**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.**

**Dr KONSTANTIN IASTREBOV** WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIRMAN** (Mr Wilkinson) - Stan, I hope you do not mind me calling you by your christian name again, but please call us by our christian names. It is informal. Can you state your full name, address, and in what capacity you are before us today.

**Dr IASTREBOV -** My name is Konstantin Iastrebov and I am a doctor who works in Latrobe hospital, Mersey Community Hospital, since 1996. I am a Director of Intensive Care and for two years I was serving as Director of Anaesthetics as well. My address is 96 North Fenton Street, Devonport.

**CHAIRMAN -** Stan, if I can help in any way. It is a situation where I believe there is no need, as far as I and any other members of the committee are concerned, to talk about your expertise, because really today has just about been *This is Your Life* without you being present. So there is no need to talk about your expertise. As I have told you before, one of the problems that prima facie I have is that I find it difficult for a non-expert body to be a de facto registration board. So, as a result of that, what we have to look at is ways to recommend to the expert body that the question of overseas-trained doctors and the question of rural areas should be answered, and it seems to me there is a problem. The problem is that here you are, you have come over, you have done your training, you work for two years as an expert and then suddenly after two years they say, 'Hey, look, you're not an expert any more'. That is the first problem. The second problem is, if that is the case, what happens to the hospital that you are training in and working in and what happens to those people in the hospital?

**Mr HARRISS** - Just to pick up that final point, Mr Chairman, we have been concerned as to the end of the period of conditional registration, what for Stan Iastrebov, and after today's testimonies you might consider politics. You would have a heap of advisers, you would have people to run your campaign and do all sorts of things for you.

*Laughter*.

**Dr IASTREBOV -** I think there are really two questions in this one question: one is what is what is to Dr Iastrebov and two is what is to all other overseas-trained doctors in two years' time after their arrival? I guess there are several ways of looking at it, but from my perspective as a doctor who is in this situation, it is pretty simple. When I was called in it was explained that there is a hospital that desperately needs an anaesthetist, and have not had one for a very long time capable of handling the most difficult cases here. I have been told that there is intensive care that needs to be made, and there is no intensive care ....., and if I am interested in it. I said, 'Yes, I am' because it was an interesting challenge. It was not only a challenge; it was also something to build on. It is like planting the tree. A new tree one day will be big. You want to come and see this tree really good later if you put it in the ground. That is how I felt at that stage, and I came over and I started my work. Now two years down the track I can look back with pride, and I can say that I am proud of the unit that all of us made together, and I took a big part in it.

Is it just a building, because we know there are also people who we treat, people in the communities that you get to know. You become part of the Australian community, of this rural Tasmanian community in fact, and you start to know your patients and they come back to you again and again for different reasons, for operations, with their relatives next time, etc., and this is what a doctor's practice means. It is not just coming in and doing the job for 15 minutes, but it also to know your patients, to

know their history, and every time they come again you know them better. And it is part of the GP practice but it also part of the specialist practice, and for me going away in two years does not mean only losing the job where I am paid - that is very good and everyone needs to be paid and it is part of the reason that I am here - but it is also losing a big thing that you built on your own. It is like you built your own house and then you walk away from it. It is like you planted this tree and you cannot see it again. And it is my patients that I leave behind as well, and their relatives et cetera. In a way I feel I have obligations. I do not know to whom I am leaving it now. That is one of the things.

The second is pretty easy, I think, to understand. Leaving by your own will and leaving with the future that you are going to build something else elsewhere when you are planning your life further is one thing, but when you are leaving after the work you have done very well and you believe so, and many of your patients probably think so, and you are leaving virtually with the word behind that you are not good enough to do this job any more, I feel like very early retirement at this point. The person who is not necessary for society any more, after all you have done for this society. It is a very frustrating feeling, I must tell you. And I guess every overseas doctor feels the same. In fact I think it reminds me at present, I would probably describe it as a very sophisticated slavery of the 21st century of what is happening. That was a very similar thing. I recently saw a program on TV about Indonesia. They are importing people from the Philippines. The Government knew about it, closed their eyes on these imported people, and these people were virtually used on the building/construction industry. They were not paid much, they had no rights, they had to keep quiet. If they raise their voice they are thrown out the same day. The government knew about these people. They were illegal legal immigrants. After they have been used, when they cannot work any more, they were thrown out.

I feel very similar. I have been used for two years, and I worked very hard, and I think I worked very well, and then suddenly after two years I get the word that I am not good any more to do the job that I did. The question is, is it so or not? That is what the question probably has to be not only for me but for all foreign doctors: what happens after two years of your practice?

**CHAIRMAN -** Because the argument that they would use to that is, of course, did you know the ground rules when you came in the first place? If you knew the ground rules when you came in the first place, are you able then to come back and say what you have just said?

**Dr IASTREBOV -** The ground rules when I arrived in Tasmania were a bit different to what I can hear now. Mr McIntosh told me many times that as long as there is no other Australian applicant, do not even worry about it. We just cannot register you now permanently, but we will just extend it year by year. Just do not worry. No one has been there before and no one will come.

**CHAIRMAN -** Did you have that in writing, because I think that is important?

**Dr IASTREBOV -** I always used to trust people on their word, you see. Back home we do not have it in writing. We always have things on word, so no, I do not. But in a way when I came I thought, 'Well, he is saying that. I will work hard and I will show what I can do, so there will be no question of kicking me out of here', and that is what we did.

I want to show you something now. Two days ago I got this information from the Australian and New Zealand Intensive Care Society, and that is a national database. What they show is, depending on the severity of the disease, the mortality rate in the country on average of what is happening. There is a special scoring system on page 2. I think you have heard today about that. They produce this type of graph, and this type of graph has Apache scoring here higher according to the severity of the disease, from 0 to 71 theoretically, but over 42 everyone dies. On the bottom here it is from 0 to 100 per cent mortality. So as you can see, the higher the Apache score, the more mortality. There are two parts. One is this little thing: that is 1985 American data. That is when this system was created, and everyone is still compared to that. It is wrong to compare to it, because 15 years down the track American figures are completely different, but local people still compare to that. But that does not matter. The next stage there is another little one, this one. I will give a copy to everyone. Now another one here is an Australian average. For this degree of severity of the disease, that is what the mortality is, on 14 April 1998. The red and green is ours, so it is what we have here. The green is 1996. The mortality rate in our unit from 132 patients that we had through the year with this severity, and we had 15.3 Apache score at that stage, and that is 15 to 17 here, and as you can see we have 11.6 per cent mortality, when the

Australian average was close to 15 per cent. That is 4 per cent down, 3.5, from the Australian average. That means that of 100 people that we treated, 3.5 people have survived better than they would in the average Australian hospital with the same degree of illness. Now this is universal. It does not matter which disease it is. It measures the severity of the disease, whatever it is.

There is another figure here that is 1997. In 1997, again 110 patients came through the unit, and the Apache ... reason we had more severe patients in this year. It was 18.5 in the unit. In the Australian average the mortality rate would be 25 per cent for this group. We had 22.5 per cent - that is another 2.5 people. Two and a half. What is half? I do not know, but three and a half, two and a half, it is another six people from the local community walking around, different from what it would be in the average Australian hospital. In two years' time it is another six lives. Is it a lot? I do not know. Probably for parents and relatives it is.

Here in 1996 and 1997 I put together the most severe cases that came through the unit, and it is called multiple organ failure syndrome. That is when several organs in the body fail. It is a whole group of patients. It always is separate because they require the most resources and art of intensive care. Not already science, it is an art of intensive care. And the average Apache score here was 30 to 32. Americans predicted in 1985 with their figures that 70 to 75 per cent of these patients would die. The average Australian mortality for this group of patients is 61 per cent. In the unit for two years, of 32 patients we have had, we had 40 per cent mortality in the unit, and 53 per cent follow-up hospital mortality. So that means it is 8 per cent better than the national average in the most severe group of patients over two years. The group is not dramatic, and I do not know if they put statistics and discrimination points how that will look statistically - 32 patients - but it is enough to show that it is significant, that it is not one or two patients, it is 32 and it is over two years.

This is figures, and it is not some claim, as the press is always saying, that 'Iastrebov claims'. Every time I open the paper it says 'Iastrebov claims'. I am quoting now. I am not claiming any more.

**CHAIRMAN -** You know not to read the paper, though, or believe the paper.

**Dr IASTREBOV -** I will give a copy to each of you so you can have it on your record. The second thing is what we have done in the last two years here for the State. I think there are a few things to remind you of: one is that probably the amount of new things for the hospital that have happened have been dramatic. We now have a level 2 Intensive Care Unit -

**CHAIRMAN -** Do you mind if I stop you there, because we will be asking some questions tomorrow to people, and just so I can get down again what you said, can I go through this because I think it is worthwhile asking questions tomorrow of the Medical Council in relation to this. Your 1996 Apache statistic shows that what -

**Dr IASTREBOV -** That is right here - 11.6 per cent mortality - this is the green dot.

**CHAIRMAN -** So 1996, 11.6.

**Dr IASTREBOV -** Yes, and Australia is just next to it. You can see it on the same level.

**CHAIRMAN -** Yes, and the Australian is what?

**Dr IASTREBOV -** Well, if you will just put the line down, so it is about 15 per cent. That is why I put lines down just to make it easier. It is about 15 per cent. That is 1997 here as well. We had 22.5 here, and it is about 25 per cent here. That is from multiple organ failure. It is about 61 per cent here, and that was 53 hospital. So that is the end stage when people go home. Not that you kick them out from the unit early and then they go to the department and die there upstairs somewhere on the floor. No. That is when they go home.

**CHAIRMAN -** So in 1996 the average was two-and-half people?

**Dr IASTREBOV -** Three-and-a-half.

**CHAIRMAN -** Three-and-a-half, thank you. And 1997, two-and-a-half, and with your major organ failures, 8 per cent.

**Dr IASTREBOV -** Yes.

**CHAIRMAN -** Thank you, that is what I wanted.

**Dr IASTREBOV -** There are several things that I would like to put on record, and there are things that we pioneered in the State that no one in the State has used in Intensive Care before. One of those was computerised extracorporeal renal support. We were the first to start it. The second was bilateral differential lung ventilation. Virtually it is the first time in the world it has been done and this is motor ventilation with synchronised autoflow in one lung and bipart ventilator in another one. That is why it has been printed in Europe and distributed. The third probably that Royal Hobart is still jealous of is a nitric oxide treatment that is a specific pulmonary vasodilator that we used in a very severely-ill young person in the department, and Royal Hobart is still trying to get an approval to use it. They still did not get to it.

**CHAIRMAN -** These other first that you spoke about, are the other hospitals - Launceston General and Royal Hobart - using those practices now?

**Dr IASTREBOV -** I do not know. We were the first to get ... in the State and start it.

**CHAIRMAN -** Did they ask you to come and lecture them in those areas?

**Dr IASTREBOV -** No.

**CHAIRMAN -** Did they ask you for any document or anything like that in those areas?

**Dr IASTREBOV -** No. We have meetings, very rare, once a year, of the Tasmanian Intensive Care Society, and as a member of the society I go to those meetings. The last two years we were meeting in Launceston, and there were propositions made to meet much more often - it has never happened - and the last meeting was that we should go and visit each other and tell each other about what we do, but it has never happened. It remains on paper.

**CHAIRMAN -** I ask that because there is a doctor yesterday we spoke with who is in the same position that you are, and yet he has been asked to go and lecture other specialists and students in relation to fields. His lecturing will allow them to be specialists and yet he is not classed as a specialist. That is why I asked.

**Dr IASTREBOV -** Well, Professor Baker, who is a tutor for the University of Tasmania here in our hospital sent me a letter of thanks from himself as a representative of the university that I lectured his students who were at the hospital at that stage when we did nitric oxide treatment, and that is as far as I could go to show our experience. I think I found it is much easier to show our experience overseas than to find interest here.

**Mr SQUIBB** - Do you think that could be because of, just for lack of a better term, professional jealousy, the fact that those who are running those departments in hospitals in this State are Fellows of the College?

**Dr IASTREBOV -** I found Professor Bell, who is a director of the Royal Hobart Hospital Intensive Care, a very approachable man and helpful in a way, but speaking to these people the last time and asking them, at the Intensive Care Society meeting, I said, 'I am a member of the society and I would like to have your support in my problems with registration', and I have been told clearly and straight in the face that they cannot go against the college. I do not think invitations to lecture have anything to do with being afraid of the college, but obviously there is a degree of support they could provide. It did not appear though and it was very disappointing.

**CHAIRMAN -** Do you think that they may say that if they ask you to give these lectures the Council might say, 'Ah, look, he's rocking the boat at the moment, and by giving the lectures you might get some achievement double-plus that they do not want you to get?

**Dr IASTREBOV -** I think that there are always ways for the Council to say it. I do not think it would be said directly but I am sure there are ways to say it and ways to suggest not to do it. I would not be surprised if it may take place but I cannot say that it has taken place, I do not know that.

**Mr LOONE** - When the bill was before the House and a number of briefings were held, some of which you attended, there were discussions with the AMA and the Chief Executive Officer was to make contact with you and work through different avenues with the idea of trying to do something about your registration, what eventuated with your discussions with the AMA?

**Dr IASTREBOV -** Nothing.

**Mr LOONE** - Did the Chief Executive Officer not visit you and go through the -

**Dr IASTREBOV -** I met with Doug Lowe twice. Both times he promised me that he will be -

**Mr SQUIBB** - How recent was that?

**Dr IASTREBOV -** Very long ago, months and months, last time.

**Mr SQUIBB** - Since the bill was introduced into the Parliament?

**Dr IASTREBOV -** Once. He promised to speak with the college and he ensured me that with the recent agreement already that the college will come and assess things in the place, the results of my work and how things are done et cetera. In my belief there is a final reason for a doctor to be trained and to do all his studies and everything is how he can treat the patient; everything else does not matter. It depends how safely and efficiently you can do your job. That is why I wanted -

**CHAIRMAN -** Practise is far more persuasive than theory.

**Dr IASTREBOV -** Yes, that is why I want the college to come and see on the place what we do, what we have achieved, what the standards of practice are. Three times I wrote to the college myself about it. The last time was probably about three weeks ago, due to the invitation to participate in an intensive care day around the country and ... I would love to participate in such celebration and I would like to promote the achievements of the Australian intensive care but I do not see how I can participate in this activity of the organisations that claim that I am not a professional in this profession. I would like to hear their remarks on that and in fact I would like them to come and see things in the place. I wrote to the Dean, Professor Duncan. I never had a reply on both of my letters, that is how it is.

Whatever Doug Lowe promised, unfortunately, has not happened. He promised me college people here, he promised me lots of things to be happening but nothing has and that is how it is.

**Mr HARRISS** - Stan, my recollection of some of the discussions we had during the briefings and the discussions during the presentation of the bill were from the AMA that an alternative pathway was available and that the AMA would facilitate that for you with vigour.

**Dr IASTREBOV -** That is right.

**Mr SQUIBB** - In fact we were told that Mr Lowe was going to in fact travel to Latrobe and meet with Dr Iastrebov within two weeks.

**Mr HARRISS** - Yes, and yet we understand subsequently that there is no alternative pathway.

**Dr IASTREBOV -** There are ways and mean. There are alternative pathways, there are, same as in the past, still now no one stops a college or an anaesthetist in any way the decide to acknowledge that this person's professional standard is suitable for the specialist. It does not mean that they have to admit you as a fellow of the college.

To be admitted as a fellow of the college can be done by two ways: one is an honorary fellowship - and it is usually given to the professors from overseas ones they know that would not come and work here - and two is to be admitted through the examination, final fellowship examination.

To be recognised as a specialist you do not need that and that is an alternative pathway and that is the pathway that three South African anaesthetists in Ipswich who came during my being here and after that have followed: Harold Bernetz, Sue Brunke, Roy Milanski, three people who have been registered by the college without examinations, without any additional training, just because they had good reports from South Africa and just because they had all papers in order.

**Mr SQUIBB** - Could I ask you, are you aware of the circumstances regarding the recognition granted to Dr Cathryn Stewart?

**Dr IASTREBOV -** No, I have never heard of her, I have never heard her name.

**CHAIRMAN -** When you say the South African - prior to 1992 I understand, and that is the date that I am using, I think they said 1992 anyway -

**Dr IASTREBOV -** No, no, no. I have been in Ipswich from 1994 to 1996.

**CHAIRMAN -** Yes, because prior to 1992 as you probably know people that were classed as a specialist in the UK or in South Africa immediately if they came to Australia were classed as specialists, suddenly something happened that that is now not the case but you are saying this happened after that period.

**Dr IASTREBOV -** 1994 to 1996, that is what I have been saying, two years and they all came after I had been already in Ipswich, so it is after July 1994.

**CHAIRMAN -** So how did those people become specialists, just by who -

**Dr IASTREBOV -** The college just recommended that it is fine, that they will satisfy the requirement of the specialist. They were not admitted as fellows, to do that they will need to sit the final fellowship examination. None of them did obviously because no one can do that working every day.

**Mr SQUIBB** - What is the different, Stan, between recognition and -

**Dr IASTREBOV -** Virtually no difference at presence. Whether you are a fellow or not, if you are recognised as a specialist, what it gives you is an access to the registration, ongoing registration, there are no problems and it gives you an access to the Medicare rebate.

At present if you are not classified as a specialist ... is an international specialist recognition committee will not register you because they virtually work like puppets on the advice of the college, the same as the Medical Council, they say they have nothing to do with registration with recognition. You tell us is he a specialist and the court says 'Yes' and .. says 'Yes'. College says, 'No' and ... says 'No'. They are just the bodies that was created to provide the paper work.

**Mr SQUIBB** - And is that the provider number?

**Dr IASTREBOV -** Yes, that is what it is.

This ... provider number, it is a very strange situation as well. I know why it was instituted, I understand how, but how can you explain that two doctors working in the same hospital, at the same time, doing exactly the same in anaesthetic and standing next to each other but one of them have Australian ethic background and the other one is Russian and one can get $300 for an anaesthetic that he has done right now and the other one has to go home?

What that is, if there is no other difference in the procedures that they have done, if they have done exactly the same work on the same level, but one is by law allowed to have money and another one by law is rejected this right, how do you call that? I call that discrimination. I see no other word to it, it is ethnic background discrimination, we are talking about simple human rights here now.

**Mr LOONE** - I would like to go back to this registration, you were saying that three people have been registered by the College of Anaesthetists in the last what, two years?

**Dr IASTREBOV -** 1994 to 1996.

**Mr LOONE** - Okay. I think we need to know a bit more about that, Mr Chairman. I think we should follow that through.

**CHAIRMAN -** Yes, we should get onto that.

**Dr IASTREBOV -** Well, college still have the right, there is nothing that would stop college to say that if someone satisfies their requirements -

**Mr LOONE** - What did they do to satisfy the college?

**Dr IASTREBOV -** Nothing. They came over to work in Ipswich. Ipswich was an area of need, the minister submitted them papers and immigration and everything was done by Queensland Health, the minister sent the papers to the college together with their request ... and the recommendations of the needs of these people and they were admitted.

**Mr LOONE** - Are they approved by the State college or the Commonwealth?

**Dr IASTREBOV -** There are no State colleges now.

**Mr LOONE** - No State college, Commonwealth college.

**Dr IASTREBOV -** It is Commonwealth, College of Anaesthetists, yes. There are branches of the college in every State obviously -

**Mr LOONE** - But branches do not grant registration, it has to come from the Commonwealth.

**Dr IASTREBOV -** No.

**CHAIRMAN -** Do they have to get the okay from the medical council in their State? In other words, is it a two-pronged thing, one the okay from the medical college in their State and then the Commonwealth college or just the Commonwealth college.

**Dr IASTREBOV -** College and State medical board are always different issues. The State medical board is virtually a government -

**Mr HARRISS** - Which delivers the final registration, based on advice from the medical college.

**Dr IASTREBOV -** That is right. But normally State medical councils have always been keen to play the right cards with the government. The government says, 'We need someone to cover here', they will give the registration as long as college have no specific objections to that. If college would not say, 'No way, you register this person at any stage' they will register, no problems.

**CHAIRMAN -** Did you ask at all the Commonwealth college why these people got their registration as specialists?

**Dr IASTREBOV -** I have been denied the right to speak with the assessor since the beginning of my conversation with the college. I asked many times that I would like to speak with the assessor and find out what has happened, I never could.

Only once I spoke with Dr Ackman who was the assessor the first time when I sent my documents to the college from Queensland, it was in 1994. I met that man in 1996 during the World Congress of Anaesthetics in Sydney and he recognised my name because when I came on, I said, 'Dr Ackman' and he said, 'Yes', I said are you an assessor, he said, 'Ex-assessor'. I said I would like to know you did reject my papers and he said clearly that there will never be a precedent created for a Russian graduate.

It is a matter of the protection of a market from the flood of Russian anaesthetists coming behind me and claiming that if Iastrebov was registered, why we cannot get registered, and that is what it is.

**CHAIRMAN -** Who are those doctors please again, the South Africans?

**Dr IASTREBOV -** Harold Bernetz, Sue Brunke, Roy Milanski. Roy came already when I was leaving; in fact I met him already after I left, it was in 1996.

**Mr LOONE** - What were there nationalities?

**Dr IASTREBOV -** All South Africans.

**CHAIRMAN -** Just as a matter of interest, what happens in Russia? If I was an anaesthetist and went to Russia, would I be classed as a specialist anaesthetist in Russia?

**Dr IASTREBOV -** I do not know because I have not met that situation when someone from an English-speaking background, not speaking Russian, would come and try to work.

**CHAIRMAN -** If I could speak Russian as well.

**Dr IASTREBOV -** We had one experience, we had a gynaecologist from the United States who came for exchange for three or six months, I do not remember, in my hospital and he was registered for that time to practise. He presented all his papers, he has been reviewed and he was practising in the big university hospital and he was registered to do so. He had to have an interpreter doctor with him to be able to speak to the patients but he could operate, he was a good operator and he did a good job, but that is how it was. I do not know otherwise what the rules are.

**Mr SQUIBB** - Is there an overseas of anaesthetists in Russia at the moment?

**Dr IASTREBOV -** At present the State is troubled with economy, the whole Russian state, and the problem for doctors is there is a lack of doctors in the rural areas - the same as here - but over-supply probably now in the centre. Whether people go away to work or not, I do not know now, I have not been there for a long time but certainly lots of doctors left to go overseas.

**CHAIRMAN -** Stan, what happened, as you probably know, the four doctors - a couple on the west coast and the east coast - were classed as being fully registered as a result of an act of parliament. That act of parliament was really given the handshake also by the Medical Council, as you probably know as well. One of those doctors stated, 'Look whatever happened, he would not be leaving the west coast'. He became emotional and he virtually swore black and blue that he would never leave the west coast and as soon as he got his full registration you could not see him for dust. I do not know whether I am being unkind to him but he certainly went and went quickly. It seems to me that that is unfair, it is unfair on the hospital that brought him out and unfair on the community that he was treating, especially after giving those undertakings.

We are not just talking about yourself here, you are the spark that started the bill and started this inquiry but we are talking about all overseas doctors. What conditions do you think should be placed upon these practitioners who come out, if they are to get extended conditional periods?

**Dr IASTREBOV -** I was expecting this question and I was thinking about it for a while. What should be the way for overseas doctors to be placed in their positions and what should be the way for Australia to manage this problem? I think there are three things: firstly, there is a need for foreign doctors at present in the rural areas; no doubt about it so we have to accept that there is a need. Last year in 1997, 86 overseas doctors were registered, I believe, by the Tasmanian Medical Council on a temporary basis. That is nearly a hundred.

**Mr LOONE** - There is something like 90 here at the moment, I understand.

**Dr IASTREBOV -** Right. If they do it every year - changing them every two years - what you virtually do is bring 200 people, you register 200 over two years, then after two years these doctors

suddenly become unemployed. By that time they are all permanent residents and they say, 'I'll go for the dole now, I'll live on the Gold Coast and live on the dole, live on the beach', and everyone else will do the same because there is no other way. What can they do? So then you bring in another 200 and make another 200 unemployed.

You bring in doctors and you do not know who they are, you just look at their papers. You bring them over and make them work, but those who already work here and have shown for two years they are safe to practice on their own suddenly become unemployed and you bring in someone else. To me this sounds ridiculous; it cannot stay that way.

The way around it is very simple. Before they come over or after they are here, because they want to get registration further now, if you want a way out of it, it is very simple: it is a contract. The contract must have penalties from both sides. It is exactly the same as when the South Africans came to Ipswich. Harold has a $40 000 penalty imposed on him if he leaves Ipswich before the three-year contract expires. It was a condition of his employment. That was something he had to sign. If he leaves early it is an expense for the Government that incurred ... and so on. That is one of the ways of doing it: it is a financial contract, it is a business.

If you bring in people to do business, to work and you register them, you cannot then say they are bad because they are not. They have been practising, they have already been registered. That is it. You cannot say after that they are not specialists if they have been for two years, but after that they have to be free because you cannot discriminate forever. Now, if they come under contract, that is one thing and it is not discrimination; it is not against the law. If you bring someone under a contract there are penalties. If you breach the contract - let us say five years, if you think it is reasonable - you say, 'All right, you work five years in my area where I need you. That is your penalty - $100 000 if you leave earlier'. That is it, and they will stay. Who will want to pay a yearly salary? No one. But that is a contract with the Government, an official contract of how it is supposed to go, and lots of doctors will come.

The question is, how can you choose these overseas doctors. There are some around already as there are more positions to fill. There are good doctors and bad doctors from overseas, the same as locals - there are good and bad. You cannot say everyone from Russia - as I read in this submission from John Sparrow. I was so angry when he said that the standards of training in Russia are inferior to those in Australia. How arrogant that is. How can he say that? It is the same as I read two weeks ago in an AMA paper that the Tasmanian - I do not remember his name - chairman of AMA claims that American training is inferior to Australia. This is ridiculous. How can someone put a stamp on a whole nation, it is stupid.

But the way around it is very simple - there are two ways in fact: firstly, to accept people in the way they have been accepted and just see if they are practising, but probably an even better way is to put them for three or six months in a big institution where you believe standards are good for yourselves, and let them practise there. If they perform well, send them to the area and let them work. If they are safe and they are practising well, and those who have been there with them say they are okay, let them practise. That is how I went to Ipswich.

**CHAIRMAN -** You have not been talking to Julie Shackleton, have you?

**Dr IASTREBOV -** No. That is how I went to Ipswich. People from Princess Alexandra said after I had been there for two months, 'Hey, why wouldn't you stay in Australia, we need anaesthetists here?', and they were consultants that I worked with. I had been a registrar ... and I said, 'How can I get registered?' and they said, 'We'll help you'. That is how I went to Ipswich; that is how I was their senior medical officer for two years.

**Mr HARRISS** - Stan, while you were at Ipswich, from your submission you indicate there that you were training their own trainees.

**Dr IASTREBOV -** I did. We had five trainees there.

**Mr HARRISS** - Was that with the sanction or recognition of the College of Anaesthetists?

**Dr IASTREBOV -** Yes. There were five trainees in our department; two of them were accredited finally as a training position, and three were non-training trainees. One of them was a GP who came for a short time from - what was the place ... - and the rest were further trainees when they would get from non-training to training positions. The college is now arguing that it is the wrong kind of attitude, but anyway. And two were training. Yes, I was part of those doctors who were training them, supervising them every night and day when I was on call as a consultant.

**Mr HARRISS** - And because of the subsequent registration of those people you can suggest that the College of Anaesthetists was happy.

**Dr IASTREBOV -** I do not know that the college was happy, they just did not speak with me really to say whether they were happy or not.

**Mr HARRISS** - No, but happy with the training that you delivered because of the registration -

**Dr IASTREBOV -** Oh yes, probably they were. As far as I know, all of those people who were there ... Some have already passed primary examinations and went through two years of training by now, and they are all doing well, but obviously none of them had problems while I was training them.

**CHAIRMAN -** Stan, I hear what you say in relation to the money.

**Dr IASTREBOV -** I think that is the best way.

**CHAIRMAN -** What about a situation where - I agree; I think it is a good idea for a person to go to a teaching hospital for a period of time, but you would have to be advised as to what the requisite time was prior to them being sent to that area of need. But rather than a financial imposition against them, there be a condition that they have that conditional registration to practise at that hospital for a period of time, whether it be three or five years. If they decide against that, what then happens is they then go back into the basket and they have to go through the examinations as proposed by the Council.

**Dr IASTREBOV -** That is something I was thinking about myself, as you remember. It is part my ... I was thinking about that for a while. I think it is still breaching the simple human rights of equity from the start - of equity. Someone is already denied the freedom of the right of movement; someone already cannot move away. It is like chaining someone to the anaesthetic machine - just put cuffs on: one side on the hand and one on the anaesthetic machine and say, 'You practise, you'll be fed if you do. If you don't, we'll put you on the street'. You cannot do that because -

**CHAIRMAN -** But before you come out, you know the rules.

**Dr IASTREBOV -** I know, but it does not matter.

**CHAIRMAN -** So you do not have to come out if you do not like the rules.

**Dr IASTREBOV -** It does not matter. It is like if you have 55 people in a group and all of them are discriminated against. One of them says, 'No, no, I don't like it', and you threw them away and you said, 'Well, you knew the rules when you came'. It is still wrong because it is still discrimination.

I think the best way round it is that people know it is a contract. They are not discriminated against - not by government, not by their friends, not by anyone. They do not feel second-class people for five years, they do not have to because they know they have obligations placed on them by their signatures that they put down. It is not their registration, they are registered. If someone is registered to practise in Latrobe, why can this person not practise in Hobart?

The question arose recently actually, and that is when I started to think. They asked me if I was happy if the people from *Spirit of Tasmania* could telephone on my mobile when there was a problem on the *Spirit of Tasmania*, because I am a director of intensive care. If there was a real disaster they could call and talk to me. I started to think about it and I said, 'No'. They said, 'Why not?' and I said, 'Because now I am in a position left step, right step, wrong - shot. I am not registered to work outside the hospital. I can't go and give advice to anyone outside the hospital'. It is contrary to this fight of moral

responsibilities and the rights that you have been given. If someone collapses outside the hospital and ... provide any more than just basic resuscitation, even an ambulance officer can do more on the streets than I can.

**CHAIRMAN -** We were told that with Kehilia.

**Dr IASTREBOV -** It is so ridiculous that one would not believe it. Another day I had right here on the corner - I had to drive to Latrobe - there was a car turned over. Just in front of me, it just rolled off. The man was bleeding inside the car and then later an ambulance came. I stayed helping them, and I suddenly thought, 'What am I doing? What if he dies now?' Then people would say, 'This doctor told me to do this, and this, but he had no legal right to treat the person there. He's really done wrong'. I would go down the drain. It is so stupid. I am all right to practise unsupervised, supervising the local people who are trained by this college in my hospital as a director of the department, but I cannot supervise the ambulance officer on the street.

**CHAIRMAN -** I hear what you are saying in relation to that, but firstly, if people come to a different country and, secondly, they come knowing what they are coming for - that is, to work in the north-west region -

**Dr IASTREBOV -** This means they come to earn money, that is all it is about.

**CHAIRMAN -** Yes, I understand that. Well, not only that -

**Dr IASTREBOV -** For the majority it is.

**Mr SQUIBB** - But also given a verbal indication that that registration would be extended, subject to there being no Australian applicants.

**CHAIRMAN -** Yes, I agree; no argument with that. Therefore they come to that area knowing that they are to work in the area. The people are more than happy - ecstatic at the treatment they are getting and the knowledge they are getting by working with you - then immediately there becomes this full registration. Those people may be let down - and I am not saying you, but we have to look at the whole and not just an individual case. They could be let down just so badly by that person immediately giving flight and taking off again. You have to look at that side as well because that has let down the hospital, the persons who expended the money in the first place to get them here - over $100 000 maybe, or more - it has let down the community, it has let down the people who work with that person. So it is not a one-way tram, it is -

**Dr IASTREBOV -** I understand what you mean. If someone decided just to fly away back home, or whatever, you cannot stop them anyway, they would still do it.

**CHAIRMAN -** Sure, I understand that.

**Dr IASTREBOV -** They would not count on this registration, they would not care less because they would just go home because they do not need it anymore. If someone is trying to move to another State, that is a different issue. That comes now to that Mutual Recognition Act, and I wanted to talk about it because I think it is a very important part. Tasmanians joined the Mutual Recognition Act, I think, in 1992. What that actually means is that a doctor moving from State to State can be automatically registered - here, in Queensland, in Sydney, it does not matter. The question is how much Tasmania has gained by now from this agreement, and did they gain anything.

**CHAIRMAN -** We have been told nothing.

**Dr IASTREBOV -** How many doctors left Tasmania having this agreement in hand, and how many arrived? And who in hell stops the Medical Council from registering any doctor from Sydney if they are satisfied with his papers and everything, without this agreement? Why do they need that? Exactly the same, I cannot see even where it is coming from. The Minister for Health signed that agreement on the conference of a two-year limitation for temporary or limited registrations. I do not know in what condition one would have to be to sign that for a State like this when 100 people a year have to ...

**Mr SQUIBB** - So perhaps that is where the two-year limitation has come from, because the act does not provide for it.

**Dr IASTREBOV -** No. It comes from the conference of the Ministers for Health, and the Minister for Health for Tasmania made, in my opinion, a tremendous mistake signing this thing for Tasmania. Maybe for New South Wales it is great, I do not know, but at least for Sydney it definitely is. But for Tasmania where there are no doctors, to say, 'We'll find someone else', where do we find them and who will it be? I think that was a real mistake. That is one of the things about it, I think it is very important. I do not think Tasmania needs the mutual recognition that exists, really, from my point of view. Tasmanian people do not benefit from it.

Those doctors who go away, if they are Australian-trained I do not think they would be refused anyway. Who is going to refuse them in New South Wales or Queensland if they apply for a job? And if the job was accepted, why would they not register them? They probably were not trained in Tasmania anyway, they were trained on the mainland, but it does not really matter. Who would refuse them - no one. They would have to change their legislation in every State then and I do not think they will go through that, no one needs that. They know it is not a problem and they will know that in this State people are registered on the basis of a ten-year contract, five-year contract, and so on.

If I do something wrong in my practice - let us say today while anaesthetising in theatre, if I injected potassium chloride into someone and it killed a person my registration would be cancelled tomorrow anyway. It does not matter if I am from Russia or from Australia, it would be cancelled. If I am practising well for five years, I do not think people in Sydney would have much problems with that, except the labour market; that is where it is all coming from. Should we, as people living in Tasmania, protect the labour market for Sydney and Melbourne at the expense of the lives of our own citizens here. We have been protecting it for very long but now the time has come to ask, do the population here in this area benefit from any of these agreements that have been signed on behalf of this population? I do not think so.

**Mr HARRISS** - In relation to that two-year ceiling which has been applied, from a practical point of view if you wanted to undertake the examination, how could you fit into your schedule sufficient time to swot up and study such as you would expect to be successful during a two-year period; is it practical?

**Dr IASTREBOV** - It is impossible. That is why Dr Thomas is now in the Royal Hobart, because you have to be in a major teaching centre, go to the tutorials, read the things that you do not use in practice because it is part of training, things that you do not really need. Things that go back in years of regular physiology, pharmacology, the things that in regular everyday practice the doctor does not use. To remember all the numbers and all the necessary names that you have to throw on the table once the examiner asks you about them. It is impossible to do it from a little place like this, virtually impossible, because of the work load that I have. I have to cut it in half at least to be able to read all the old stuff I do not need. I have now four journals in my bag; three of them are unsealed still and my current journals are coming now from States and Europe on intensive care and I hardly find time to read that. I am just going, going always. I submitted an article to the American Society of Critical Care ... for October meeting in London, the annual meeting. I had to find two ... nights to write it because I did not have time otherwise because I was stuck on work.

There are lots of things a doctor does to improve his skills. Going back in ... to what I have done ten years ago to deteriorate my skills, not to improve it. That is why when people say, 'Go back and do three years of training, you are young; what is that?' I am not that young any more, I am thirty-three and will be thirty-four soon and the years go by very quickly, and going back three years, during this three years here I could do so much. As much as I do every year now I could do it, but if I go back in three years I cannot.

**CHAIRMAN -** Should there be a system where the Council should look at a number of these articles that you write and be able to assess you on those papers? Also, as Geoff was saying earlier, having somebody oversee your work on an intensive care day or something - something along those lines?

**Dr IASTREBOV** - I think there are two things about it. That is something I was trying to ... the college for for so long, to come here and have a look. The articles that one writes, certainly they are open for everyone, no problems. I do not think you can judge a person based on one of the articles, just realistically - not about me but about anyone - because articles are always very narrowly directed. Let us say the last article on tissue velocity imaging and transfied ... electrocardiography -

**CHAIRMAN -** What is that again?

*Laughter*.

**Dr IASTREBOV** - That is a new thing that no one in this State does and I am happy because when a cardiologist from Hobart comes in and he sees it he says, 'Can you spend a day with me to show me how to use this machine?'. He has not seen it before. We are the first in the State to use it. Now that is something, tissue velocity imaging in the transified ... electrocardiography. Now that is a very narrow thing in critical care. It is a new thing, very narrow. I do not know if they can assess a whole -

**CHAIRMAN -** But you see, you just do not look at one paper; you look at a number of these things.

**Dr IASTREBOV** - I have a number of them, yes.

**CHAIRMAN -** You look at the practise which has been overseen by a person on a day, two days a week, I do not know. You look at a number of different articles, papers that you have written, and even though it might be a paper on a very narrow field, over time there is going to be a number of different papers over a number of different fields, and it would seem to me that people could understand a person's expertise if they read those papers, coupled with going into a practical situation with the person and see how that person reacts.

**Mr SQUIBB** - Is that not the most important, the latter?

**CHAIRMAN -** I agree.

**Dr IASTREBOV** - I think the best way to assess overseas graduates is to look at what they do, what they produce and how they work - practise.

**CHAIRMAN -** That is now, but in future it would seem that there may - this is just my point of view and I do not profess to know - but it would seem that it would be best if that overseas doctor trained or practised in a teaching hospital for a period of time and then went to that area of need that he first came out to go to.

**Dr IASTREBOV** - From my point of view, yes it is better. When you import someone you do not know at all, even if the papers are all right, it is better if you can see them, just for a few months to see what the person is really, can he anaesthetise safely. That is the most important, the safety, it is not flying in the clouds, it is safety. That is the most important thing; if someone is very safe, no problems let them go and practise. People have different ways of doing things. You will find five anaesthetists in the Royal Hobart completely different. But, yes, that is the best way to do it for those who are already here, to send them down to Royal Hobart. I do not mind, I can go for three, five months or whatever is necessary. But I think it is taking me away from this community for six months again and I do not think there is any need really for me to go there. I think so much has been done already and so many things have been produced that, for my personal standing, I am happy for anyone to come and assess it at any stage.

**Mr HARRISS** - Before coming to Australia, Stan, what was your intention regarding the required examination, if you understood that there was going to be an examination process, what was your intention with regard to that and in what time frame did you expect to undertake the examination?

**Dr IASTREBOV** - Before I left Russia I was a fully-qualified anaesthetist. Then I came to England. I was one of five Russian anaesthetists who were examined by Richard Jack, a professor, he was an Oxford overseas training scheme at that stage, and he examined a lot of us. There was a big selection process and finally five of us went through from the USSR and I went to England. They took us as

trainees. We were already trained; some of us were already Bachelors of Science but they took us as registrars still. I spent one-and-a-half years in Gloucester and Britain sent me to Australia on an exchange program of registrars; that is how I came here. I did not come for exams. I did not expect to stay in Australia in fact. I came to the Princess Alexandra just to see the place.

When I was asked in England if I would like to go to Australia, it was an honour for me and it is an honour for everyone over there because they usually select the good ones; they would not want to send someone who would shame them. When they asked if I would like to go, I said, 'Yes, I would like to'. I had seen Australia once before, I like the country and I said, 'I'll go and spend six months; that's great'. I did not know where Brisbane was at that time. So I came over and I spent two months, after which I was asked by the consultants in PA, 'Would like to stay? We need anaesthetists in this country'. Having been here two months I would like to do more so I said, 'Yes, but how can you sort it out?'. They said, 'That's all right. We'll sort it out, but it is a bit difficult.'

While I was in Queensland at some stage when I had just started to work at Ipswich and they were telling me they were trying with the college, the college would not move, and they gave me great references which did not help because there was no precedent to be created for Russian. So they said you have to do this, this and this. At some stage I said, 'All right I will do it'. It has been nearly four years ago. And what happened, I have never been placed in a training program because I have been told, 'First priority, Queensland; second priority, Australians; third priority, Commonwealth. Everyone else next' - but there are no places any more.

After that I decided that enough was enough: I am not going to do what I have done before; I see no reason for it. I had seen many Australian anaesthetists by that time and I knew what ... anaesthetist is about and I knew where I stand in relation to it, by myself. I did not want to accept any more. I have to be an ... for three years for no particular reason, going as a boy around people who I can teach sometimes.

**Mr LOONE** - Just one question. I would like you to explain to us now what is acceptable to you? The position you are in at the moment, your registration expires in December, what is acceptable to you as far as registration or acceptance into Tasmania or Latrobe? Just tell me what is acceptable to you?

**Dr IASTREBOV** - At present my situation is, as you say, very simple. On 31 December the Medical Council bluntly indicated that they were not going to extend it any further, and I have a letter to that -

**Mr SQUIBB** - You have that in writing?

**Dr IASTREBOV** - I have it in writing from them. They asked me to sign that I understand that is how it is going to be. I never signed that because I do not think it should be that way and I decided that until the Parliament finished the inquiry it will be the Parliament to decide what will happen: whether Parliament will proceed or not or what will happen altogether. So I never heard again from them but from a number of correspondence that I have seen in between, although not directed to me but to other sources, I understand the Council still stays with that date. So for me the acceptable thing is the permanency in Mersey Hospital.

**Mr SQUIBB** - So, as an overseas-trained doctor, what would you think about a process whereby those doctors coming from overseas, whether they were assessed on arrival or not, there was a system where they did their two years on provisional registration, then there was the opportunity for a board of some sort to provide an evaluation based on observation and supervision as to whether that person was a suitable specialist to remain? If the answer was in the positive, if there was a system whereby extended provisional registration be provided - I am not talking about annual; I am talking five years or ten years - to enable that specialist to continue to practise their speciality at a particular site. Do you think that would be acceptable to yourself and other overseas trained doctors?

**Dr IASTREBOV** - I think if the length of time is sufficient so people can settle, buy a house, start a family etcetera, it would be acceptable.

**Mr SQUIBB** - Would you think five to ten years would be acceptable, bearing in mind that rather than having to have your situation assessed each year it was done every five or ten years, and on that basis

there is still a chance that at some stage in the future you may not continue to get full registration? Or course bearing in mind that all the way through there is always the option of going down the path of the examinations anyway if one wanted full registration.

**Dr IASTREBOV** - I think it is no sharp corner option where no one breaks their neck. It is an option not to crash the system of colleges, not to crash the neck of the Medical Council who will be very upset if something else has happened. It is an option. For me personally it is acceptable.

**Mr HARRISS** - Stan, where we are at at the moment with this committee is that sitting in abeyance is still the bill which -

**Mr SQUIBB** - It has been removed from the Notice Paper because of the prorogation of Parliament.

**Mr HARRISS** - Okay, but it can be brought back.

**Mr SQUIBB** - It can be brought back on.

**Mr HARRISS** - This committee has a broad range of terms of reference, as you are well aware. If the situation ends back with the Parliament to deliver to you registration, how do you think it is appropriate to pursue that process? What I am trying to get at is, to what extent should a parliament be involved in usurping the role of a professional body, whether it be in this case a medical body or a legal body or an architects body or anything else, because the flip side to that could well be that the Parliament might take upon itself the role to deregister somebody from a profession and how would you feel about that if you were a previously registered person and the Parliament took upon itself the role to deregister you without relevant expertise to assess your competency?

**Dr IASTREBOV** - I think the Parliament in every country is the top body to develop laws and the rules for the country where they rule. If Parliament makes any decision in this country unless it is highly, or extremely I would say, extremely unlawful decision that can be challenged in the international court, this is the end of the decision. It is a new law that has been established in the country. The way of Parliament being involved in professional registration is a very tricky question. It is the Parliament who in the first instance has created the law that gave the power, unlimited power to the colleges, medical councils and the Australian Medical Council to decide how many doctors are practising in this country, in what capacity and where. It has been unlimited and it has been abused for many years in the way of protecting the work force. As a result, for many years rural Australia has had problems, and I believe it is the responsibility of the Parliament now to step up and say, 'We have given it to you for a long time. What have you done, people, to our rural community? Have a look what is happening'. They have been warned before and all they do now is they are holding for their rights to be the ultimate decision-makers and that is all.

There is nothing to do with professional registration in my issue. I have been registered in 1996 in Tasmania, when I came over, and Medical Council decided that I can practise. Parliament does not decide now whether I am able to practise or not. I think it is clear to everyone around that I have been practising for two years, and the question now is, its the length of time of the practise. Not the matter of registered or not registered. It is the length of time of registration - myself, other people, etcetera. De-registration by the Parliament probably is a remote, scientific possibility but not a practical thing that can happen. But from any point of view, Parliament is the last body that has the last word, in my opinion, in the making of the law of the land, and if the land is in suffer it is time for the Parliament to change the law that does not work. It does not matter when it was taken - last night, five years ago, or ten years ago. If it is a new law or old, if it is wrong and it works against the community, it has to be changed.

**CHAIRMAN -** Do you need a medical council?

**Dr IASTREBOV** - I think at present the Medical Council is working only in a way, as I say, as a puppet of the college in the way of assessing the specialists.

**CHAIRMAN -** So is your answer no?

**Dr IASTREBOV** - So I think Medical Council as such virtually is not needed at present, in the way of how it is functioning. You can just directly apply to the college and say, should we register or not register, and there would be one clerk in the Medical Council who will just put a stamp on it. You do not need the mob of people who just vote against only on the base college saying against. And that is what I mean. That if you are to establish a Medical Council that is going to assess people on their merit, not on the paper from the college, it is a different thing. It is a different kettle of fish altogether, but if the Council remains how it is, there is no point to have it. I think it is just a block, something that stops the future development. It does not mean that Parliament have to decide on each doctor - register or not register - I think the question now is, if my bill will go through, what is next? I think there is a big need for the Australian and Tasmanian community, and actually all Australian rural community, to have the mechanism in place that would be workable.

**CHAIRMAN -** My final question. I do not want to keep you any longer - no doubt you want to get back. That is why I asked you that question, because if you do not have a medical council and there are all these other doctors waiting in the wings, and I understand there are a vast number of them, who assesses them?

**Dr IASTREBOV** - But all assessment happens on the paper. I can write on the paper easily.

**CHAIRMAN -** I understand that, so what should we have instead of the Council?

**Dr IASTREBOV** - I think there must be professional bodies in each State, professional bodies, not just the mob of bureaucrats sitting there looking through the papers but those who will be appointed, advising Government, maybe paid a bit more, but those who would be in the major ... institutions, who would know. They are there to assess and practise. Mr Iastrebov, Mr Popov, I do not know - whoever. The Government needs someone on the north-west regional coast, for example they need a cardiologist. Fine. The Government find someone in South Africa, anywhere, in Russia, and bring them over and people here will say, 'Hey, give him to us for a few weeks, for a month, whatever'. It is for them to decide how long. Something reasonable. Probably a few months is reasonable to see what the person is doing and if he is practising well, this will be the professional people that should say, 'Okay, he will be all right to practise in a north-west regional hospital as a cardiologist. We are happy with him. He is doing a good job. We really need someone there. Register him for ten years. Let him stay there'.

**Mr SQUIBB** - Just to ask one final question. If, as a result of this committee's recommendation to the Parliament, the Parliament was able to put in place a system of extended provisional registration - which I referred to earlier - and provided that could be put in place to enable somebody like yourself to make application prior to the end of this year, would you see that as being an alternative to the bill which was before the House last year?

**Dr IASTREBOV** - I think it all depends what that recommendation will be. I do not really care which way my registration will be done, through the bill, through the Medical Council writing down, that is fine. Let Stan Iastrebov continue to practise for another ten years. There is no difference for me. As long as I know that after 31 December, I do not need to go and look for a job somewhere on the Solomon Islands, I will be happy with that.

**CHAIRMAN -** Thanks Stan. Thank you for your input. All the best.

**THE WITNESS WITHDREW**.