is airway management.

That was a very costly exercise, as you can appreciate. They have to go down there for a week and be accommodated there and it was very expensive. So negotiations with the regional board up here of the ambulance department, and resting on Dr Iastrebov's skills as well as other anaesthetists at the hospital who were prepared to assist, the ambulance officers now undergo their airway management training in the hospital and actually do it in a real situation in terms of going to theatre and learning to manage patients in a real acute situation. So it is not a false situation, it is a real situation where the ambulance officers go to theatre and learn management of airways there and this is critical to their training.

Mr SQUIBB - Did it have to be approved by the minister or the Director of Health Services?

Mr WALSH - No. It was negotiated between the ambulance department and the hospital. I hope we have not trodden on any toes in that one.

Mr SQUIBB - No, it was just that I found that if in fact it was Dr Iastrebov that it was slightly ironic that here we have a specialist who is not recognised by the Government but yet is being utilised by the department for training.

Mr WALSH - Sure. I think if I can just highlight one of the issues that is of concern to me. I suppose it is to do with the Medical Council's licensing of provisional licensing. It seems to me that the existing arrangements present a totally double standard. The medical council okays an overseas graduate for a minimum period of time with the right to provide services, specialist services or whatever they might be, to public patients. That is done on receipt of the curriculum vitae and a checking that the doctor concerned has the qualifications, albeit wherever they might be obtained overseas is not a criteria, providing that they have the qualifications from some deemed by the medical council a recognised training institution.

To me the anomaly is that you have a medical council that is prepared to approve specialists from overseas-trained colleges which recognises that college as a specialist training facility and then recognises the person graduating from that training facility as having the expertise to provide the service to public patients. I think in a whole lot of this that the presentation, and in discussions with Dr Iastrebov, we never ever sought the need here for him to get a provider number. I think this is where the college is coming to grief, that they are protecting their own patch, that they are restricting the number of providers out there who can access the private health funds. We have never sought in our deliberations and discussions and Dr Iastrebov has never sought to gain a private provider number; that has not been his whole aim and thrust. The whole aim and thrust is to get him recognition of an enduring nature as a specialist so that he can have security of tenure. That is a reasonable ask for anyone in this day and age, to have some security of their future.

He has deliberately not chosen to undertake the medical examination and that is his choice. We, as his colleagues, have had many discussions with him about that and he feels very much affronted that with his training and the specialisation that he has to have to undergo another examination. He feels that is an affront to his specialty. I am not going to argue the rights and wrongs and wherefores of that; that is his decision and he rests with that.

What we have sought then is some consistency with the Medical Council's approval of overseas graduates. If they approve a person for twelve months, why only twelve months? If that is based on the fact that we cannot - here in Tasmania and right across the board there is something like, I think, 90 overseas graduates supporting the medical system in Tasmania, without which the system would collapse. If then the Medical Council sees fit to register these people to provide an essential service, if we cannot attract Australian-trained college fellows then to me it seems a highly unjust system that we live in that the Medical Council does not have the right to approve these people permanently. There can be provisos put into that.

CHAIRMAN - Such as?

Mr WALSH - Such as that if in the event an Australian qualified person was able to present himself to a facility then the person could lose that right of practise there and this is the tenure in which it is granted now, albeit an assumed tender that if there is an Australian graduate that these guys cannot

come in; and we would want to preserve that. I think in the interests of health we would want to preserve that the Australian graduates, we accommodate them in our home country.

Mr HARRISS - Do you think that is the reason why this one year and then another year with a maximum of two?

Mr WALSH - Yes, I think it has something to do with that, Paul; it is limited there so it is always reviewed. But I think we have to look at the historical perspective here. It has not changed in Tasmania for a long time and it is not likely to change despite the real incentives that are going on. We still cannot attract specialists to rural areas, right throughout Australia; it is impossible. The dilemma we have here is typical of the mainland.

So it seems that there is an opportunity there where we can create an environment; some special powers, be it the Medical Council or a separate body which may be set up, to look at these people and to give them some security of tenure. They come to this country, and we can appreciate the trauma that is. They come, they move their whole family here, tremendous trauma for them. They set up here and if we can give them some security of tenure vis-a-vis - take the Mersey for instance, we would see that Dr Iastrebov might be given registration to practise at Mersey Community Hospital and I think that is a reasonable request that I believe could be honoured. He came to Mersey, he stipulated and said to many people around this table that he wants to be secure here, he wants to have a future here, he wants to become a family person, put down roots and establish himself as an integral member of the community.

To me, I believe there is an opportunity for a mechanism through the Medical Council, through maybe an alteration to their act under which they function, or a separate body that can grant this approval. If Dr Iastrebov then decides to move, that is on his head. If he decides not to do the examination, that is on his head. We have given him the right to practise permanently in an area of need. If that is given for a decent period of time, five years with a right to renewal whatever it might be, some provision there, I think we are going to calm things down and we are going to provide a service for the community.

CHAIRMAN - Do you have your doctors on contract who come?

Mr WALSH - Yes, we do.

CHAIRMAN - What is the average contract?

Mr WALSH - We put them on a three-year contract, but it is all individual.

CHAIRMAN - Is there then an option for a further three?

Mr WALSH - Yes.

CHAIRMAN - So it is three and three?

Mr WALSH - Yes. What happens is that we credential our medical staff. They go through a peer review where their peers credential them. So they apply to the hospital to have admitting and practising rights at the hospital and that is approved by the medical committee at the hospital. It then goes through and is formally approved by the Health Care of Australia board. That is a standard practise in any hospital.

Mr SQUIBB - Are you doing that for your overseas -

Mr WALSH - For anyone.

Mr SQUIBB - So you offer your overseas doctors a three-year contract yet they can only have registration guarantee for twelve months?

Mr WALSH - Yes. Again, that can be individualised. If someone, for some reason, wants to go longer then we will consider it longer than that. But essentially it is a three-year contract that anyone is offered there, but it is a formality in terms of the renewal of that.

Mr SQUIBB - Is that conditional upon their registration being renewed?

Mr WALSH - It is conditional upon them being registered of course and being certified bona fide practitioners, conditional upon them exercising due diligence and care; that they have had a good report, they have fulfilled their professional responsibilities during that time at all times. Then they have undertaken peer reviews; they have done audits on their work and that is available.

Mr LOONE - That is subject to the AMA approval. If they come in on a temporary basis they get one or two years temporary registration, not a three year registration. You are banking on that being extended to the three years, are you?

Mr WALSH - No, we are not, John. It is a formality in the hospital that people coming there are given three years credentialling by the Medical Council. That is a formality, that anyone who practises at the hospital gets a three-year period.

Mr LOONE - I thought it was a maximum of two first up.

Mr WALSH - No, it is three years.

Mr SQUIBB - In the case of an unregistered, overseas-trained doctor, are those positions advertised - is it not necessary to advertise those positions annually?

Mr WALSH - Yes, it is.

Mr SQUIBB - And if an Australian-trained doctor - in the case of Dr Iastrebov, for instance, an anaesthetist was to apply for that position and it was an Australian-trained doctor you would have to give the position to him, I understand.

Mr WALSH - Subject to him having the qualifications, the experience, fulfilling the hoops that any doctor has to, Geoff.

Mr SQUIBB - Assume that he does, you then have an Australasian-trained doctor who you must appoint?

Mr WALSH - Yes.

Mr SQUIBB - You then have also on your books an overseas-trained doctor who has completed one year of a three-year contract. What legal implications does that place on the hospital?

Mr WALSH - It is an interesting scenario that we have never worked through. The credentialling of the doctor to the hospital gives him access to patients and to practise his specialty in the hospital. It is not a contract in terms of what the hospital will pay him; it is a right to practise in the hospital and he then generates his own fee. In the case of the overseas-trained guys, they cannot generate their own fees so we have to pay them. Now we have never ever to date come up with a -

Mr SQUIBB - A nice position to be in, do you think?

Mr WALSH - It would be a lovely position to be in because at the moment we have to keep moving them through because they know it is only going to be twelve months or two years and so that is the extent of it and that has never been tested but it is an interesting one.

We are just negotiating another three-year contract with Dr Iastrebov and there is a reticence on both parties at the moment to sign that document because if we have a contract with him, it has to be so worded 'subject to registration'. Now this does not give any comfort to anyone at all.

CHAIRMAN - It seems obvious, as you can see in the terms of reference, looking at the specialist anaesthetist work force with emphasis on the north-west coast, and there appears to be a great need for it because in years gone by there has not been one, and there has been talk that it costs a lot of money to get them. There was a number of advertisements placed in a number of papers around Australia and

you could not get one. Can I ask a bit of history about that, please, because I think that is important when we look into these overseas doctors coming in.

Mr WALSH - When we took over the hospital in July 1995 we recruited four specialists - an anaesthetist, a paediatrician, an obstetrician and a urologist. The urology situation was very interesting. I was requested to appear before the College of Surgeons (Tasmanian Branch). After receiving a letter from the college stating that the two urologists at Launceston were not prepared to service the north-west coast but they wanted to block anyone else coming in, I had to appear before the College of Surgeons and speak to this advertisement. That was the initial reaction we got. So then we advertised, I think, two or three times in national papers and international papers and got nothing. We then recruited a head-hunter, IPSM Medical Recruiters - very well-renowned - and they went on a campaign for us which cost us $110 000 and did not recruit one person.

Mr LOONE - Was this in urology?

Mr WALSH - No, this was across those specialities, John - the four or five specialities that I aforementioned. They did not recruit one person. So then we went back to the drawing board and again readvertised and out of the advertisements that we ran Dr Iastrebov applied - the only anaesthetist who applied to us; the only anaesthetist who has applied to us following advertising.

CHAIRMAN - How long did those advertisements take place for?

Mr WALSH - It would probably be over a period of eighteen months. We constantly ran advertisements and it has cost us in excess of probably $150 000 advertising continually. But then there are the hidden costs.

CHAIRMAN - What are they?

Mr WALSH - The hidden costs of continually having to pay for - if we recruit a locum, and that is all you can get these people for, to fill up the gap of the speciality - you are up for their airfares, you are up for their accommodation, you are up for any incidentals, out-of-pocket expenses, you have to provide them with a motor car, running costs. They are all the added costs that we have to provide for these people to get them to come to the hospital service to service the people and it is ongoing; it does not stop. The only way it stops is if you have got a permanent appointment that is when it stops, that is when you can stop focusing most of your attention on recruiting. This is experienced by every public hospital in Tasmania and certainly on the mainland, and you only have to look in the weekend papers to see what the cost of advertisements must be for medical staff. The frustrating part to us is when you get no response to advertisements. At the moment, at Mersey, we have a locum surgeon and a locum paediatrician - overseas trained - for twelve months and that costs us a premium as well - the ongoing cost to them for the recruiting agencies to get the people. Overseas resident medical officers, we have to recruit them and they cost the hospital the normal recruitment stuff and then it is roughly a fee of about $5 000 a person a year on top of their salary and wages for the recruiting agency to supply this person to you.

CHAIRMAN - So that is money that HCOA spend?

Mr WALSH - Yes.

CHAIRMAN - Would that money be then, if it was not expended for advertising and getting your locums in, spent on upgrading the hospital - getting new facilities?

Mr WALSH - Most certainly.

CHAIRMAN - It sounds a silly question, I know, but -

Mr WALSH - It is money that is ill-spent. It is wasted, as far as we are concerned. We would like to get a urologist at the hospital. We need a urologist here in Devonport. We do not have the funds at the moment and a lot of that is because of what we have to expend in recruitment and the oncosts involved in recruiting people. If we could get someone at Mersey, like all specialties - and maybe this is the

other side of the angle I would like to present to you - but given that Dr Iastrebov is given registration, some permanency of registration to function at Mersey. The other scenario that may be of interest, and it will certainly make recruitment of specialist staff a lot easier, is if that specialist registration, permanent registration for the hospital, can also be included in giving them a provider number then this defrays an enormous cost to the public health system in this State, because you no longer have to employ them as staff specialists. The staff specialists cost you, roughly, about $120 000 a year for that purpose because you cannot get an Australian graduate. If you do not have that you get the service a lot cheaper - probably a half of that cost - if we could get them registered and a provider number. We will have to fight the HIC for that one and they are not easy.

CHAIRMAN - Yes. To me that seems to be one of the underlying causes, if not the most underlying cause which the council are holding onto, to stop these overseas people coming in because they want to hold onto these provider numbers because of what may be classed as a closed shop.

Mr WALSH - Yes, well it is a closed shop at the moment. It is a very difficult shop to break through.

CHAIRMAN - Do they therefore want to protect their own patch and therefore protect the amount of people getting provider numbers?

Mr WALSH - Most assuredly, and I think you have only got to see the evidence of the control over the graduates in any discipline coming through. We have a dearth of ENT surgeons. I think orthopaedics is not too bad now but in a lot of specialities there is a dearth of graduates coming through. It is very much, I believe, a control market situation that is being governed there. And of course the attraction to these people is to the urban areas. It is a different kind of person that we have to attract to the rural areas; they have to want to live in the country. It is very difficult to attract the young ones because they have wives, who are the most difficult person - sorry about that. If we can attract the wives we can get the specialists but it is the wives who really dictate the shots of whether a specialist goes to a country area because she is more concerned about the children's education, her social networks, et cetera, and that is a realistic request of the wife. So it is a different kind of person and it is very difficult to get young graduates permanent to the rural areas because of those reasons, that they are either starting a family or they have not got a family and they want to stay in the rural areas where all the schools and facilities are great and it is nice.

Mr HARRISS - Given the recognised area of need that the Mersey General has been granted, if you like, what would be your reaction as an employer to a proposition of geographically-allocated provider numbers, rather than the provider number attaching to an individual?

Mr WALSH - I think that is a great concept, Paul.

Mr HARRISS - It is not my idea. It has been put to us by another witness who has difficulty in Dover, for instance, of attracting appropriately qualified doctors.

Mr WALSH - I think that is an excellent concept, but my only fear about that one is how do you define that area - is it where people live or come from or referred from? For instance, at Mersey we get a lot of people referred from Launceston, Hobart - from all over the State - we get people there. Is it where the people live or where the practitioner practises, and I think in terms of a geographical location it must be the area of the province where the person has been given the right to practise in that province.

Mr HARRISS - Yes.

Mr WALSH - I would support that 100 per cent because, as you are aware, the other difficulty that we have had is the general practitioners here. We have been approached on, I do not know how many occasions, can we help provide some general practitioners to the general practice surgeries and we have been able to do that with the RMOs. Here is another dilemma, we get RMOs to the hospital, similar to the same processes of a specialist in terms of an area of need, and we have to employ them full time because that is the only way you get them and that is the only way you make a quid and we accept that. But of course the workload varies and there are usually periods in the day for an RMO, from one o'clock onwards which is pretty quiet and you cover it well and there is one of them who can

always be off. So the GPs approach us and say, 'Can you help us out with someone to help us in GP land because of the dilemma?' and we have been able to do that and there are two people who are currently helping out in GP land who are RMOs at the hospital.

Mr SQUIBB - Are they fully registered?

Mr WALSH - They have been given provisional registration and they have been given a provider number as well, I believe, in the general practice. The interesting scenario there is that when we put up a couple more to the Medical Council they said, 'Hey, how can you be an area of need if you can give these guys time to go and practise in GP land?' Now we are quite concerned about that because that is a very narrow perspective because part of an RMO training program is for them to end up becoming GPs. Most of them end up into GP land once they finished their exams. So you have an ideal situation where you are able to provide great hospital training for these people, you have been able to provide them with the opportunity of going into the community and learning community rural medicine, which is part of their training and invaluable, and yet the Medical Council says, 'Hold on a minute, we can't do any more because you can't have an area of need in your hospital for these guys if they can be wandering out to GP land'.

CHAIRMAN - Is this the Tasmanian Medical Council?

Mr WALSH - Yes.

CHAIRMAN - So they do not even realise the problem and, as you say, the anomaly with that?

Mr WALSH - I do not think so. I think they realise that there is a problem there but I think they are hamstrung in terms of what they can do to resolve it. I mean, we continually hear the mutual recognition and one does not dispute that mutual recognition, it is a very important part, but if it is not working why adhere to it? If something is not working do you go with it - surely you fix it and make it work for this State. We know that the drain that we have from our hospital is to the mainland, as the rest of Tasmania.

CHAIRMAN - Is it to Melbourne and Sydney?

Mr WALSH - Most of it to Melbourne, Sydney, Western Australia. We have that experience first-hand that these guys gravitate to the mainland because that is where the action is, I suppose. One of our best RMOs went to Western Australia - he was offered an incredible deal to go to Western Australia to practise as a GP - one of our best RMOs. We could not keep him here. So there is opportunity, I believe, to meet the need of the community and that is all we are seeking and I suppose we would see it that we grant geographically-specific registration. We would put firstly that it is permanent registration to practise in the hospital. We would add to that, if possible - and this is the big ask - that they be granted a geographical provider number for that specific registered area and that that registration be granted for a period of time - three to five years - with a right to review at the end of that, which then gives both parties a lot of time to sort out and see what is happening. If the person moves out of the area their registration expires; it does not accompany them, it is allocated to a particular hospital.

What we would further like to see - and I am speaking specifically for the Mersey - is that there be an enabling process wherein that if the department recognises it is an area of need then that is virtually automatically granted for that person coming in. If there is an area of need for a general surgeon and we cannot get one and the department declares it an area of need, then the person that is recruited for that can virtually by a formality be granted that registration right. I am sure we do not want to go through this every time and if there is some mechanism which can be implemented to speed it up so that the services are not disrupted and this is one of the problems.

Mr SQUIBB - Are you suggesting that instead of having the two year with annual reviews that that period ought to be extended out from day one or are you suggesting that at the end of the two-year provisional registration there ought to be some mechanism whereby a further assessment, as opposed to examination, can take place to provide ongoing extended registration?

Mr WALSH - Geoff, that is one way. We do not have any particular bias to which way it goes. We hope that the result of this committee will be a mechanism that makes this tenure of employment possible.

Mr LOONE - When you bring someone in from overseas on recommendations of the providing companies that find a doctor for you, you would not want to put him on a five-year contract without having seen him work for twelve months or -

Mr WALSH - We do that on a three-monthly basis, John.

Mr LOONE - Whatever his initial trial period before you would then extend to him a lengthy contract.

Mr WALSH - Most certainly. Any doctor coming to us is on a three-monthly probation, particularly with overseas guys, that is inherent and it cannot be any other way. That is all of them, RMOs and specialists are on a three-month probation to see if they have the skills that they are supposed to. But we do a rigorous referee check on all of these guys, they are not just plucked out of the air. There is a rigorous referee check that is done, both written and verbal.

Mr HARRISS - In Dr Catchlove's submission, and you are probably familiar with it, he has made a comment that the Medical Council did not require any oral or clinical examination of Dr Iastrebov's expertise in either anaesthetics or intensive care. He then went on to talk about censors from the college have not visited the doctor to personally assess his skills, and then to dismiss without investigation the qualifications granted in Russia seemed arrogant in the extreme. All of that makes it pretty clear - it seems clear to me, at least - that your organisation is critical of the process that the Medical Council undertakes in determining conditional registration, first of all, and then secondly, to at some stage deliver full registration and not to take into account qualifications obtained elsewhere is arrogant. That nonetheless may be consistent with standards applied across the nation, though.

Mr WALSH - Granted.

Mr HARRISS - So that is a suggestion, then, that the whole system needs -

Mr WALSH - The whole system we believe needs overhauling, it really does. It is anomalous that on a piece of paper the Medical Council - here and in other States as well -are prepared to grant an overseas guy the right to practise on public patients. We send the CV to the Medical Council and it is gone through, no doubt, by the correct process that they go through, and it is endorsed. Of course the subject provisos are that the guy practises safe and does not do anything stupid, and so on, but it is a very cumbersome process to take someone off the registration if they are not practising correctly. We believe that we do our homework better than that before we recommend someone to the Medical Council.

But without having seen the specialist practise, without having seen him over a period of time or being able to assess what his work standards are, they are prepared to grant conditional registration. They virtually are saying that we are able to grant 99.9 per cent of the right for this guy to practise -

CHAIRMAN - On a CV and your say so.

Mr WALSH - On a CV, right. They go down there and meet Ian McIntosh and they have a quick chat and a cup of tea with him. No doubt Ian puts them through some sort of interpretative process, but to 99.9 per cent we are saying, 'We will grant this to you, regardless of the examinations'. No one is querying whether those examinations equate to Australian examinations, but we are saying, 'We'll grant you conditional registration on your overseas training'. Ninety-nine per cent. It is that 1 per cent in terms of permanent provider number and college recognition which is the dilemma.

We do have a situation where - and you are probably coming to grips with this - one of the most frustrating processes is to go through the Medical Council, the college and the HIC about granting professional college recognition. They will continually say, 'It's not our responsibility, it's the Medical Council's'; the Medical Council says, 'We can't grant it unless the college gives professional status to

these people'. So there is virtually a nexus between the two that neither will move without the other, and the catalyst for it is the completion of the Australian examination.

One of the things we believe is wrong is that there are censors in all of the colleges. It seems an indictment on the college that they are prepared to condemn an overseas graduate, be it in any specialty, but they are prepared to condemn him as not meeting Australian standards, without every having assessed his work. We have said all along that we are prepared to pay and bear the cost of a censor coming from a college to assess first-hand specialist work, and in the case of Dr Iastrebov to come down and spend a week with him and go through it and question the guy and grill him. If at the end of that week he says he cannot be granted specialist fellowship then that guy should not be allowed to practise on any patient in our hospital.

CHAIRMAN - I agree with that. It seems to me that rather than this written examination, which most of the colleges believe to be the be-all and end-all, it is a far better way of assessing competence by having this practical examination over an extended period of time.

Mr WALSH - Sure. Not having seen an examination, but certainly having spent a lot of time with the specialists who have undergone it, the examination is searching in terms of the rudiments of medicine in lots of areas. It is like any specialty that you are in or any training that you undertake that when you do your degrees you learn the nth degree and down the minutiae, which is important to know. As you move into your specialty your minutiae becomes very blurred and becomes memory-ridden, and we are expecting these guys - proven specialists - to go back and relearn all this stuff, which to them at the time was a challenge. It was pretty irksome, it had to be done and they did it. They have jumped through that hoop.

Mr SQUIBB - And it is not even really being used as a method of testing their competency because it is used as a method of allocating the numbers and controlling the supply and demand.

Mr WALSH - Exactly, and that is the other dilemma that we have. Should Dr Iastrebov submit to an examination - and I think it is right; I do not think he has made any friends with the college in his process here -

CHAIRMAN - They often say the squeaky door gets the oil, though.

Mr WALSH - One has in the back of one's mind that if he submitted himself for examination, the golden rule would apply: those who have the goal make the rules. One would seriously question whether he would ever pass an examination. Yet I would challenge the censors at the college to come and personally inspect Dr Iastrebov's work.

Mr HARRISS - That view is confirmed again in Dr Catchlove's submission where he is critical of the inflexibility of some colleges versus others.

Mr WALSH - Yes, exactly.

Mr SQUIBB - And inconsistencies.

Mr WALSH - Yes. Andrew Hanusiewicz. We are delighted that Andrew was granted that, but why was he granted that? Was it because Andrew was not outspoken? Was it because he got political push? Was it because of power politics? Was it because of college politics? I do not know. But how inconsistent that one gentleman, who is at the latter days of his life -

Mr SQUIBB - His career, anyway.

Mr WALSH - His career - sorry.

Laughter.

Mr WALSH - He has - and I say this not critically, but analytically - a limited value to the community in terms of what he can offer in terms of longevity of service compared to Dr Iastrebov who is starting

out at the peak of his career. He is young, enthusiastic and he is 'go'. One gets it. Is it because he is at that twilight age of his profession and therefore he is no real ongoing threat to the status quo, against Dr Iastrebov who may be a threat to the status quo?

Mr LOONE - We are talking about uniformity between the States with registration but, as I mentioned to Mr Hope when he was here, there is no uniformity between the medical colleges. In some cases they were registration without examination or -

Mr SQUIBB - Or even within the colleges, because we heard yesterday of an example where an anaesthetist was granted full registration without examinations.

Mr WALSH - This is true.

Mr LOONE - That is where it wants looking at, even from that level, the registration procedures.

Mr WALSH - Exactly. I do not think it is overcritical or a presumption, but it is club mentality that we are really dealing with, and a very powerful club.

Mr LOONE - This is coming out in evidence.

Mr WALSH - It is a very powerful club that we are dealing with. I stipulate here that in the health care of Australia we are the first to want to uphold the Australian standards. We will not be part and parcel to any process which would water down the standard of the medical profession in this country. We would want to uphold that, but we believe the inflexibility of the current system does not meet the needs of this country, and that is our concern.

Mr LOONE - Could I put one question to you. You are dealing with overseas-trained doctors on a regular basis and bringing them in, and this of course is where our main problem is arising. Do you think that the majority of those would accept the type of conditions we have been talking about where they come on a three month's trial period, as you suggested earlier, and then to be offered an appointment of five years, or whatever the given period may be, because they cannot become fully registered under our system, that the majority would accept that type of appointment? If they come here for six or seven years, would they accept an appointment under those conditions?

Mr WALSH - I believe so, John. I believe that is important and that would be such an incentive to put to people coming. I do not think we want to open up the floodgates through this process.

Mr LOONE - That is the farthest thing from our point, and that is what is worrying us most. We know the problem.

Mr WALSH - We would not want to open up the floodgates, but I believe if we have areas of need we have to address those areas of need specifically. As long as we can give the people some permanency: 'Here we can offer you five years'. Bingo. 'At the end of that time we will review it and if there is still an area of need and we can't fill it, the recommendation will be for you to be given another period of five years', or whatever it might be. However if, in the period of five years he is here, that person wants to undertake the Australian examinations and do them and so become qualified, so be it. That is his discretion and that is his right to do that, and we would honour that.

That would have a two-fold effect. We would hope that after five years the person so loves living in this area they want to stay - and we know that happens with many of these people; they love to stay here. So we have the opportunity of having them inculcated into our society over a five-year period. If in that five years they do their examination and get Australian qualifications, I believe that 95 per cent will still stay anyhow, but when they still stay they then reduce the cost to the Government for their employment because they have their provider number and they are right. So there are enormous benefits.

CHAIRMAN - No doubt you have put what you believe would be a fair way out to the council: that is, your geographical registration, your three to five-year period; if they move out of the area then they go back into the basket again. What has the council said to you about that?

Mr WALSH - The Medical Council?

CHAIRMAN - Yes.

Mr WALSH - I think it is beyond their concept of dealing with it. I think they are restricted because of the existing act, and that is their governing power at the moment.

CHAIRMAN - But the act, to me, does not seem to restrict them with that because it gives them the discretion -

Mr WALSH - No, it does not, I was just going to say that. I believe there are outs in the act for that to occur - a public need and an area of need. We believe that there is interpretative value in that being expanded.

CHAIRMAN - But there is no time limit in the act, is there?

Mr WALSH - No, there is not. It is a twelve-month registration thing.

Mr SQUIBB - It is not in the act, it is only in the implementation.

CHAIRMAN - It seems more of a convention that has grown up - this two-year period.

Mr WALSH - Exactly. We believe it is a convention and it is not doing us any good in Tasmania. We are losing; we lose so many good people that we could keep here if there was some permanency of tenure.

CHAIRMAN - Getting back to the point where you say it is costing you each year, would you be able to average out what it is costing you each year? You said $150 000-odd, but that was over a number of years.

Mr WALSH - The hidden costs, the on-costs would be between $50 000 to $100 000 a year.

CHAIRMAN - And you were saying if that money was available not for the advertising but for the hospital, would it be just added to the bottom line and a profit to the hospital or, alternatively, would it be put to the use of updating medical facilities and perhaps bringing on new specialists and improving the medical facility within the Latrobe district?

Mr WALSH - It is very easy to say, I suppose, that the natural inclination would be that it can go to the bottom line profit margin, but what the problem is today is, we need to save every cent in medical care to survive. It is not like you can take anything out of one basket and put it straight to the bottom line. For instance, we are currently faced with up to a 15 per cent nursing increase over three years in this State; the medical staff just got a 5.5 per cent increase. So there are these enormous increases that are going -

CHAIRMAN - Administration?

Mr WALSH - Unfortunately no, it is the specialists. There are these enormous increases that are going, so it is not a matter of taking something and adding it to the bottom line. It is being able to reduce the unnecessary costs to enable us to continue to function rather than add to the bottom line. People think $50 000 or $80 000 does not mean much to the bottom line, but it is certainly a cost efficiency that enables us to absorb these costs that have to be absorbed. When nursing costs are running at 4 or 5 per cent a year, that is what we are posed with. We have superannuation coming up in July of another 1 per cent and you have at least a 4 per cent nursing increase this year; you have a 5 per cent increase, and inflation is running at 2 per cent, so we do not need to be mathematicians to work out what is happening.

CHAIRMAN - Another question I wanted to ask was, is part of Dr Iastrebov's conditional registration that he act under supervision?

Mr WALSH - It is.

CHAIRMAN - To me that is odd. On the one -

Mr WALSH - They all have to act under supervision.

CHAIRMAN - But under supervision from whom? From a GP or from another anaesthetist?

Mr WALSH - I think it is part of the protocol and that a granting of the condition they have to be put 'acting under supervision' which one would expect. Now the 'acting under supervision' is that at Mersey we have an Australian college graduate in the twilight of his career -

CHAIRMAN - In what?

Mr WALSH - Anaesthesia - recognised by the college. This gentleman is the nominated supervisor of Iastrebov.

CHAIRMAN - I see.

Mr HARRISS - Is he learning from Dr Iastrebov at all?

Mr WALSH - Well, here is the anomaly. This guy here - come on, we are talking chalk and cheese - Stan has probably forgotten more than this guy has ever learnt.

Mr HARRISS - Does it not make a mockery of that convention?

Mr WALSH - It does make a total mockery of the whole thing - the supervision. I know for a fact that one of our gentlemen here - an overseas-trained guy, an anaesthetist - went to Hobart as a registrar to do the exam, again under supervision. I said, 'Who supervised you?' He said, 'Oh, don't be stupid'. It is a perfunctionary thing rather than an actual thing.

CHAIRMAN - So even though they say 'under supervision', there is this person who, as a figurehead, they can say is supervising him, but in practise he is not really supervising him in any way at all.

Mr WALSH - I would not insult Dr Iastrebov by asking this other doctor to supervise him. It would be an insult. This is the crazy thing, that this gentleman at the end of his career has got full college scholarship and full rights and yet his anaesthesia expertise is very, very narrow indeed.

Mr SQUIBB - In the letter of approval, or in the letter of application for approval, do you have to indicate who the supervising specialist is going to be?

Mr WALSH - No, you do not. They will be under supervision. It is interesting, Geoff. Sometimes they ask who will be supervising. I remember once that, I think the first letter - and this is purely memory - was Dr Iastrebov was supervised by our orthopaedic surgeon.

Mr HARRISS - Bob, one of the terms of reference for this committee is we are to consider the extent to which Parliament ought to be involved in a registering process. Dr Catchlove's submission concludes by saying that ...strongly supports the passage of the bill. What level of involvement is appropriate for a Parliament in this sort of a process, given that it could be argued pretty strongly that on balance most members of Parliament would have no medical expertise to make a judgment of competency of either Dr Iastrebov or anybody else?

Mr WALSH - It is a good question and it is one that we have certainly talked about. I believe that the Parliament's involvement is to enact some legislative capacity for the Medical Council to either further interpret their existing act for the benefit of this State or to provide some mechanism to allow this to occur. There has to be some professional assessment of it. We certainly agree with you.

The last thing we want is for parliament to be assessing medical qualifications - or indeed qualifications in any speciality. That is not parliament's role. But I believe to enable somehow, whether it be by decree, dictum or regulation, that the Medical Council be given the power, or be given the interpretative right to implement what I believe is already there to grant this, then the Parliament can provide some mechanism for the professional qualification evaluation of these people. Certainly we do

not see, and would not want, that the Parliament have any involvement in the assessment of medical practitioners. That is certainly the farthest thought from our minds.

CHAIRMAN - It is dangerous, is it not?

Mr WALSH - It is fraught with tremendous danger.

Mr HARRISS - It could equally be argued that such an assessment has already been made in that Dr Iastrebov or others have been granted conditional registration. Somebody has already made the assessment of their medical capacity to operate. This process may be argued that it is merely extending what has already been delivered - his condition.

Mr WALSH - That may be so. I think the Parliament having set up the Medical Council has done the right thing in terms of it has delivered that power over to a body who has the professional expertise to evaluate a professional, and I think that is correct. I think the overall ruling thing here is, let us get some flexibility into the system that is going to meet the needs of the community because they are the people who suffer in the end. Life goes on but our community suffers because we do not have the right people on a consistent basis to deliver services in health care for them. Let us get some flexibility into the system that acknowledges that we cannot get in rural areas the professionals that we need to run the medical services.

Mr HARRISS - What does the future hold for the Mersey General when Dr Iastrebov's registration expires?

Mr WALSH - It holds that we will be back in the process of overseas recruitment -

Mr SQUIBB - An extra $100 000.

Mr HARRISS - Which has been fairly futile in the past?

Mr WALSH - Well, it is overseas recruitment of overseas-trained people. We have reached the stage where, 'What is the point of advertising in Australia?' You may as well just throw money down the drain because it has not borne any fruit to date, and there is no reason to believe that that will change. So when Dr Iastrebov's future transpires at the end of this year - his licence is not granted further - there are a few things that we are faced with. One is the need to recruit other specialists - anaesthetists to start with, just pure anaesthetics. We need to recruit again and so we are on the overseas bandwagon once more. Secondly, if we cannot recruit another intensivist, then we really have to review the level of surgery we are able to provide at the hospital, and this is a real concern to us.

CHAIRMAN - That would be the major concern, Bob -

Mr WALSH - It is our major concern.

CHAIRMAN - because as I understand it - and I am sorry, I do not want to cut you short with your answer - you can be a general practitioner and still be an anaesthetist but - and this is what we were told yesterday - the intensivist is a real speciality perhaps over and above an anaesthetist. I am no expert; I do not know, but that is what we were told yesterday.

Mr WALSH - If I can just delineate this, you can be a general practitioner/anaesthetist - be very wary about that one. General practitioners in their training do do a block of anaesthesia. It is usually about a six-month block and some of them become proficient at it. We have a GP at the hospital who can do GP anaesthesia, but it is very minor work; it is virtually limited sedation, or mild sedation work, mainly for colonoscopies - fairly non-invasive sorts of procedures. That is virtually where it lies and stops. The anaesthetist as such - a qualified anaesthetist - can do general anaesthesia in terms of severity of operations. The problem with anaesthetists as such is that the post-operative experience does not usually extend to intensive care. The difference between an intensivist and an anaesthetist is the level of care post-operatively or an intense trauma life-threatening situation, where their expertise and their training comes to the fore. Just general anaesthetics does not have the extent of that training that an intensivist has.

Mr SQUIBB - If I could just ask then - it is probably a low-key comment and it was not given as evidence - but somebody indicated to me yesterday that there are more patients lost during anaesthetics than there is during surgery. I am interested in your comment.

Mr WALSH - My comment, Geoff, is in any surgical procedure the danger is the anaesthesia. It is acknowledged. It is not the intervention - the cutting - it is the anaesthesia because your airways - your vital support system - is out of your hands; it is in the control of the anaesthetist and machines, whereas much the surgical intervention is the control of the specialist. The anaesthetic is the critical part of any operation. You may survive the operation but you may not survive the anaesthetics. That is true.

CHAIRMAN - Did that answer your question, Paul? I am sorry I cut you off.

Mr HARRISS - Yes. That is very thorough; I appreciate that.

CHAIRMAN - Is there anything else you wanted to put to us, Bob?

Mr WALSH - No -

CHAIRMAN - Thanks very much, it was terrific and most helpful.

Mr WALSH - Our ultimate aim is that some really positive outcomes will come of this select committee, that will remove this ambiguity, remove the inconsistencies. We are not just speaking of Mersey here because we are linked into all the other services around. The dilemmas we have at Mersey are magnified and copied in the other areas. We see it as a general State need, that we have to do something about it. We lose good people. At Mersey we train these RMOs, we get them up to speed and then they go.

CHAIRMAN - How many have you lost in your time?

Mr WALSH - RMOs?

CHAIRMAN - Yes.

Mr WALSH - There would have to be ten to fifteen who have gone through since we have been there.

Mr SQUIBB - Has that been worse since mutual recognition?

Mr WALSH - I could not comment on that, Geoff. It certainly has not been enhanced, I do not think. The problem is they will come here for twelve months, and if they have to do the exam, if they fail the exam, they have to kick off. What we would like to do with RMOs is for them to come out here and we be able to offer them permanent employment as hospital medical officers. This would be terrific.

We acknowledge that they are not going to get into GP land now with the ten years they have to go through. Some of these people are going to be in their 30s when they come here, so 45 before they can possibly get into GP land, if they can get in - and there is a big 'if' whether they are accepted into the general practitioner training program. So the opportunity exists for us to offer them a really nice lifestyle practising medicine in a hospital for which we train them for, but if we cannot offer them any permanency in that regard they just take off; they go back home. Some of the lucky ones will complete the exam and move on. But now that door has been shut as well, because of this ten-year training program they have to go through before they get a provider number as a GP. So that is another problem.

We could, with some permanent registration and security, offer them a career in hospitals, and believe you me, there is an incredible demand right throughout the hospital system for career medical officers. It is an unmet need and it is in every hospital. You only have to pick up the weekend papers to see the need for that. So we are hoping and trusting that something really positive will come out of this that will ensure the health services of this State.

Mr LOONE - You are saying that this is not just about Mersey, and we are finding that we have to make sure that this is not just about Dr Iastrebov.

Mr WALSH - Exactly.

Mr LOONE - It seems to be the general opinion that this is all about getting him registered and it is not; it is about registering overseas-trained doctors.

Mr WALSH - Yes. We endorse that, John.

Mr LOONE - We are finding a lot of the time people tend to think it is all about Dr Iastrebov. He is part of it; he is the instigator probably, but it is about general registration.

Mr SQUIBB - Dr Catchlove picks that up in the last page of the submission where he says whilst they support the bill before the House he believes it is only a piecemeal solution; that it is a wider thing.

Mr WALSH - Yes.

CHAIRMAN - Even though it is a supporting of the bill it seems to me it is not a supporting of the parliamentary intervention to register doctors. It is a supporting of putting forward a process to enable the Medical Council to get out of their cemented ways in granting registration. Would it be fair to say that, Bob?

Mr WALSH - I think that is the interpretation that we would put on it. If the bill is the process, I agree with what John says; it has to be broader than Iastrebov. It is virtually the catalyst, I suppose, if I could use that.

CHAIRMAN - Sure.

Mr WALSH - It has to be broader than Iastrebov; it must be broader than Iastrebov otherwise we could be meeting here every week.

Mr LOONE - Well, it is his case that has brought it out into the open.

Mr WALSH - Exactly; it has.

Mr LOONE - The problems that you are facing, that every other hospital are facing, it has brought it out into the open air.

Mr WALSH - We do not want any special favours for Iastrebov. What we want is something general, that is all-encompassing to secure medical staff in our hospitals.

CHAIRMAN - One of the things, in closing, that was ridiculous yesterday was when you look at, say, Dr Edwards, the paediatrician in Burnie. When he was a specialist in New South Wales from 1975 to 1983 - and I have mentioned it a couple of times - he went to Papua New Guinea; he was a specialist there. New South Wales said, 'Look, because you're not training in New South Wales any more you can't be still on the register as a specialist'. He comes back here and he cannot get his speciality, even though he has been asked to prepare a course for rural medicine - a number of different things. It is just crazy.

Mr SQUIBB - Whereas if he had been registered in Tasmania prior to going to New Guinea he could have still retained it.

Mr WALSH - Yes.

CHAIRMAN - That is odd, to say the least.

Mr WALSH - It is very difficult.

Mr LOONE - There are anomalies galore.

Mr WALSH - It is. Mutual recognition has not done one thing -

Mr SQUIBB - For Tasmania.

Mr WALSH - for Tasmania. Not a thing at all; it has not helped us, and I do not believe it ever will. Our plea would be, 'Let's look at our State's needs'. I do not believe mutual recognition is helping us in any way to deliver more effective health care. I believe if we continue to hold up the mutual recognition thing as the thing that we must not violate in terms of our Federal counterparts in the other States then I believe we are not going to get anywhere.

CHAIRMAN - But we are not violating it, are we, if we look at it to be in the public interest in order to practise in a declared area of need?

Mr WALSH - Exactly.

CHAIRMAN - There appears to be no violation at all.

Mr WALSH - There is not.

CHAIRMAN - It just appears to be an easing of that discretion that the council are not using at the moment.

Mr WALSH - Yes.

CHAIRMAN - Thanks very much; it is much appreciated.

Mr WALSH - Thank you for your time. Can I just ask a question?

CHAIRMAN - Yes.

Mr WALSH - What is the time frame?

Mr SQUIBB - A good question.

Laughter.

Mr WALSH - You have been asked it before.

CHAIRMAN - We would love to say next month but I do not think it will be.

Mr WALSH - Sure.

CHAIRMAN - John, being the wise head, said 'Probably July/August' and probably at the end of the day that might be the case, even though we will try to get it done earlier.

Mr SQUIBB - Bob gave evidence to a previous select committee dealing into transport needs. I think we can assure you it will be quicker than that one.

Mr WALSH - The reason why I ask of course is that 28 December looms.

CHAIRMAN - Yes, I understand that.

Mr SQUIBB - I think on *Hansard* I indicated that unless this process was over within a reasonable time I was going to bring it back on.

Mr LOONE - We are aiming to do it as quick as we can with sitting times and things.

CHAIRMAN - It seems to me, Bob, that after we conclude today then we have Launceston tomorrow. There seems to be a couple of legal matters that have to be worked out. Once they are worked out - and hopefully they will not take long - we can get to coming to our recommendations and then putting the report forward.

Mr SQUIBB - I think some definite trends seem to be emerging.

CHAIRMAN - Yes. You can probably understand the trends.

Mr WALSH - I will write it for you, if you like.

Laughter.

Mr SQUIBB - We made that offer to a previous witness but he declined.

Laughter.

Mr WALSH - Thanks very much for your time.

THE WITNESS WITHDREW.