Dr MICHAEL MARTIN, COUNCILLOR, AND **PROFESSOR GARRY DAVID PHILLIPS,** PRESIDENT, AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS WERE CALLED MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIRMAN (Mr Wilkinson) - Thank you, Garry and Michael, for coming. Before we start I have to ask you state your full name and address, your occupation and in what capacity you are before us, please.

Prof. PHILLIPS - Garry David Phillips, I am the Professor of Anaesthesia and Intensive Care at Flinders University of South Australia. I am here as President of the Australian and New Zealand College of Anaesthetists.

Dr MARTIN - I am Mike Martin, I am an anaesthetist in private practice in Macquarie Street, Hobart. I am here in my capacity as a councillor on the Australian and New Zealand College of Anaesthetists.

CHAIRMAN - Thank you. Can I first thank you, Garry, for coming down as well because I understand it is at the College of Anaesthetists' expense, which is very kind. Really we do acknowledge the cooperation in coming down and speaking with us today, thank you very much.

Prof. PHILLIPS - I thought what I might do just to make sure that you did not have any difficulty with the submission that I put in - the written submission - and then comment particularly on Dr Iastrebov, if that was the appropriate -

CHAIRMAN - Yes, by all means.

Prof. PHILLIPS - I restricted myself in my written submission to the terms of reference that I felt the college had a role in. The first point was to point out that the college does not recognise specialists. What we do is to recommend whether someone is suitable to be a specialist to the relevant registering authority. So the medical boards, the NASQAC, the Australian Medical Council, if they have a question about, 'is someone suitable to be a specialist?', from their point of view, what is the college's view? We express that view but then that body makes it own decision. I just wanted to make that quite clear, we do not register specialists.

CHAIRMAN - So you look at it, you then advise the Tasmanian Council for Tasmanian Anaesthetists and the Tasmanian Council then decide whether they are to be qualified specialists or not?

Prof. PHILLIPS - I presume that they do. I do not actually know the details of each State's registration procedure. For example, in South Australia it is the Medical Board of South Australia that registers a person. For the purposes of the Health Insurance Commission, they also take advice from the college as to who is a specialist and who is not a specialist.

Mr HARRISS - But nonetheless the advice of the college, or the assessment by the college, is absolutely fundamental to the whole process in terms of -

Prof. PHILLIPS - Normally it is taken as given that if the college recommends that someone is a specialist then the relevant body will say that that is fine. If we say, 'No', they will say to us, 'What do they have to do to become a specialist?' and then we would advise them.

The basis of our advice, which I think I went through in the next couple of items, was that in order to be a specialist an Australian or New Zealand doctor has to do a certain amount of training which is two years - an internship and a residency - so it is two years of general rotations. And we believe that that is fundamental before someone specialises. Then they do four years training as a specialist trainee in hospitals that we approve because we have people there who can supervise the training.

They have assessments every six months along the way to feed back to them what problems they have and what they have to pick up on. There are two examinations: we have a primary examination which is carried out early in training and that is basic sciences - physiology, pharmacologically, statistics that sort of thing. Then they have to pass the final examination which is a clinically related examination before they can do their fifth year of training.

Then we have a few other things in the training. They have to do a formal project which is a research-type activity; they have to undertake the trauma course that the College of Surgeons run. So there are a number of things they have to do in order to finish up getting the diploma of the college. That is, if you like, the basis on which the States and the AMC, et cetera regard someone as a specialist.

In the case of an overseas trained specialist the normal procedure is that they contact the Australian Medical Council and say, 'I am a specialist from another country, I would like to become a specialist in Australia'. They write to the college and say, 'Will you accept this person as a specialist or not?'

We will normally get all the details that the AMC can provide us with, including CV, original documentation et cetera. We would then consider whether the person fitted into a category that did not require interview or did require interview. If we thought an interview would benefit our understanding then we have an interview. Then we, on that assessment, go back to the AMC and say that this doctor has fulfilled our requirements, or has not, and this is what he would have to do.

Can I use 'he' instead of 'she' so I do not confuse things?

CHAIRMAN - Yes, it makes it easier.

Prof. PHILLIPS - Sorry, I have been brought up that way.

In the case of Dr Iastrebov, can I go through his sequence very briefly before I proceed?

CHAIRMAN - Yes.

Prof. PHILLIPS - Because he initially wrote to the college directly in 1994. In 1994 we were changing over from the old system of recommending to State boards that a person was suitable for specialist registration to a process of going through the AMC as agreed by the Australian Health ministers.

He wrote to us in 1994 and said, 'I would like to be a specialist, I am a fully-trained Russian specialist'. We assessed the documentation he provided at that stage and told him that his training and examination status was deficient in a number of areas ... in some of his overseas training he would have to do three years training. In fact I think it was three years and seven months.

Mr HARRISS - I think it was in your submission.

Prof. PHILLIPS - And he would have to do both examinations. He did not pursue that but in March 1995 he provided a new CV and he provided some supporting letters from the hospital he worked at in Brisbane and also from Gloucestershire in England. We restated our position at that stage, we dropped the requirement for seven months of additional residency training based on the information. We said he would have to do three years of primary and a final.

CHAIRMAN - So therefore he did not have to do the two exams.

Prof. PHILLIPS - Yes, he still had to do the two exams but we reduced it by seven months because we were satisfied.

CHAIRMAN - So he would have been a registrar perhaps in a teaching hospital?

Prof. PHILLIPS - He was a registrar in Gloucestershire and he was a registrar at Princess Alexandra in Brisbane.

CHAIRMAN - And you were saying that he should have been within a Tasmania, a registrar for three years, is that right?

Prof. PHILLIPS - Well, we did not specify where, we just said that he would have to work in approved training positions.

We carried on really until December 1997 where he made a further request and provided more information. Because of the changes to our policies, procedures, regulations, as a result of things that were happening between 1994 and 1997, we made a decision that we would grant him two years of his Russian training - in other words, of the three years training he did in Russia as a specialist we would allow two of those - we would allow eighteen months in Gloucestershire and six months in Queensland because we now knew that they were both an approved post. So we gave him four of the five years of training.

We now came back to a position where we said to him that he needed to have one year of further training in Australia but because he had not passed examinations equivalent to our primary and final he still had to do both exams.

That brought us in line with decisions that we had made on advice to do with antidiscrimination, if you like, that we had now got to a position where previously we had accepted training in examinations in places that we understood - like England, Ireland, South Africa, Canada, because they were former British colonies and had the same system. In order not to discriminate against anybody what we said was that any specialist who came into this country, no matter from where, would have to do one year in a post we approved and our final examination. And they would have to do additional time and exams if we thought that they required it.

So I think it is important to appreciate that someone now coming fully trained from England, South Africa, Canada, America would have to do one year, plus our final examination. The only additional requirement we have for Dr Iastrebov is that he do our primary examination. There are two reasons for that: one is that we have not had information that he has passed an examination equivalent in Russia; secondly, we have a letter from England to the effect that he actually sat and failed the English primary examination. So that is the situation, I guess, we are in.

Although it is difficult to communicate with Russian authorities we have attempted and I have had a conversation, via an interpreter, with a lady called Professor Damir who, at the time when Iastrebov was training, she was my equivalent in whatever the Russian organisation is. And I do not have the details of that but I can get it.

Her comments were that he was a very competent registrar and we have accepted that. His qualifications in terms of basic medical qualifications are not in doubt. But we also have information that the facilities, equipment - all of those things in Russia at that time - were not of an equivalent standard to here. Her belief was that he was a very suitable person to do whatever we required in order to become a specialist in Australia. That is really where we are now.

CHAIRMAN - You hear a number of things that have occurred and it would seem that a number of people say that he is obviously a competent operator. When you look at his mortality rate in the hospital, the mortality rate, I understand, is less than the national average. What is it, is it sixteen the average and his is fourteen, something along those lines. Does that in itself show that he is a competent practitioner or is it just one of a number of things that show that he must be doing the right thing, one would think?

Prof. PHILLIPS - My only comment on that is that it is very difficult to assess whether what somebody says and claims is actually fact, as you know. The College of Anaesthetists has a mortality committee, for example, which assesses data in response to deaths reported to coroners.

Mr HARRISS - Can I just jump in there, Garry? We have been given the APACHE -

Prof. PHILLIPS - I have not seen that so I do not know.

Mr HARRISS - I just thought you might have been referring to that process.

Prof. PHILLIPS - That is intensive care, not anaesthesia. The mortality committees in each State consider deaths reported to them and get information from the coroner. Tasmania does not have a mortality committee but it reports deaths to New South Wales. We cannot isolate any of the data, it is aggregated data that we get. So I do not know whether Dr Iastrebov has reported any deaths that he has had to the New South Wales committee investigating deaths under anaesthesia, for example.

I have not seen his data - any of it - so I do not know what his figures are. But it is very difficult, I think, to assess somebody and their results other than by some formal process. We are not in the business, or the college is not in the business of doing if you like, spot checks of competency. I think what we are interested in is the training and examinations as a process which fits somebody to be a consultant anaesthetist. So I cannot really comment on that.

CHAIRMAN - This committee is not only dealing with him but other overseas-trained doctors with conditional registration, but with his situation it would seem impossible for him to continue on in the Mersey hospital and be able to carry out the exams and training that would be needed, being the one year in a teaching hospital, to get his fellowship. It would seem that he would have to say to the Mersey General, 'Look, I can't be there for a year. I have to go down to the Royal Hobart Hospital or a like hospital to carry out my year and also I have to do the exam. I would need some time to study up for that as well' and therefore he would be unable to continue on at the Mersey General. Is there any other way that he can be assessed, such as peer assessment or, alternatively, is there any way that an anaesthetic could come as a type locum to the Mersey General for a period of time whilst he goes into the Royal Hobart Hospital?

Prof. PHILLIPS - I think there are several things. I will preface the comments by saying that Dr Iastrebov knew in 1994 that he needed to study and pass the primary and have a plan and he, in fact, not only did nothing about it but also indicated to the college that he thought it was totally unnecessary.

In relation to your comments, it is true that we would not approve time at the Mersey as time of peer review or supervision because we would need to have him in a hospital which is approved for training by the college. In Tasmania, that would mean he would have to go and spend a year at either the Royal or at Launceston General and in order to do that it would really be up to - I mean, what the college would do is talk to the Tasmanian Regional Committee, of which Dr Martin is a counsellor, to say 'Can you help in the situation by perhaps giving him a post?' which would not necessarily be a registrar post, it would be a - we call it a Fellow, if you like, a senior person to work in the Royal or the Launceston General and 'Can you provide somebody to backfill the Mersey for twelve months while this happens?' We have endeavoured to do this in a number of other States. In some places it has worked because it has been feasible, in others they have said, 'Look, it's all too hard, we can't do it'. But we have not gone to that stage of inquiring of Tasmania because Dr Iastrebov has indicated he, to date, has not been interested in pursuing what the college requested.

CHAIRMAN - There has been some talk that it is a closed shop. What do you say about that?

Prof. PHILLIPS - I think the closed shop is obviously something that can be levelled at any section of society. I would argue against that obviously, and the reasons are that I think the college, which has now been in operation since 1952 first as a faculty and then as a college, has really been training anaesthetists in this country and in New Zealand since that time. We cooperated completely with AMWAC and with the Medical Training Review Program in their investigations. They told us that we did not have enough anaesthetists so we had to train more and where the funding was available, because the jobs are paid by the relevant public hospitals, we agreed to an increase. So we have increased our number of training positions well beyond what AMWAC requested, particularly in rural areas. They only asked us to increase by a very small amount in Tasmania and we have exceeded that.

Provided people do the time, do the exams - and the exams are certainly proper examinations - then we do not restrict it to anyone in particular. I have just come from our college ceremony at our scientific meeting in Newcastle where probably one-third of the doctors graduating as Fellows were actually from overseas or of overseas origin, so we had people from South-east Asia, from India - there was in fact a Russian who graduated. You have working here in Hobart an Indian man who trained in India,

worked in New Guinea for seven years, which is how I got in touch with him. He wanted to be a specialist in Australia; he came down and did three years training - which is want we ask - primary examination; final examination and is now a registered specialist in Hobart. So other people do this. We do not say, 'Unless you went to the appropriate school somewhere you can't join us' because there are lots of overseas-trained people who have gone through the process we have suggested and have successfully completed the program.

Mr SQUIBB - What is the pass mark in the examinations? Is it 50 per cent or much higher than that?

Prof. PHILLIPS - The primary examination is about 50 per cent.

Mr SQUIBB - About?

Prof. PHILLIPS - It fluctuates, but that is first time up.

Mr SQUIBB - Why does it fluctuate?

Prof. PHILLIPS - It fluctuates because the examination questions are different each year - we cannot ask the same ones.

Mr SQUIBB - But surely there ought to be a consistent pass mark?

Prof. PHILLIPS - No. If you talk to any examining panel, whether it is matriculation school, undergraduate university, post graduate, we do not set a pass mark and say that -

Mr SQUIBB - Either they are qualified or they are not qualified.

Prof. PHILLIPS - That is what we are trying to get at. What we do not do is to say that we will only let so many through this time. We do not set that at all.

Mr SQUIBB - You do not say that but you just set the pass mark different each year.

Prof. PHILLIPS - We set a pass mark which is determined by the difficulty of the examination. That is taken into account when the pass mark is set. All I am saying is that examination assessment techniques allow for a variety of methods educationally sound of how many people pass an examination or what the pass mark is which determines how many people pass. The primary examination is around 50 per cent and it fluctuates and you have to bear in mind that we examine in Australia, in New Zealand, in Hong Kong, Malaysia and Singapore and what I am giving you is an overall figure.

Mr HARRISS - And that is not an unusual process, Garry, with -

Prof. PHILLIPS - Not at all, but I gathered that you thought it was.

Mr HARRISS - No. I do not believe it is given today's educational assessment processes which occur all over the place, not just in your particular field of expertise.

Prof. PHILLIPS - I am a university academic and I do not believe it is unusual at all. But what I am getting at is that someone sitting for the primary exam - and some people will sit first, second, third or fourth times - and someone who really wants to do anaesthesia who sits the primary, the eventual pass mark is something like about 80 per cent. The final exam is, because it is clinically related and because people have then been three or four years in training, the pass rate is between 70 and 80 per cent but for people who repeatedly sit it it gets up to 90 to 95 per cent. There are some people who never pass either exam.

CHAIRMAN - That is not unusual in specialities though, is it? That happens in paediatrics and it happens in other areas of expertise.

Prof. PHILLIPS - We have, I believe, a higher pass rate than a number of the other colleges.

Mr SQUIBB - Why do you have the exams in places other than Australia or New Zealand?

Prof. PHILLIPS - Because, historically, the College of Surgeons, of which we were part up until 1992, offered their examinations in parts of south-east Asia and we went along with that. Since we became a college we are in the process of establishing closer relationships with the places where we have a history of involvement. So although Kuala Lumpur, Singapore and Hong Kong all have their own full training programs, some of their people elect to double up and do our program as well as theirs.

Mr SQUIBB - Even though they train in those other countries they actually sit the same exam as what an Australian or New Zealander do?

Prof. PHILLIPS - Yes, they can.

Mr SQUIBB - And that would give them the same recognition?

Prof. PHILLIPS - If they complete all the training requirements and pass both exams, then they become a Fellow of our college.

Mr SQUIBB - That does not include Britain or South Africa?

Prof. PHILLIPS - No, we do not train in Britain, South Africa or any other place because they already have their own examinations. We started off assisting those areas of South-east Asia where, historically, Britain had had a major involvement but was withdrawing and we supported their education system. So that is all we do.

Dr MARTIN - If I can just add to that, I think the requirement is not only passing the exams, it is in relation to the in-training assessment and working in hospitals that have been accredited and are regularly re-accredited by the college and, for example, in Hong Kong that is the case, these people who do sit for our exam have been going through training that is equivalent to here in institutions that have been visited and are accredited by a panel of people who go out to the hospitals and the same occurs in Malaysia.

Mr SQUIBB - So if you are lucky enough to have done your training in one of those visited by your colleagues, you are right.

Prof. PHILLIPS - Well, you would not be lucky enough, you would have planned it that way. We sent a senior inspection team to Hong Kong last year and approved some hospitals and not others which met our standards. I am going with a team to Kuala Lumpur and Singapore in August for the same process and provided they meet the same requirements in terms of the facilities, the supervision, the number of our Fellows who are there doing the training, then we will approve them as training hospitals.

Mr SQUIBB - So I guess that is probably how you could justify the registration of Dr Stewart on the north-west coast, for instance, who -

Prof. PHILLIPS - I do not know Dr Stewart on the north-west coast.

Mr SQUIBB - No, you probably would not. But you would be aware of Dr Stewart as an anaesthetist who was able to gain full registration without doing exams.

Prof. PHILLIPS - But when was that?

Mr SQUIBB - 1995, I think it was. She made application in 1995.

Prof. PHILLIPS - Well, if he went through -

Mr SQUIBB - She, sorry.

Prof. PHILLIPS - If she went through the Australian Medical Council to the college I would have to go back and look at her file to find out if and how that happened because up until 1994 certainly, when the system was changed because of the AMC requirements, we did recommend for specialist registration people who had an acceptable overseas qualification and training that met our requirements without them coming through and doing our fellowship. So the rules changes about 1994.

CHAIRMAN - What do you say with the mutual recognition and the problem that it would seem the Mersey will have if Iastrebov in January gets his ticket back to wherever because he cannot continue to practise as an anaesthetist, it seems from the evidence we have had it took the Mersey approximately twelve months to eighteen months to find an anaesthetist -

Mr LOONE - And many thousands of dollars.

CHAIRMAN - Yes, I understand it was around about $100 000 or a bit more that they spent to try to find an anaesthetist and other doctors. If they are unable to continue on with him as an anaesthetist, what they have got to do is go through the whole process again to find an anaesthetist, it would seem, to go into that hospital and it may be an anaesthetist who is no better qualified and has no greater competency than Dr Iastrebov.

Prof. PHILLIPS - I cannot answer that and I am not answering it because the college is not interested. The college is interested in providing services to the community all over the place but there is a shortage of anaesthetists, particularly in public hospitals in Australia. I have recently advertised three positions at Flinders Medical Centre and had no applicants. So it is not peculiar to the Mersey.

I think that the college is really in the business of saying when a specialist is appropriate to receive our fellowship and become a registered specialist, which have become the one thing, not because we requested it but because we were told that was the way we should go. I think that there are other options for places like the Mersey, depending upon what the Government of Tasmania wants. We have in fact, and I think we are the only college that has gone to the point of saying that we accept that not only should there be specialists anaesthetists, there should be general practitioner anaesthetists - and we participate in their training - but also that there is a role for what have been called in New South Wales career medical officers who are people who have a lot of experience but have not done the training and the exams. But our interests in those people obviously has to be when they work in hospitals where we have people who can supervise them and that is not the case with the Mersey.

CHAIRMAN - I have no argument at all that. If they know the rules and where the goal posts are when they come out, if they come out they have to abide by them. I have no argument with that because they know the rules, they come out knowing the rules that have been set down. But in a situation like this - and it would seem from the evidence that you are saying that Dr Iastrebov knew the rules but he did not want to abide by them - and I can accept that he should not get full registration, but should his conditional registration continue for a period of time and, if so, for how long?

Prof. PHILLIPS - Well, that is up to Tasmania. That is not up to the college. As I said, we do not register specialists and the only reason why the college is involved in this is that we were included in the terms of reference and asked to say what we did for our local graduates and what we recommend for overseas-trained doctors. But I would assume that the Tasmanian Government or medical board or medical council are entitled to do whatever they want and that does not concern the college.

CHAIRMAN - Would that offend against the mutual recognition?

Prof. PHILLIPS - I think it is potentially a problem. Yes, clearly, because in the past we have had numbers of people who have come into the country before the rules changed where we could recommend them for specialist registration and many of them do not often stay where they had their specialist registration to practise.

I do not know Dr Iastrebov, I do not know what his intentions are but clearly there is a problem if the normal process of Australian Medical Council College is bypassed and the Government here says well, forget about that we will register you as a specialist and there is mutual recognition. Then eventually there will be a lot of people around who actually not only have not done what we would regard as

equivalent training and time and examinations and assessments but who are not, therefore, included in the recertification and maintenance of standards and all of those sorts of things.

Mr SQUIBB - I thought that conflicted with your earlier statement where you said that it really was up to the Tasmanian Government and it is not really, is it, because it all boils back to the recommendation of your college?

Prof. PHILLIPS - I think that if the system is to persist as it is now which requires the college to assess his training and examinations and say that in order to become a specialist - which means he complies with our requirements for fellowship - then he would have to do these things

Of course we would be concerned if someone bypassed that and created another group of people and it could happen differently in different States you would finish up eventually with a very different standard, if you like, of the speciality factors in Australia because you would have one body -

Mr SQUIBB - Well, it would certainly be in conflict with mutual recognition.

Prof. PHILLIPS - It would.

Mr SQUIBB - You did sit in during part of the AMA's evidence earlier on are you aware of the recommendation that was in their submission which we are referring to?

Prof. PHILLIPS - No.

Mr SQUIBB -I do not know if we have a spare copy. It probably would be unfair to ask you for a comment off the cuff but to me it did seem to be a workable proposal which would enable the public health system in this State to continue in operation after the end of this year and I think some of the evidence we have had it could well be in jeopardy if registration is not continued for some of these specialists, not just Dr Iastrebov -

Mr LOONE - Mr Squibb, would you care to give a couple of minutes to read that submission because it is only half a page and it may make it easier for you.

Dr MARTIN - Can I just make a couple of statements. I missed out a little bit on some of the areas that have been raised.

I think there are some important issues in relation to how the college approaches this and one is that our processes need to be transparent and they need to be non-discriminatory and I think that really that in recent years there has been a move down this track to put that in place and that certainly has been recognised by the so-called Grennan report and also by the AMWAC report earlier.

I think the other thing is that what we are doing is no different to what a lot of other colleges are doing or in fact no different to what is happening overseas. It would appear that there are mechanisms in place to try to bypass some of what are transparent and non-discriminatory-type activity. It also appears that we are now at a stage where some of that is coming to a head so to try and perhaps prolong it, I do not know if that is necessarily the right approach. That last statement being a personal one.

From a personal point of view, if I was to go and practise elsewhere in the world I would have to go through a similar process. For example, eight years ago I organised to go to the United States and for me to go and practise in the United States I had to sit the equivalent of their final medical exam. I studied and passed that final medical exam and that really is no different to people coming out here. I think this is now an established practice around the world. Years ago you could take your certificate and work elsewhere.

Mr SQUIBB - Except that we are allowing people to come into this country and practise on an annual basis, some of them for ten years or fifteen years at least, some of the given evidence, without having to do that.

Dr MARTIN - We have, yes. The question is: are you going to let that continue?

Mr SQUIBB - I think when you consider that the public health system in this State consists mainly of overseas-trained specialists and most of those are not fully registered we are going to have to find a way to enable it to continue. And that is what I hoped that recommendation might enable.

Prof. PHILLIPS - Well, firstly the college cannot and will not buy into discussions that are really more relevant to either the Australian Medical Association or the Society of Anaesthetists. In other words, industrial issues and salaries and pay and all of that sort of thing. The college will not have any problem with this recommendation in the sense that the college is not involved.

Mr SQUIBB - And it does not provide full registration anyhow.

Prof. PHILLIPS - No, it does not provide full registration but I think as Dr Martin has said that really what this does is to continue, as I understand, the existing situation and then in ten years time you will still be dependent upon overseas-trained doctors on limited registration.

Mr SQUIBB - Except that I do not think it would be an annual one. My understanding of it that there would be greater permanency provided that the employing authority continued to renew the contract.

Prof. PHILLIPS - Well, it solves the mutual recognition problem and also guarantees services at the hospital to which the person is contracted.

Mr SQUIBB - That is all which really was sought initially.

Prof. PHILLIPS - Yes. I did think the original bill had a limit of five years followed by unlimited registration.

Mr SQUIBB - No. A condition precedent was five years at the Mersey then limited to serving at the four public hospitals in this State. So it was still limited.

Prof. PHILLIPS - As I say, the college cannot object to this because it is not the college's business. What the college, I guess, would say is that in order to guarantee, if you like, uniformity of standards in Australia it would be much better that the people who provided the services were either specialists or general practitioners in rural areas who have gone through an approved process or people who are appointed as career medical officers who work alongside and with the help of specialists.

The problem I see with this, if this were applied to Dr Iastrebov, is that he would have to work at the Mersey -

Mr SQUIBB - Unless he went down the other option of the exams.

Prof. PHILLIPS - And that certainly would be what I would personally encourage him to do, which is if he were to want to do that then I think it would have to be referred by the college to the Tasmanian Committee to say, 'How could we help this guy to get into a post which will be approved?' and I think before he did that he really needs to look at is he prepared to do the exams. Because if he is not prepared to do the exams then there is no point in going through the exercise.

Mr SQUIBB - That is the options that are there. And we are not talking just to Dr Iastrebov, there are other specialists in other specialities in other parts of the State, particularly in the north, who are in very key positions who have received letters indicating that unless they commence their examinations or steps towards gaining full registration their registration will not be renewed after the end of this year. A lot of those people are in positions where they cannot leave those posts and go and do the examinations. So it is a serious situation.

At least with that it provides the option of giving them some permanency in their positions and also having the option that if at some stage in the future they want full registration, which would enable them to apply for registration anywhere in Australia, that option is still there. But if they only want to work at site 'A' for the rest of their working lives they can do it.

Mr LOONE - Another point you have not raised either is that the majority of these people we are talking about were in Tasmania working as specialists on conditional registration before any of these changes were made in 1994. So they are really the ones who seem to be concerning or concerning us most with the evidence that has been put before us.

Those coming in now it is made quite clear the changes have been made and I think they clearly understand what they must do. But the people who came in prior to 1994 are the ones who have the big problem.

Prof. PHILLIPS - I understand that and this happens in a number of countries to a greater or lesser extent but I think the important thing is that whatever is done now to solve the problem of service to the community that there is a plan made, and you are suggesting that it has been, that eventually there will be people with appropriate registration which is acceptable for mutual recognition.

Mr HARRISS - Garry, just going back to your comments regarding that recommendation by the Australian Medical Association, you made a comment along the lines that you really cannot express an opinion about that because it is not a matter for you to deliver registration of any kind, we understand that. But, nonetheless, fundamental to the whole process, is that your college would be intimately interested in delivery of an excellent service across the nation.

Prof. PHILLIPS - Absolutely.

Mr HARRISS - That then takes me to a question about, particularly in this case Dr Iastrebov, what process has been undertaken so far to assess his capacity to deliver that excellence of service?

Prof. PHILLIPS - We have not discussed in any detail, nor do we have any mechanism for assessing his competence, if you like. It is something that if the college was asked to do that we would have to then discuss can we set up a mechanism for doing it. At the moment we do not have that.

Mr SQUIBB - I understood from the previous witness that the college was prepared to have somebody actually go to Latrobe and do an assessment.

Prof. PHILLIPS - That has never been discussed with the college.

Mr SQUIBB - Was that your understanding?

Mr HARRISS - Well, we would need to confirm that from referring to the transcripts but yes, something along that line was mentioned.

Mr SQUIBB - I thought it was mentioned this morning.

Mr HARRISS - Yes, that is what I am saying, by the Australian Medical Association.

Prof. PHILLIPS - I did hear Dr Walpole taking about it this morning but there has been no approach to the college, I am sorry. Dr Iastrebov in one of his letters may have said, 'I am quite happy for someone to come down'.

Mr SQUIBB - I think he requested it and that request was refused and I think I made that comment this morning when Dr Walpole or Mr Lowe indicated that it would take place. And I said, 'Well, that is a change of opinion'.

Prof. PHILLIPS - There is a complication in that Dr Iastrebov has written not only to the college but also to our Faculty of Intensive Care, which is a separate specialty. My understanding is he has had similar replies from both organisations. But I do not believe that either has agreed to come on site and assess his practise. Because in terms of recommending him for specialist registration and for fellowship, because he does not get to first base with the requirements of training and examinations in order for us to do that.

In our recertification program, or maintenance of standards program, we have a provision for an anaesthetist to request another anaesthetist to come and observe their work and write a report on what

they think about them and for that they get a certain amount of credit towards their recertification.

Mr SQUIBB - Can the person making the request name the anaesthetist or is that just a request for -

Prof. PHILLIPS - The college does not actually provide the service so it would have to be arranged by the person requesting it and, in order for it to be accepted as part of our maintenance of standards program, the person who is doing the assessment would have to be an appropriate person.

The reason I am vague about this is that this is a provision in our maintenance of standards program which we have not yet implemented and we are currently reviewing that whole thing. But all I am mentioning that for is not to say that the college, on request, would go to the Mersey, assess his practise and make a statement because what the college has really been asked to do is to assess him for specialist recognition and specialist recognition has to include the training and the examinations. We cannot just come in for a day or a week and say, 'Oh, he's all right, we will forget about the fact that he has never trained adequately or done the exams' because we have no mechanism for doing that.

Mr HARRISS - Can I just pursue that a little bit, again harking back to the AMA this morning. They made a comment that most of the colleges have a procedure which I recall they said something along the lines of 'practise eligible' track which can be assessed. Is that provision available through your college to assess the competence of an anaesthetist?

Prof. PHILLIPS - The short answer is no - and I do not believe that it is available through most of the colleges. What there is provision in our regulations, as there are in a number of other colleges, is provision to elect to fellowship people who for one reason or another have demonstrated, usually by dint of being a professor somewhere and publishing and teaching and all of those issues - in other words, someone prominent in anaesthesia - we can elect to fellowship without training and examinations. For example, in Newcastle last week we elected to fellowship a professor of anaesthesia from Munsta in Germany and a professor of anaesthesia from Harvard. They are prominent international figures who we invited to speak at our meeting and we decided to elect them to fellowship but it has to be a special category of person so we would not elect somebody to fellowship unless they had done something like that.

Mr LOONE - Doctor, I maybe naive to ask you such a question but I find it hard to understand why someone like Dr Iastrebov, who has not met the registration standards required by the Australian Medical Association, is allowed to travel around and present papers and virtually teach other professional people when he himself is not recognised as being totally qualified.

Prof. PHILLIPS - Yes, it is a good question. Reading through Dr Iastrebov's CV, my understanding is that most of the teaching that he has done around the world has been either by invitation of particular people or through the World Federation of Society of Anaesthetists. The World Federation is quite different to the college in that it is a federation of the society of anaesthetists of all countries in the world. There is a society of anaesthetists, for example, in Papua-New Guinea which I visit and they are members of that World Federation so if somebody, including Australia, wanted to invite the senior anaesthetist from Papua-New Guinea to come here and give a lecture we are quite entitled to do so but that person we would not consider for election to fellowship because they have not done the training and the examinations.

There are people who travel around the world all the time lecturing, teaching, even publishing articles, who do not necessarily fit the qualifications that we require, nor do they fit the requirements of the British college, the American boards, the Canadian college, South African college.

Mr HARRISS - Earlier on, Garry, you mentioned that Dr Iastrebov's qualifications are not in doubt.

Prof. PHILLIPS - His medical qualifications?

Mr HARRISS - Yes. That suggests to me that nobody is disputing the fact that he has undertaken some educational training in his country to become qualified to the level acceptable in that country.

Prof. PHILLIPS - That is correct. He has a basic medical degree recognised by the World Health Organisation - or whatever that body is - and also he has done the training required of a specialist at Russia at the time he did it.

Mr HARRISS - How then do those qualifications compare to Australian qualifications? I will tell you why I ask: at an earlier time - and I cannot recall from which organisation, but it was Dr Sparrow and I do not recall which organisation he represented at the time - he made a comment along the lines that qualifications obtained in Russia are vastly inferior to the qualifications here, so that is why I asked the question.

Prof. PHILLIPS - I cannot answer that because I do not have first-hand knowledge. All I know is that the standard of anaesthesia training in the countries that we have traditionally related to is fairly well understood.

Mr HARRISS - What are those countries?

Prof. PHILLIPS - The prime one was Britain because that is where Australia came from; I am not saying we should stay there. The British college, for example, was the college where going back to the thirties, forties and fifties Australians used to go to England to get their qualification because we did not have one.

When we set our own up it was modelled substantially on the British one but we said, 'Well, you don't have to go to England now, you can do it here'. We now have got to the stage where we say the English one, because of mutual agreements, is not acceptable in Australia just as ours is not acceptable now in England. So it is becoming increasingly difficult to move around the world and there are various reasons for that.

Britain has now linked with the EEC to the point where they cannot make a decision without reference to the EEC resolutions. South Africa has now closed off and is relating to the rest of Africa. Canada and America, as I have said to other people, remains splendidly isolationist in that they accept nobody, so if I were to go to America now I would have to start and do all my anaesthetic training. So it is really the origins that have determined a little bit where we are but we have now changed. We are totally independent of the British background in terms of what we actually do and in fact some of our innovations the British take up because they think they are a good idea. Now I have forgotten your question, I am sorry.

Mr HARRISS - It was just about the Russian education process.

Prof. PHILLIPS - Okay. We do not have detailed knowledge of the training and qualifications in every country in the world and nor can we. What we did was to inquire of Professor Damir, through an interpreter. We asked about the sorts of things that they did in Russia at that time, both in under-graduate training, post-graduate and anaesthetic training, examinations and compared it with ours. Our interpretation is that firstly the anaesthetic training to be a specialist in Russia was less in duration than ours. They did not have clearly defined primary and final examinations equivalent to ours and also the resources available in Russia at that time were not to the level that were available here and by resources I mean the standard of operating theatres, equipment, drugs, all of that sort of thing.

The place where Dr Iastrebov worked was a very good place and he was regarded as a very competent person so I have no doubt, by Russian specialist anaesthetic standards, he was good, but it did not match ours.

Dr MARTIN - I think anecdotally we obviously have an international anaesthetic community and there have been some Australians who have visited Russia and some who have spent some periods there. The anecdotal sort of evidence that they give us - and this is not being highly objective - is that the standard of care - and that is really what we are talking about - is probably somewhere in the order of fifteen, twenty years ago that we had here. That is purely anecdotal but I think that perhaps give you some concept of the difference and that standard of care is related a lot to both the techniques, the available of ancillary service, the equipment and also the overall mentality.

I think standards of care here are the crucial element. We referred to before of the accreditation of hospitals and also the official visits to hospitals to look at this, this is not done on a subjective basis. The college now has something like over 50 policy documents relating to the standards of care which are regularly reviewed and updated to reflect changes in current practice and really now become highly acceptable for organisations that accredit hospitals such as ACHS, government, health authorities and also the legal profession. I think there are quite a few areas there that coalesce to try to provide this sort of standard care - it is not only Australian, it is New Zealand and parts of South-east Asia - to their community.

Mr LOONE - Would not it add greatly to his credibility in the fact that now at Latrobe they have state-of-the-art equipment? It is looked upon as one of the most efficient and professional intensive care set-ups in the State. He is operating that more than capably with great credit, would not that be assessed in his registration qualifications?

Dr MARTIN - Well, for example, as Professor Phillips does, I have travelled to the Pacific not infrequently and I have visited various hospitals there that have state-of-the-art equipment but it is in a back room where the people have not been appropriately trained in relation to the use of it, to its maintenance and to its upkeep. That is a perception rather than necessarily a reality, for what you are putting forward.

Prof. PHILLIPS - I have not visited the Mersey since I worked there, which was a long time ago, but I doubt the anaesthetic community in Australia would regard the Mersey as a top intensive care unit.

Mr HARRISS - Could I just pursue that matter of qualification versus clinical ability. In your submission, Garry, on the final page, you have referred to representatives of the Princess Alexander Hospital indicating that Dr Iastrebov was at the stage he worked there about equivalent of a fourth-year college trainee, that was back in 1995 and in need of primary and final examinations. As far as you are aware, did that apply to both educational qualification and clinical qualification? I suppose they are linked, are not they?

Prof. PHILLIPS - They are related but the prime concern was educational qualification. My understanding from the people at Princess Alexander is that there was no real question about his technical ability, for example, but educationally it would relate to things like breadth of knowledge, understanding of basic sciences, the way equipment worked, those sorts of issues, but we did not go into that at all. It was because of their representation in fact that we decreased our requirements. We said, 'Well, if they think he is at the level of fourth-year registrar taking into account the other things, then he really fits into the category of people like someone with an English fellowship who would come here who needs only more year but because he did not have the primary examination equivalent we set two exams'.

Mr HARRISS - I want to be really clear in terms of the college's procedure in monitoring or assessing the clinical capacity of a conditionally registered person for their subsequent application to become fully registered. I recall you said earlier - and correct me if I am wrong - that your college has no procedure to assess or no process to assess clinical ability, am I wrong?

Prof. PHILLIPS - No, you are right in the context in which I spoke, which was that the college has not been prepared to come into a situation where they have had no involvement with someone's training, for example, and do a spot check and say. 'This guy is competent'.

What we do with our trainees, and what would happen if Dr Iastrebov were to go to a training institution to spend twelve months, is that although he would not necessarily be in a registrar position - meaning junior - he could be in a senior position and we would probably call him a fellow rather than a consultant, is that he would be assessed, he would be allocated work as he does not but in an environment where he could be rotated around different lists, for example. He could assess patients pre-operatively, he could do paediatrics, obstetrics, general surgery, urology - all of those things. He would be monitored by a person nominated to monitor that and he would at least every six months have a formal assessment and discussion with relevant people in the department to say, 'You are very good at this, you're a bit weak on that, we'll move you to that' et cetera so that there is a formal assessment of our trainees which is carried out and that is what would happen to him.

Mr HARRISS - And in regards specifically - and we understand this inquiry is not all about Dr Iastrebov - but in his case what process of monitoring has been undertaken while he has been conditionally registered to practise at the Mersey Hospital?

Prof. PHILLIPS - None at all, because he has indicated to the college that he is not interested in pursuing the college process.

Mr HARRISS - Just one other one which interested me earlier on during this select committee was the fact that in referring to the Federal Coalition's immigration policy, they have made it quite clear that as a coalition they recognise the serious concerns that have long been expressed about aspects of the current system of recognition of overseas-trained doctors. In that same policy document there was reference to a Human Rights and Equal Opportunities Commission decision in 1995 regarding a Dr Siddiqui - and I do not know from what which discipline he came - but the commission in its judgment said: 'In its present form, the system of governing the admission of overseas-trained doctors to medical practice in Australia is grossly unfair resulting in unnecessary trauma, frustration and a deep sense of injustice to many doctors, their families and friends'. And the coalition then went on to address that as an issue and I think subsequently there was judicial process which called to question, in a major way, the Human Rights and Equal Opportunities Commission statement. But let us take that statement at face value, that that commission made that assessment of the present process. What is your reaction to that?

Prof. PHILLIPS - I do not know the details of the Siddiqui case or that judgment. I am aware of the name and aware of what happened, vaguely. I think all I can say from the college's point of view is that we do not distinguish, if you like, between people from different countries, different races, different religions, in terms of our process and all we require for overseas-trained specialists is for them to be acceptable to the Australian Medical Council and if they fit into the category of an overseas-trained specialist then we will look at their training, look at their examinations, interview them if necessary and say, 'Look, we would like this guy to be a Fellow of our college' - which gives him specialist recognition - 'but this is what he must do to gain equivalents'. And apart from saying that we do not distinguish or discriminate between anybody and, as I said, some of the people that you have in Tasmania have in fact gone through that process.

Mr SQUIBB - I think it was also indicated to you, Professor Phillips, that we might be requesting some background on the registration of three South African anaesthetists who were given as examples during some evidence. Are you able to provide that background, please?

Prof. PHILLIPS - I have no details because that has not officially, I do not believe, come to the college. But I may be wrong there because the registrar of our college, who is the chief executive, did mention to me about this and she indicated that she had looked at the files, gone to the assessor of the college to say, 'Is this is all correct?' My understanding is that the people in question came under the old regulations which was that they had a qualification which at the time was acceptable to the college and we recommended them for specialist registration. Now I could be wrong and I do not have the details.

Mr SQUIBB - My understanding was that they were post-1992.

Mr HARRISS - Can we mention the names: Harold Burnett, Sue Brunky and Ray Malanski.

Prof. PHILLIPS - I recall the names but I have not brought the details of their information with me. But -

Mr SQUIBB - Is it possible for you to submit that?

Prof. PHILLIPS - Absolutely. We can provide that. The changes occurred, as I understand it, from 1994 and they predated the changes. But I will write to you with a detail of each of those, if you would like.

Mr SQUIBB - I have just one other question, similar to which they asked the previous people in relation to compliances with the Trade Practices Act -

Prof. PHILLIPS - Yes.

Mr SQUIBB - the question of third line forcing. Does your college have an opinion on that? Has it sought an opinion?

Prof. PHILLIPS - Yes, we have sought a legal opinion on our position in relation to the Trade Practices Act and the ACCC. We have been advised that we, firstly, must take all of this very seriously and, secondly, that provided we fulfil certain criteria that we do not have a problem with the ACC. I just noted down some words here from a statement that we had and they were: that the college training program has clear public benefit; it is not structured or intended to operate anti-competitively and that it operates to maintain fair standards, requires supervision and is constrained by funding and that we have no desire to restrict numbers.

Mr SQUIBB - So that they are within your own college's mission statement, are they, rather than the criteria - that is the criteria set down by the ACCC?

Prof. PHILLIPS - No, that is an extract from the legal opinion that we had commenting on where we stood in relation to the ACCC. So our legal advice is that because we do these things and not other things that it is unlikely that we would be in conflict with the Trade Practices Act. That will only become evident if it is tested in court.

Dr MARTIN - The base problem we face is the provision of medical services to the rural community and other areas of need and I think the college is not ignoring this problem. I think that there certainly has been a lot of work done and there is a lot being enacted. Although some of the problems are market forces and industrial issues which are outside our domain, there are many other ways of trying to attract and keep rural practitioners in rural areas. We have a rural special interest group that is working currently in particular to look at reactivating a locum service and to pushing that further. We are about to instigate a lot more electronic communications in relation to being able to bring continuing education to rural practitioners because that can be a real problem. There have been active moves in terms of rotation of registrars through rural areas and that certainly is an increasing area. For example, in Tasmania I was involved in going up to the north west to have a look at the hospital there in relation to rotating registrar through there and I think as of this year we are rotating a registrar from the training scheme in Launceston and Hobart through there.

There is also the need to put in rural incentive programs and I think to facilitate in particular the fact that people who are working in rural areas can be it to meet college needs or in particular are looked after. So it is not something that is being ignored by the college, it is part of our mission statement to be able to meet the needs of the community and it is a major area of concern and, I think, of endeavour.

Mr SQUIBB - But until those needs are met, do you believe that it is unfair on us to take advantage of these specialists on an annual basis and then at such time in the future that our training requirements are able to meet the needs, say to them, 'Sorry, fellows or ladies, you are no longer required'?

Prof. PHILLIPS - It was actually a recommendation of AMWAC, which we cannot disagree with because we were part of that process. The only thing, as was mentioned earlier, in the discussion was that to be fair to the people concerned it is much better if they come in and try to comply with the college requirements because then they have no problem in staying.

CHAIRMAN - Do you think that it is worth recommending that there should be a period when an overseas-trained practitioner comes to Australia and to Tasmania - because that is what we are dealing with here - that that practitioner should practice in a teaching hospital for a period of no less than three months in order that the peers can properly assess him before he is - for the want of another word - let loose on the rural area.

Prof. PHILLIPS - That is a complicated one. We have had the problem of having requests, firstly, for people to exchange with overseas specialists, so someone from here wanting to go and work, say, in England or Africa or somewhere and arranges for one of their people to come to Australia. We do support that as a sort of an interchange and educational process. But the problem of saying that someone is suitable to come and practise as a specialist for a limited time but then is not suitable to

stay is difficult. I think the concept of them coming to a training hospital and spending time is a good one, but if they want it to lead to specialist recognition then they really should inquire, find out what they have to do in total and set about doing that.

CHAIRMAN - But in situations like Iastrebov it would appear that he came to the Mersey hospital with a CV and his qualifications and immediately moved into the Mersey hospital, knowing of course that he had worked in the UK and worked in Queensland as well for some period of time. But it may lead to a situation where if a practitioner practises without this peer assessment that it might be found that they are just incompetent. I understand that there has been a person fairly recently at a certain hospital in Tasmania who was found out to be just that. I do not know whether that was an overseas-trained doctor or not but -

Prof. PHILLIPS - That certainly would be a better process in terms of evaluating somebody than having them just come in, but it does not solve the problem in what capacity are they going to work. Is it as a career medical officer or salaried officer but not a specialist because the specialist business, because of mutual recognition is particularly specific.

CHAIRMAN - Could I ask Michael what he thinks of that, please?

Dr MARTIN - What was the question, sorry?

CHAIRMAN - The question was if an anaesthetist, let us say from Russia, wanted to come to Tasmania to fill an area of need in the public interest aspect and there were no other doctors to do it, do you believe that that doctor should first come to the Royal Hobart Hospital for a three-month period, or however long you think the assessment should be, prior to him going to the Mersey hospital to practise?

Dr MARTIN - I do not think that fits any set process, so from a hypothetical point of view I think it is probably better than what is going on now. But we really do not have any ability to assess that first. There is no process to assess that person and in fact if you were to assess that person, for the reasons that you just said, you would be sticking your neck out. As you said, if somebody came through, 'Right, three months for you, you're right to go out there' and they turned out to be disastrous, who is going to carry the liability?

CHAIRMAN - But is it not better now to do that as opposed to coming over with just the CV and a couple of references and letting them loose? Is it not an extra protective barrier?

Dr MARTIN - This is a chicken-and-the-egg-type situation. If we are going down the track of filling positions with our own recognised be it specialist medical practitioners that meet our own recognised standards, then at some stage we are going to have close the doors and say that is what we are going to do. And certainly if you look at the band power figures that have come out from AMWAC, there is not a national shortage of anaesthetists but like in most other be it professions or occupations, there are regional needs that perhaps have difficulty being met and there is turnover that occurs as well. Now certainly some areas have major problems. At our meeting we had an elderly practitioner from Dubbo - they have been trying for six years to get somebody to Dubbo and have offered all sorts of incentives and have not even had one phone call. So we have to address those real problems. Is bringing overseas-trained doctors a solution or is it really just putting back the fact that we address these problems properly?

CHAIRMAN - If overseas doctors want to come, if Australians doctors do not want to go into the areas, the areas deserve medical attention, surely bringing overseas doctors into those areas that Australian doctors do not want to go into is going to be an improvement, one would think, on the public's ability to obtain fairly ready access to medicine.

Prof. PHILLIPS - It is a potential solution - in part a short-term solution. If you were, for example, to open up entry and registration to overseas doctors all around the world with no limitations -

CHAIRMAN - I am not professing that at all.

Prof. PHILLIPS - you would have probably more doctors here than you would have population in Australia within six months. I think the difficulty has been - and this has been particularly so in Queensland and it has happened in the cities as well, including Adelaide and Sydney - where people have been brought in to fill particular positions because usually in public hospitals where they have not been able to attract people, that certainly a significant proportion of them come, fulfil the requirements, get their specialist recognition and then disappear. And they disappear largely from the public hospitals into private practice or from the country to the city. That is something that I think the college is trying to address; I think the health funding system is trying to address it, but it is not as easy as just filling all the positions that are difficult on the conditions that are there with overseas people who happen to want to come to Australia. I do not think in the long term that is really going to solve the problem.

CHAIRMAN - Am I right in saying that your belief is that at the end of the day it is best if Australian practitioners fill those areas? For Australian practitioners to fill those areas, there seems like there have to be some great incentives for them to go out into the areas or some other way of getting them out into the areas. Are you able to help us at all as to how that should be?

Prof. PHILLIPS - No, not entirely. I would desperately love to go and work in such a place, and the reason I do not is my wife and children do not want me to. That is one of the reasons I go to New Guinea, to escape them.

CHAIRMAN - We were told the wife is the major problem, it is not the doctor.

Prof. PHILLIPS - I believe, as a college person and a professional of some standing, that it is the responsibility of the profession to fill the needs that the community wants filled. I think we do have a problem in relation to, if you like, conditions of service - and I do not really mean just money, in fact I would even take the money away. But because of the increasingly difficult environment in relation to the health care system, it really is a question of what environment people are coming into and what do they want to do versus what is available for them to do. That is why, for example, major teaching hospitals in some of the capital cities cannot attract anaesthetists to work there because they find that other hospitals have better environments. Maybe they get access to teaching, they can do research, they can do other things as well as just provide clinical service.

When you come to rural areas it becomes more difficult because to train in a city environment particularly and then move into a rural one where you know you have less attractions, not only for yourself but for your family, you also cannot get away once you are there, it becomes a disincentive. I think what the college is trying to do and what all the colleges and the medical community have to do is create an environment where there are mechanisms for people to supply places like the Mersey. I see no reason why the Hobart and the Launceston anaesthetists cannot work out a system within this State of helping the Mersey eventually to achieve what it wants to achieve, assuming that the Mersey and those anaesthetists want to cooperate with each other to do that.

We had the same problem in Adelaide where the women's hospital lost all its staff because of a particular issue. My anaesthetist came to me and complained about how terrible things were at the women's -

CHAIRMAN - It has raised our curiosity there, we will have to ask you why.

Prof. PHILLIPS - Well, I do not know. My answer was, 'We are the anaesthetic community in Adelaide, the women's is a major hospital, we must support it. So whatever the problems are you had better fix it', and they did.

Dr MARTIN - Getting back to your quote, I do not think we want to fill the job with Australian people, I do not think that is the intention. I think the intention is to try - it would appear that the choice at the moment is that places either have no service or they have a service of questionable standard, and it is questionable because it has not necessarily gone through a process. Surely what we should be trying to do is fill them with people who are of a standard that really is equivalent to what the rest of the community is receiving.

Mr SQUIBB - Whether that be for twelve months or longer.

Prof. PHILLIPS - Yes. An extension of that is, for example, if, as I expect it, Hong Kong would become an undesirable place to live following the handover to China - it has not yet, but if it had been - and we had had applications from a lot of Hong Kong Fellows of our college to come to Australia, we would have no difficulty with that at all because we know their training, we know their status and they are equivalent. So they can come, I would have them in my place.

Dr MARTIN - I think the third point is that this is not just about getting somebody of a standard in there, it is of maintaining that standard. Certainly in all the specialties, anaesthesia is no different and in fact it may even be more different because of recent changes. Standards change and certainly patterns of practise change. The colleges instituted a maintenance of standards program, for example, that it is looking at being able to keep people up to some certain level, so it is important that anyone that we release out into the community can continue along those sorts of lines. This becomes also one of the problems if you have people who have not gone through an Australian system, that they are really starting from a different background.

Our maintenance of standards program is actually open to non-fellows of the college, so people can participate from being GP anaesthetists or specialists who have achieved recognition through other means. I think the AMWAC report says something like 90 per cent of the anaesthesia in this country is given by specialists and about 90 per cent of those specialists were Australasian Fellows - that was 1994 figures.

CHAIRMAN - Mike, if you wanted to go to America next week and practise as a specialist anaesthetist, would you be able to go in and practise as a specialist anaesthetist?

Dr MARTIN - As I stated, I set up to go to America in 1992 for a sabbatical year. To achieve that I had to pass their basic medical exams which had both a clinical and basic sciences component. That was a two-day exam; I had to go to Melbourne to sit that. Anaesthesia has a nice background to do that because we have a fairly broad involvement in various specialties, so I was able to pass that. That alone only got me into being able to be employed within a hospital to practise within a supervised capacity; I could not have been able to go out into a specialty practice as such. I did not take the option up, for various other reasons, but I went through the process of actually being able to get there. But to practise as an anaesthetist I would then have to sit their board exams, unless I was an eminent figure like Professor Phillips here.

Prof. PHILLIPS - The American system is quite different to here in the sense that any medical graduate can set themselves up as a specialist anaesthetist in various states in America, but if you want to be recognised by their specialty boards as a consultant in anaesthesia then Mike would have to do all of their training and their examinations. He would not be given any credit at all. We are the most liberal of the English-speaking countries.

Mr HARRISS - Given that there seems to be broad criticism, as I referred to earlier, from the Human Rights and Equal Opportunities Commission and others - or some criticism, at least - of how we go about assessing the qualifications of overseas-trained medical practitioners, has your college made any moves to broaden its acceptance of overseas qualifications other than New Zealand? I recall what you said about our previous mutual recognition of Britain and South Africa.

Prof. PHILLIPS - On advice, in order to be not accused of discrimination we have made it more difficult for the people who used to have an easy access, to get access. One of our problems is that we have doctors here from all over the world, including specialists from all over the world, and we are not in a position to go back to eastern European countries to South American countries to Asian countries and say, 'Let's look at all your training and examinations and we'll see what's equivalent and what's not'.

Mr SQUIBB - But you have done that for Hong Kong and other places.

Prof. PHILLIPS - No, we have not done it for Hong Kong. We do not accept their college's qualification.

Mr SQUIBB - But your exam.

Prof. PHILLIPS - They do our full training. They graduate from medical school, they do two years' rotating residency, they then -

Mr SQUIBB - Whereabouts? In their country?

Prof. PHILLIPS - They can do it all in Hong Kong, but in hospitals we approve.

Mr SQUIBB - Yes. You have been there, you have checked their hospitals and their equipment -

Prof. PHILLIPS - Yes, and we go back regularly and they agree to follow all of our documentation.

Mr SQUIBB - So is that not in some way providing an advantage to, say, a person living or working in Hong Kong compared to Russia because you have not been to Russia to do it?

Prof. PHILLIPS - Certainly that is true, and we cannot go to every country in the world because we do not have the resources to do that. They have a full training program of their own, so one of their trainees can become a Fellow of the Hong Kong College of Anaesthetists, which we do not recognise. Someone who does their training who comes to this country would have to do our year's training and our exams. But what we have done is to say, because we now have some hospitals in Hong Kong, Singapore and Malaysia where most of the staff are actually fellows of our college who trained in Australia in the old days but now are resident there, they are appropriate people to supervise and run our training program offshore. In Russia we do not have any fellows, so we have not bothered to go and look at it.

What we are doing is unusual. The British colleges grant offshore degrees, the Americans do not. Americans do not let anybody train except in America. What we happen to have, for historical reasons, is enough of our Fellows who can conduct our training program to a standard where they can sit our examination, and it is the same exam. They have to come here for the final exam and if they pass all of that and fit in with all our assessments in an appropriate hospital, then we will grant them fellowship of our college.

Mr HARRISS - You used the term, 'What you do is unusual'. I would see that as positive.

Prof. PHILLIPS - We see it as positive, yes.

Mr SQUIBB - But in itself it is a form of discrimination, it is only offered to certain -

Prof. PHILLIPS - No, no. You could argue that we are discriminating in Australia for New Zealanders as well.

Mr SQUIBB - Yes, I have.

Laughter.

Prof. PHILLIPS - But we happen to have an Australian and New Zealand college because that is the way most of the colleges are set up. Now the New Zealanders can do all their training and examinations and assessment in New Zealand, but what they get is an Australian and New Zealand fellowship. You could argue certainly that we are discriminating for people in Hong Kong, but I think that would have to be tested in court as well.

Dr MARTIN - Just to pick that point up. We do not actually go out and say, 'We want you to become a training hospital'; the actual contact is in the other direction. We do not have anything within our rules that does not say that a hospital in Russia could approach us and say, 'We want to be set up as a training hospital'. It is an interesting discussion because with the changes in the health service in Australia, initially traditionally the teaching hospitals were public hospitals. Now we find that we have teaching hospitals that are private and it is a bit hard to distinguish between the two. It is not the college going out and saying, 'We want this hospital to improve training'; they come to us and as long as they meet the set criteria, so it is not discriminatory in that manner. It does not really matter what country it is.

CHAIRMAN - I was talking to you prior to the committee commencing and you were talking about orthopaedics where you can now get a photo taken of your knee operation, or whatever. It seems to me that the rural areas are going to benefit with this techno-revolution, especially with the training that obviously is going to be involved, because with the techno-revolution what you will have, it seems, in the future, if necessary, is a TV monitor going into the operating theatre can be viewed if necessary from the north-west coast down to Hobart, or vice versa. Therefore the teachings are going to be greatly increased and are going to be benefited greatly by this type of technical revolution that is going on at present. Do you think that will happen, and therefore people will more readily go into the rural areas because they have the facility of being able to tap in straightaway to a teaching hospital?

Prof. PHILLIPS - I believe that is true. When you said all that I immediately thought that Australia was one of the countries that actually led the technology revolution in the 1920s with pedal wireless, and operations were conducted at a distance on instruction by radio or by wireless. But you are quite right. For example, the Flinders Medical Centre runs a weekly meeting for our anaesthetic trainees and we are currently video conferencing that with Darwin. It is a university link and we participate. The new undergraduate program at Flinders is linked to the Riverland and the Eyre Peninsula and other country places, and we have students out there who can link into the teaching sessions.

CHAIRMAN - Do you find they could more readily go out there because of that ability?

Prof. PHILLIPS - Absolutely. The country rotations for undergraduates now are quite popular and they will become for postgraduates. Our college, for example, has said now that if a training program believes it is appropriate then they can mandate that a person entering training must be prepared to go to a country hospital in terms of part of the agreement to undertake training. That is a form of forcing, I guess, but what we are doing is saying we regard rural training as so important now that unless you expose people to it during their training, they will never work there. From South Australia we have registrars in Alice Springs and Darwin - I guess they are country - but in New South Wales and Victoria of course it is more common because there are bigger regional centres.

I think in Tasmania traditionally it has been Hobart and Launceston, but Burnie is now going to have a rotation attached to it and eventually hopefully the Mersey will too. But in order for the Mersey to be in a position to ask us to look at that, they would have to have a Fellow of our college there and that is something they have to attract.

CHAIRMAN - What I am trying to do is get some recommendations from you, obviously, and the whole committee is. It looks like making it mandatory to go into the rural areas will assist the rural areas, firstly.

Prof. PHILLIPS - I think, firstly, undergraduate exposure to rural areas is essential, so you have to get medical students there. Then you have to get trainee registrars there, and the only way you can do that is to get agreement from the specialists communities to have appropriate specialists there who can supervise and train the people. For example, if I were wanting the best of everything, I would be arguing that Burnie and Devonport, or Latrobe and Mersey, should work out some mechanism, if necessary, in consultation with the relevant people in Tasmania to get a specialist of the appropriate discipline there, so that they can look at attracting registrars.

I know you tell me they can advertise for ten years and get nobody, I do not believe we are that short of anaesthetists that it is impossible to get somebody to a hospital if you design a package - not necessarily financial - which is linked with somewhere like Launceston or the Royal to make it attractive to somebody to go there, even if you did it on a rotating basis. So a group of people agree that one would go this year, one would go next year, one would go the following year and you build it up.

CHAIRMAN - So there is that. It seems if you had the finances, the technical and the new technology, if you got those into the areas as well that would certainly assist with training and therefore attract people to those areas to some degree.

Prof. PHILLIPS - Yes, although my suspicion is that most hospitals in Australia are pretty well equipped now, or are in the process of getting pretty well equipped. We have always been of a fairly

high standard and I suspect that if I were to look at the Mersey, I suspect that the equipment there would be pretty good, but I do not know.

CHAIRMAN - I mean more the equipment so you could tap in if necessary to a major or interesting anaesthetic or intensivist course in Hobart, whilst you were still up at the Mersey.

Prof. PHILLIPS - That facility exists in lots of places, I do not know whether it exists in Latrobe.

Dr MARTIN - Well, it does. I think - this is a particular interest of mine, I am particularly working in the area of Internet. The problem is not the technology, as Garry says, the technology is available in a lot of areas. And it is interesting how many hospitals have teleconferencing facility, which remains idle most of the time. The problem really is in both the leadership and the application of the technology and the people being able to appropriately apply it.

Anaesthesia has got, I think, some particular peculiarities and one is that you are on your own. You cannot actually help somebody intubate someone down a video conferencing line. You can help them set up an organise various things towards it. You are working particularly on your own and it can be a bit more immediate than perhaps the needs of the surgeons at times.

CHAIRMAN - Although you can see the work of your peers can't you, quite readily?

Dr MARTIN - I think the application is there. I think that really, getting down your list of things that we need to address, it is this - call it leadership and involvement of the technology and usefulness that needs to be addressed.

CHAIRMAN - And also the recommendation, that does not offend you in any way that was put forward by the AMA?

Prof. PHILLIPS - It does not offend me in the sense that it is not college business, put it that way. I recognise - and everyone would - that you have to maintain services in Tasmania. What the college would be pretty unhappy about but could not do anything about, was that if you were to decide that the college's recommendations were irrelevant and should be bypassed. We would obviously not be very happy with that but there is not much we can do about it.

CHAIRMAN - What about you, Mike, with that?

Dr MARTIN - I cannot help but feel that one of the first priorities should be the facilitation of these people to meet appropriate, be it AMC or other, requirements. I use the term 'facilitation' in other words they are not left out on their own but be it through the request of the college through appropriate funding, through meeting some of these other things that we have mentioned there, that in fact you do bring people up to a line so that the community cannot actually question that they have been dumped and left with somebody of questionable standards.

CHAIRMAN - What about the pre-training, if I can call it - pre-practise training of a period of appropriate time up to three months?

Dr MARTIN - Issues like that do have to be addressed. But if you do have people of appropriate standard, then with support, with appropriate in particular use of locums or whatever, to be able to undergo training then perhaps we should pursue down that line. That is a big ask. But as I said, I resat my American basic medical degree some thirteen years after I had completed it here. There had been a lot of change and it just required some time and effort and if you like people of the same standard throughout the country perhaps that is where we should be heading.

Mr SQUIBB - Would you agree with that recommendation that the onus is certainly going to be on the CEO of the employing hospital?

Prof. PHILLIPS - I am getting a little bit concerned that I am making statements about a recommendation which is very complex and I have just seen it. I will answer your question, but what I

would quite like to do if you were happy is to write to you with a commentary on that, together with information about those three people that you asked me to comment on.

I think the question about the onus being on the hospital, I do not know what the rules are in Tasmania but I believe that hospitals should be required to have appropriate privileging committees who decide who can do what in a hospital. In some States it is a requirement that in the particular speciality area a representative of that college is on that committee - not to tell the committee what to do but to say what the college's view is - which can be taken into account. I do not know whether the Mersey has that sort of committee but if it has not it should.

Mr LOONE - Just one question I would like to ask Professor Phillips. What part does your college play in recognising the conditional registration of an overseas doctors? We keep using Latrobe - probably it is a good example - Dr Iastrebov when he made application to join the Latrobe hospital, did you have any part to play in his going to that hospital?

Prof. PHILLIPS - None at all. If asked we would reply but because we do not have a role in specialist recognition but only in recommending what someone would have to do in order to achieve it, certainly if the hospital wrote to us and said, 'We're thinking of appointing this person, can you tell us what you think'. We would tell them what we thought they needed to do in order to achieve specialist recognition.

Mr LOONE - In that case where he has been at Latrobe now for two or three years or whatever, can you see any problem in his registration being continued on to, say, a two-year period providing that the hospital is totally satisfied with the service he is providing and the expertise he has, that they continue to renew his contract without him seeking professionalist approval from your college?

Prof. PHILLIPS - I think I do actually because having been sent his details and letters from a variety of places Dr Iastrebov is not a person who in the college's view is appropriate to be a consultant anaesthetist and intensive care specialist.

Mr LOONE - The point I am trying to make and probably not doing a very good job of it, he was seen fit to be appointed by the Mersey hospital to take up the position as an intensivist or specialist to handle their intensive care and to be an anaesthetist. He has had a two-year appointment, he has carried out that two-year appointment with all flags flying. He has been a wonderful asset to the hospital. They see fit to renew that for two years, I cannot see where the problem is. If he has done his job properly for two years why can he not have another two years?

Prof. PHILLIPS - As far as the hospital is concerned, I see no problem with that. All I am saying is that the college can only comment on what it sees is his level of standing, if you like, in terms of equivalence, to what we would regard as a consultant anaesthetist and he does not meet the requirements.

Mr LOONE - I know exactly where you are coming from. I am only probably trying to see a way around a community or an area like Latrobe - or it maybe Burnie or wherever next time, it is not just there - that they are going to be disadvantaged when his contract cannot be renewed or is not renewed for the various reasons of getting registration. They are going to have a less level of protection -

Prof. PHILLIPS - I understand that.

Mr LOONE - in the case of emergency or what not, and it seems ludicrous that he is forced away and the area is going to have less coverage.

Prof. PHILLIPS - I understand that. But if that is the decision to do that then I think both he and the hospital ought to be on notice that next time this comes up - within two years or three years - either he has agreed to follow the right path to get so he is a genuine accepted specialist consultant, or there is a clear understanding that something else has to happen. Otherwise we will be meeting every couple of years.

Mr SQUIBB - Not if that recommendation goes through. That would enable him to continue at Mersey or the other specialist at Launceston for instance, in those roles. It gives them security of tenure. It does not allow them to go anywhere else.

The onus must be now on the CEO. And surely the safeguard would be that the CEO and the company, or the public hospital that employs the CEO, would have a duty of care and, I guess, would be liable for negligence if they appointed somebody that was not competent.

Prof. PHILLIPS - I am not as sure of the future as you are, I do not think. I believe that the changing in the health environment, the decrease in funding, the increase in interest in managed care and all of those things will potentially result in importation of a lot of people to solve a few problems. And the end result will be a decline in the standard of health care in Australia, I have no doubt about that.

CHAIRMAN - Because presently Australia's health standard is excellent, is it not, from what I understand?

Prof. PHILLIPS - Yes, it always has been.

CHAIRMAN - Yes. As I understand it now, previously you used to go to the UK to get your fellowship, but they come here now, and I understand that the reason for that is the health system they have over there has led to -

Prof. PHILLIPS - There is no question. I came back one month ago from a meeting of what used to be called the 'English-speaking Presidents', which really means the presidents of the anaesthetists in England, Ireland, Australia, South Africa, Canada and America. It is quite clear to me that the EEC will result in a decline in standards of care across Europe from the excellent - which really have been places like England, Denmark, Sweden, Germany, France - to a level between there and some of the countries which have not had the standards. The eastern block countries are one of them, Greece is another, various other countries there. Because of the EEC that high level will come down.

In Africa it will even be worse, much worse, because South Africa now, which was one of the pre-eminent countries where the first heart transplant occurred et cetera, is now going to come down much lower than that to fit in with the sub-Sahara and African countries.

Mr SQUIBB - The processes that are in place in Australia though, that will not necessarily mean that the standard in Australia is going to go down.

Prof. PHILLIPS - No, no I had not got to Australia.

Mr SQUIBB - I thought you said earlier that the standard was going to come down.

Prof. PHILLIPS - I believe it will, but for a variety of reasons. Australia and New Zealand at the moment has a much better future than either England or South Africa in terms of the way they will go. Canada and America, because they have remained isolationist, will continue with what they have. I am not saying they are perfect either, because America particularly has a wide variety of people practising all sorts of things. Canada is probably a better model. Australia and New Zealand's standards now are probably as high as anywhere in the world and better than most. All I am saying is that for a variety of reasons, including financial ones and the intention to cut funding in the aims of efficiency and so forth, will eventually lead to some decline of standards in Australia and New Zealand.

Because you cannot run a first-class system once you get to a critical point. You can do it by reducing some funding but eventually it has to fall. That is a personal view, not a college view.

CHAIRMAN - The college obviously has dealt with this problem - or has spoken about the problem - and it is nothing new in getting people to rural areas. Are there any other ways that you believe you could help in telling us ways of making sure rural areas are properly serviced?

Prof. PHILLIPS - The only things I can suggest at the moment really are that, firstly, I think the anaesthetic community in Australia - and the college can help in this - ought to discuss how the rural

areas in Tasmania can get a better service. I think the College of General Practitioners we have an agreement with in terms of training and there is no reason why GPs cannot be encouraged to provide anaesthetic services in areas where you do not have specialists.

I think on a temporary basis you probably are going to be dependent upon the overseas people that you have here. I do not believe that can be radically changed rapidly but I think important to come out of this whole process, is a plan to eventually not be relying on overseas people to come in for a limited period and go away, because I do not think that is very satisfactory for continuity of standards.

CHAIRMAN - So therefore any person who does come to fill these areas, it should be made known to them prior to them coming, that if they are to come and fill the area they are expected to at least attempt to carry out the examinations to allow them to obtain fellowship and therefore full registration.

Prof. PHILLIPS - I believe that is fair to them and in the better interests of the community as well.

Dr MARTIN - I would not use the word, 'attempt'. I think if you are going to bring in overseas-trained doctors you really need to put a time period on it but, more importantly, you need to also facilitate that process. I do not think you can just put somebody in an isolated area and say, 'You've got to pass all the exams and by the way you're going to be working seven days a week, 365 days a year'.

CHAIRMAN - What do you think you should be saying?

Dr MARTIN - I think there has to be some resource put to it, so that if you cannot fill these areas of need you need to bring people in for some period or whatever, as equivalent. Have a time effectively time-stamped and say, 'We will be providing support and whatever to be able to fulfil the criteria.

CHAIRMAN - Is seven years a fair time? I understand seven years is the maximum time you have to pass a speciality, is that right? Seven years is the maximum time that you have once you commence an exam, or once you commence a speciality -

Prof. PHILLIPS - Do you mean from the point of view of immigration or -

CHAIRMAN - No, from the point of view of, let us say, anaesthetics or paediatrics or orthopaedics.

Prof. PHILLIPS - Yes, that is if you are starting from medical school. If you are looking at overseas-trained specialists who come in, most of them will only need one year. Some of them may need two but they also have to complete the exams. I think what Dr Martin is saying is that if the college is involved in this process as well then between the college and the hospital they can provide the resources, the time, the supervision to allow the people to do that. You cannot do that, as he is saying, if you are the sole anaesthetist at somewhere like the Mersey, available all the time.

Dr MARTIN - That one year, I am not sure if I am correct, does not necessarily have to be one complete year. You could say in a four-year period we will rotate three month blocks -

Prof. PHILLIPS - It could be split up; we just have not had that.

Dr MARTIN - It can be split in our method so that you could rotate them through other public hospitals. It does not have to be that they will be away for a whole year.

Mr LOONE - In the case of Dr Iastrebov then, he needs to do a twelve months training at say Launceston or Hobart. Could he go and do a two months period or three months and go back to his job at Latrobe and then in six months or eight months go and do another three months period?

Prof. PHILLIPS - I think that would be feasible. We have not specified any break-up but we would certainly consider that, so that if it were feasible for Launceston or Hobart to provide support to the Mersey while he did that then that would be a possibility. But I think the other problem he has is being prepared to do the exams.

Mr LOONE - Yes, I understand that.

Dr MARTIN - I think there are minimum periods. I think most training programs would look at three months as being a sort of minimum for rotation and most would look more at six months, but there are options for this.

Mr LOONE - Just to clarify one other point from evidence we were given that there was a possibility that the college would assess Dr Iastrebov on site at the Mersey hospital. That is definitely not the case?

Prof. PHILLIPS - It is certainly not the case now and we have never considered that because we see the whole training examination process as a continuing one and do not really accept that you can say 'somebody needs another year and two exams but instead of that we will come and assess him on spot and sort it out then'. We do not believe that is appropriate.

Mr SQUIBB - Mr Chairman, Professor Phillips indicated that it was less than ideal to have these overseas-trained doctors coming in for two years and then disappearing - and I would certainly agree with him - but given the situation we are in where there is a shortage of doctors, are we not better to encourage overseas-trained doctors who have proven in that two years that they are competent to remain, rather than take the risk on bringing in another one - quality unknown?

Prof. PHILLIPS - I know you are being specific about specialists because, as you know, Australia as a whole claims that there are too many doctors and we are medical graduates to ensure that there are not enough.

You could argue that, yes, that if you have someone you know and he appears to function satisfactorily at a particular level and the hospital is happy and the community is happy, why not keep him, instead of saying, 'You are expired now. You can go and we'll bring someone else in'. That is a reasonable community argument, I think.

CHAIRMAN - And it seems the only real problem that I can foresee, and I think it is a problem, is if we start giving them full recognition because of mutual recognition they are able to move anywhere they like and what we have found is that if you do give them full registration they do move from here and immediately go to the major cities.

Prof. PHILLIPS - Yes. I think that is the case unfortunately. I train at my hospital a lot of registrars. They do not stay in Adelaide because it happens that, because each State has its own award conditions and pay and all that sort of thing, that South Australia now is the worst-paid State. So my fellows will not stay with me. They say, 'Well, thanks very much, we would love to stay here but actually I can earn twice as much on the Gold Coast'. So off they go. It would be very nice if we had similar conditions across the country so that they could not do that.

CHAIRMAN - Thank you very much for attending and I really do say thanks very much for coming down at the college's expense; it was really was appreciated. And likewise, Mike, thanks for coming along.

THE WITNESSES WITHDREW.