THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON REGISTRATION OF OVERSEAS-TRAINED MEDICAL PRACTITIONERS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 8 MAY 1998.

Dr BRYAN GEOFFREY WALPOLE, BRANCH COUNCILLOR, AND **Mr DOUGLAS ACKLEY LOWE**, EXECUTIVE OFFICER, THE TASMANIAN BRANCH OF THE AUSTRALIAN MEDICAL ASSOCIATION WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIRMAN (Mr Wilkinson) - As you know, Doug, at the commencement of the proceedings I have to ask you your full name, address, and the capacity in which you appear before us, please.

Mr LOWE - Yes, certainly. I am Douglas Ackley Lowe of 2 Gore Street, South Hobart. I am Executive Officer of the Tasmanian branch of the Australian Medical Association.

CHAIRMAN - Can I ask you the same question, please, Dr Walpole?

Dr WALPOLE - I am Bryan Geoffrey Walpole. I am a branch councillor of the Australian Medical Association at 2 Gore Street, South Hobart.

CHAIRMAN - Thank you. Can I leave you to present your submission to us in any way you feel most comfortable.

Mr LOWE - I think, Chairman, I will simply summarise the submission in the following way. The Australian Medical Association has a national policy in support of the medical manpower policy of the Australian Medical Council, however in relation to the State's public health care system in particular there are elements that do require precise attention, notwithstanding that overriding commitment to due accreditation of the medical work force at which ever level the medical practitioner may be serving. In this State the reliance of the public hospital system, in particular in the south, north and north-west of the State, has been very dependent on the availability of suitable overseas-trained medical practitioners who are capable of providing specialist medical services in those hospitals under conditional registration from the Medical Council of Tasmania.

As our submission says, the deadline of 31 December this year, by which time the expectation according to the policy outline from the Medical Council is that individuals should either have been accredited in accordance with the requirements of the Australian Medical Council or alternatively have moved substantially towards accreditation, is a matter that, from the knowledge that AMA has of a number of individuals serving in those public hospitals to which I have referred, it is highly unlikely those individuals, given their existing work load, would be able to progress themselves in accordance with the requirements of the Medical Council.

It is therefore the recommendation of the Tasmanian branch of the Australian Medical Association that your committee consider recommending an amendment to the Medical Practitioners Registration Act - I think it is section 19 of the act, according to the copy of the act that I have - that would in essence establish a formal category of general registration - maybe general registration (hospital) - so that those medical practitioners whose services have been engaged by the chief executive officer of the hospital on contract, and for the reason that an appropriately fully-qualified specialist in that field has not been available for the position should therefore be able to continue to serve the public hospital system while they remain contracted to that hospital.

Mr SQUIBB - Indefinitely? Assuming that the hospital continues to issue contracts -

Mr LOWE - To renew contracts on that basis because there are set protocols that the hospital itself would follow in an effort to obtain appropriately qualified specialists who have general registration. But with that qualification, yes.

CHAIRMAN - One thing that concerns me as a layperson, not knowing much about medical practise, is when people come across to fill a position as an overseas-trained doctor, it seems they come across with a reference and also their certificates to say, yes, they are trained, they have received the appropriate qualifications. There does not seem to be, from what we have been told, any ability to have seen how they actually operate on patients in hospitals prior to them commencing work as an overseas-trained doctor. Firstly, is that true and, secondly, do you believe it would be a fair recommendation to make sure that the doctors who come over here are appropriate doctors and therefore should train in a training or a teaching hospital for approximately three months to be under the eyes of their peers prior to them going out into the work force to commence their contract?

Dr WALPOLE - I think you have been very perceptive there. The maldistribution of the medical work force in Australia has been a problem for the medical profession for some time. You are probably aware that the Australian Medical Work Force Advisory Committee finds that there is something like 45 000 medical graduates in Australia and there are probably about 5 000 more than we actually need to provide the clinical services. But of course the issue is maldistribution between rural and city and between the branches of the profession, and this has traditionally been filled by people who have come from overseas.

The Australian Medical Work Force Advisory Committee made a recommendation to the Federal Government about four years ago that in fact we bring the medical work force into line with the requirements, and this process is tripartite between the Federal health and family services, the AMA and the Federal health department to look at how many people we need in each specialty. There is a plan - are you aware of all this? - by 2005 to bring the two into harmony, and they have already been through anaesthesia, orthopaedics, ENT, emergency medicine, dermatology, and I think they are doing general practice and some other specialties at present. That process actually finishes at the end of this year.

Even when we reach 2005, things are not going to be perfect but at least there will be an attempt to match the two. As we would see it, the problem has been in the past that people have got into the country, have a medical degree and are then registered provisionally by a State, or something, on application and are here because of an area of need. Then they are picked up by somebody who is desperate for a doctor, with no assessment as to their quality. In my role at Royal Hobart Hospital for thirteen years, I have observed people put on the staff who practise a quite different standard of medicine from locally. Unfortunately, in several cases we have had to dismiss those people, and we then turn our backs and find they are working in another hospital in the State that has never rung us to ask what this person is like because their need is so great.

The new system is whereby these people on a temporary visa are going to have to come in with references and a period of assessment, but that is to be done where people say they are specialists through the colleges. So if somebody comes in and says, 'I'm a surgeon from the Soviet Union', first the AMC will check that they are in fact a proper medical graduate and then they are sent to the surgeons and they say, 'This guy's the professor of cardiac surgery from Moscow, he looks pretty good. His papers and the literature are good, references are okay. He is a cardio-thoracic surgeon'. The next level down is somebody who is maybe at that level but they are not sure. They say, 'Go and work with somebody for six months and get a reference so we can see how you are', and at the end of six months say ,'Yes, you're acceptable', or, 'You need to do the exam or you need to do some training'.

Then there is a series of levels under that where they say - for argument's sake, people from places like Iran or Iraq, or somewhere - 'You standards are different from here, you'll need to do two years of training and then sit the examination'. That process is fairly transparent because there were rules about the hearings, transcripts are actually taken, there is an appeal process, and so forth, but that actually has not come in for places like Tasmania which have a need. What we would see is, there needs to be some transition that is not quite as crisp as 31 December this year because for Tasmania that is going to mean, particularly up north, there are going to be huge holes in our medical services.

CHAIRMAN - I understand there are presently 90 overseas-trained registered doctors who are conditionally registered in Tasmania.

Dr WALPOLE - There are about 40, I think, who are practising in hospitals - is that right? Forty-four, or something who are -

Mr LOWE - Providing specialist services, yes.

Dr WALPOLE - We cannot go on like this forever. Tasmanian hospitals and the health department have to come to recognise what are the terms and conditions of service that will get these people, either that or tailor the services so that rural people get access to the services but maybe not locally. I know it is another question, but there has been recommendation after recommendation there be one base hospital on the north-west coast. That has been said for 25 years. The Government sees otherwise and this is what happens in that there is no nucleus of people to provide the terms and conditions of service to get people to practise in a place like Latrobe with the same standard as around the rest of the country.

That is both a political and a clinical dilemma, but we would see there needs to be a transition process between now and 2005. That is actually seven years, and seven years is actually the maximum training time for any specialist college in Australia. The surgeons, the physicians and the anaesthetists have seven years of training from the time they graduate, and many of these people will get one, two, three or four years accredited. What we would like to see is those transition arrangements run out in 2005 when the medical work force issue is supposed to be, well, not solved, but at least in large measure addressed, so we do not get someone in 2004 who needs another five years.

Mr LOWE - The great advantage of that of course is that during an interim period the AMC exam is not the sole pathway to medical specialist recognition. The colleges themselves have a record whereby they do have their own process for evaluating an individual's capabilities. Quite recently we had a specialist on the north-west coast who was recognised by the College of Surgeons and given fellowship of that college, and of course obviously then immediately receives general registration through that recognition.

Mr SQUIBB - An orthopaedic surgeon?

Mr LOWE - Yes. I would expect that that process in the intervening seven years would be one that would be critically looked to by some of the specialists concerned, but in the interim we have to make sure that we keep stability and equilibrium within the public hospitals we have. We have a second issue here of course, and that is the continuing operation of our medical school. Of course people who are providing services at the specialist level, even if they are overseas-trained doctors, are expected to be of a standard where they can engage in the education of the next generation of medical practitioners through the Medical School.

Mr SQUIBB - You are using people in that role who are not fully registered.

Mr LOWE - Not fully registered, but I think we would say that the vast majority of people who are in that role have proven to be highly competent specialists in the field.

Mr SQUIBB - Exactly, but they are the same people who have letters to indicate that their registration will not be renewed after the end of this year.

Mr LOWE - That is correct; that is why we are here before you.

CHAIRMAN - It is going to be a real problem if there is no flexibility, it seems to me, when you are going to have a number of doctors having to leave. That is going to be a problem for them because it would seem to me, on the evidence we have had, they have been given a nod and a wink before they came here that their conditional registration would continue ad infinitum. Therefore they sell their house, they bring their family out to Tasmania into a certain area and then they suddenly have to say, 'No, I'm sorry we can't have you any more because of the political arguments'.

Mr LOWE - In my experience I think they are made aware in the first instance that there are restrictions both in time and scope for conditional registrants, and even with the recommendation that we have placed before you by the establishment of a special category of general registration for hospital-based doctors there would still be restrictions that would apply.

CHAIRMAN - But the restrictions are loose, are they not, because for Dr Naidoo, for one thing as I understood, firstly if there was another doctor within Australia who would take that position, that doctor was told, 'You'll have to leave'. But around on the north-east coast, of course, there was another doctor a short distance away who was an Australian-trained doctor, and yet obviously people felt some sympathy towards Dr Naidoo because he had been there for twenty years and was able to remain on, first as a conditionally-registered doctor, even though it went against the guidelines of conditionally-registered doctors.

What I am saying is, the rules have been stretched to -

Mr LOWE - There is a medical work force shortage throughout that entire north-east and eastern coast area anyway.

CHAIRMAN - Yes. It seems also that each of the colleges differ in relation to their registration. The orthopaedics appear to be willing to look at peer assessment, and Dr Hanusiewicz, as I understand, was one of those people who obtained full registration through peer assessment.

Mr LOWE - Correct.

CHAIRMAN - Yet some of the other colleges are not willing to look at peer assessment as readily as perhaps the orthopaedic area.

Dr WALPOLE - I do not think that is true. I mean I am part of my own college's peer assessment process and there is a committee of presidents of medical colleges, which is a professional forum, and we have all looked at our procedures. Of course we cannot be exactly in sync but we all have the same multi-stage process of assessment. I would put it to you that anaesthesia might be a little different because it is a finite sort of specialty with a narrowish scope of practice and a very strict set of procedures and competencies built into it that might not be there in something like psychiatry, which is a lot more subjective. But I do not think any of us feel that any college is particularly more or less strict on people's assessment than any other; and I really do feel that.

Mr SQUIBB - The process is seen to be different, both between the colleges and within the colleges. If we could come back to the anaesthetists, we had evidence that a particular practitioner in anaesthesia on the north-west coast was granted full registration without having to do the exam, yet the one who was subject to the bill that I introduced is required to do the exam. There does not seem to be any consistency.

Mr LOWE - I would want to know all the personal details in relation to that because in my experience there have been legitimate explanations for those circumstances. But you are correct, there is a variation. I think they all do it here to a process of peer access through their peer review process but it is very much tied down to the status of the profession or the specialty.

Dr WALPOLE - Australia is unique in medical specialties in that we are the only country where the profession actually controls the entry, the education, the exit exam, and the credentialling. You go to the United States and in fact there is a board in each specialty that consists of people from education and law and so forth who look at specialist credentialling.

Mr SQUIBB - One thing we have had difficulty finding out, what is the pass mark for passing the exam for full registration of a specialty?

Dr WALPOLE - It is almost impossible to say because the exit examination consists of a multiple choice examination, a written examination, some long cases and some short cases. I mean -

Mr SQUIBB - But surely if a person passes to a certain standard they ought to be able to be fully registered and that pass mark ought to be consistent.

Dr WALPOLE - They are. If anybody sits the final examination of a college and passes then perforce they have to be registered and there is significant precedent whereby colleges have sometimes tried to stop people practising who have passed and have been overturned at law.

Mr SQUIBB - So what is the pass mark we are looking at; is it 80 per cent or 60 per cent or 90 per cent?

Dr WALPOLE - I think it is difficult to actually say what the number is because it will depend upon the information on which that is assessed. My own college, the pass mark you have to get 50 per cent, but in order to get 50 per cent in some of the things you are only allowed to make three mistakes out of ten and if you make only three mistakes out of ten you get 50 per cent. Now they are subjective but we give them a number to try to make them objective but there is a fuzziness to it.

Mr SQUIBB - Is that pass mark consistent each year, the same each year, or is it adjusted at all?

Dr WALPOLE - Within my own college it is consistent every year. In other words, we consider that we are criterion reference rather than norm reference - in other words, these are the hurdles we set and if you jump them you are in and we do not shift the hurdle. The problem always is in assessing the middle ground and sitting at an examination table, I mean 50 per cent of the people clearly pass, 30 per cent of the people clearly fail, and the other 20 per cent take a lot of discussion to work out whether they pass or fail. I think that is the same in any examination.

CHAIRMAN - It was interesting to me, I was talking to a friend a couple of weeks ago who is an anaesthetist and there was some implication that there were two exams: one for overseas students and another for Australian students. I understand that is wrong; it is only the one exam.

Dr WALPOLE - At the basic level you are correct. The Australian Medical Council sets the basic qualifying exam. So if you come here from other than New Zealand and you do not claim to be a specialist, then you need to do the Australian Medical Council exam. That exam has been under enormous challenge over the past fifteen years on the basis that it had, how shall I say this, ethnic bias built into it, that it was more difficult than the local people have to do. In almost every case that has not been found to be so. The general feeling now it is based at about the level of a fifth-year medical student at the end of the year. I know Professor Correy was actually on the committee that looked into that and I did read their report and they could find no systematic or structural bias. But that certainly differs from the final exam for Australian graduates, but then the final exam for all Australian graduates is not the same; it is totally different at places like Newcastle and Flinders from what you will find at Melbourne and Sydney.

CHAIRMAN - But there are no names on those papers either. There are no names; they do not know what nationality they are; they do not know what sex they are; they are just a number. I understand that is important, because of any argument at a later stage for bias, that they do remain a number and the only way they will ever know who they are is if they are in that fuzzy area that you were talking about between 30 and 50.

Dr WALPOLE - Even then the name does not come out. But, recognise, in a clinical examination - and the AMC's part 2 is a clinical examination - you cannot help but know who you are examining in terms of their visual appearance and accent and maybe their clothing and so forth, it is clearly evident if they are Australian or not, and there is a potential for bias to be in there. But as I understand it, no one has ever really demonstrated it. So there are two processes, but as a specialist it is one call for everybody.

CHAIRMAN - I know rules change as years go by, but prior to 1992 everybody who was recognised as a specialist in the UK or in South Africa immediately came to Australia and they were recognised as a specialist within Australia. That is not the case now, is it?

Dr WALPOLE - No. They were not automatically recognised. They could put up their credentials but it depended a lot on whether they had done what we call 'accredited training'. So if you came from, say, South Africa, then it was most likely you would be recognised, but not automatically. Prior to 1992 they were recognised by the National Specialist Qualifications Advisory Committee, which was independent of the colleges, although it was made up in large measure of college people. But now that has changed.

CHAIRMAN - I understand also that prior to 1995 - and I hear what you say, that everybody knew the ground rules before they came out - I understand that was particularly so after 1995 but prior to 1995 there was this fuzzy area where they were virtually given a nod and a wink and they were told that so long as the two criteria are met: one, public interest; two, area of need and also the fact if no other Australian doctor was willing to go into that area, their conditional registration could continue ad infinitum.

Dr WALPOLE - I am not aware it was ad infinitum. Their medical registration is - everybody's is year to year. The provision in Tasmania is that it had to be reviewed each year and that is so in most other States.

CHAIRMAN - But I understand with that renewal they were told that as long as they continued on and continued to practise well their registration would continue.

Dr WALPOLE - I do not know that.

Mr LOONE - Just one other point, Mr Chairman, that surfaced a number of times, getting back to the examination, passing examinations, that the pass level is regularly changed; it is not always maintained at 60 per cent or 65 per cent or 70 per cent, that according to the number of applicants - the number of people sitting the exam - and how many registrations were likely to be accepted, say a dozen out of this exam, that the level would be set so that only a certain number would pass?

Mr LOWE - It is probably related to the inherent degree of difficulty of the examination.

Dr WALPOLE - I am not aware of that in any college and I would think that under the rules of natural justice any college that did that may well find themselves at appeal before the courts. The colleges have not seen themselves as regulating the work force. I mean, the workforce is regulated in fact by the market and the Health Insurance Commission and the State hospitals. I know there has been a lot said about people like, say, ophthalmology, that they only put through a small number of people and control the market. If you actually look at training in ophthalmology, there is a large amount of it now done in the private sector and training in the private sector is difficult; it is mostly done in the public sector in that there really is not the space to train another, say, 50 ophthalmologists a year. AMWAC, in their discussion with the ophthalmologists, will say what they feel the work force requirement is. It is then up to the States to make those positions available in their hospitals so those people can be trained, albeit without diluting the quality of the output.

Mr LOWE - The provisions of the Trade Practices Act now are relevant as well.

Mr LOONE - This is evidence we have had and that is why I asked the question.

CHAIRMAN - With Tasmania, it seems to me, on the evidence, that mutual recognition has not really worked. What happens is if people get their full registration they immediately jump on a plane and go elsewhere - and I say that with Dr Kehilia. I do not know whether I am saying anything disrespectful to him or not but when he came before the Legislative Council there were tears, there were pleas, there were promises made that he would not be leaving; he would stay for obviously some period of time. Immediately full registration was given, you could not catch him before he went to the airport. Now that is a problem as well.

With registration, do you believe that the registration, if people come out to service an area, they should remain in that area or attached to that hospital for a period of time? If yes, how long do you

think that period of time should be?

Dr WALPOLE - I would like to think that post-2005 we do not need that sort of short-term fix because it has huge problems for the hospitals, the professionals. I mean that is why you are having this inquiry. If there is something like, say, there is a technique or a procedure that is not done in Australia and we want somebody to come from London, New York or Paris to demonstrate it, then I think that is a legitimate reason for registering that person for three months, six months, a year. Or if somebody wants to come and do their sabbatical leave here to either learn or have input, that is reasonable to do it for the term of that leave. But in the long term I think we need to get rid of it altogether.

Mr SQUIBB - Is it fair to those who have helped this State out of a hole, the public health system in particular, in that interim period to when we get to the stage of having sufficient numbers trained within Australasia to say to them that their registration is finished and they have to leave.

Dr WALPOLE - They have the option of qualifying. That is why I say a seven-year transition between now and 2005 - and I do not know the person to whom this bill refers, but there is actually sufficient time in there for this person to be assessed and if the person is as good as they say they are, to go through the qualification process and join his peers.

Mr SQUIBB - I am talking in general because we have taken evidence from a number of specialists who are working in the State hospital system and have been here for a number of years and who only want to work in those particular locations and only want security for the rest of their working life. They are prepared to commit themselves to our health system because we do not have the specialists. Is it fair that at the end of the period when we do get the specialists that in the case of those who have been here - I am not talking about those who are coming in the future - in the case of those who are here at the moment, do we say to them, 'Thank you, fellows and ladies, for your assistance over the past fifteen or twenty years. We now have sufficient Australian trained. You must leave'?

Mr LOWE - I think you have to look at - I know of some of the people you are referring to and some of them in seven years time will be on the verge of retirement. I think that you have to see people -

Mr SQUIBB - Some will not though.

Mr LOWE - No, that is correct. I think you have to really look at the circumstance of each individual case. I think there is an overriding responsibility on the hospital concerned - that is, the chief executive officer concerned - to make sure that adequate opportunity is given for that doctor to be able to pursue further training and further continuing medical education to enable them, if they want to exercise their right to apply to the college for recognition, then they can do so. The majority of the people who you are referring to in your comment I would suspect simply do not have time to prepare themselves.

Mr SQUIBB - Or it is not possible from the hospital in which they are working to do it.

Mr LOWE - One of those doctors in fact is one of the principal preparers of research papers for his particular college. He travels the world advising on what is a complete specialty and yet, himself, is not able to get time to be able to further develop his prospects of recognition within his own college.

Mr SQUIBB - And does not wish to practise in any other location, according to the evidence he has given us.

Mr LOWE - No, and I think that is his genuine position.

Mr SQUIBB - Quite frankly, the recommendation on page 5 of your submission I think is - I do not have any problem with that, particularly - I just pose the question to you again, your recommendation would also encompass the concept of permanent provisional registration, located to a site and permanent from the point that -

Mr LOWE - I think you have to be very careful with your terminology.

Mr SQUIBB - Or ongoing.

Mr LOWE - My approach to this recommendation may vary with Dr Walpole's because I am looking at it from a layman's point of view looking for a legislative remedy. I would submit to you that it is inappropriate to try to intervene or second guess on the specialist colleges. I think that they are involved very heavily in negotiations at the national level on determining the future nature of the medical work force and that is a matter that predominantly is really beyond the control or jurisdiction of this State.

The one area that does have jurisdiction is the issue of registration. My recommendation, and the recommendation of the AMA, is to concentrate on that point and look at the issue of a category of general registration for people who are exclusively providing services in the public hospital system and give them recognition under section 19 accordingly, which would, I believe, enable them to obtain continuing registration for the future, provided they are working within that hospital.

Mr SQUIBB - You do not believe, or the AMA does not believe, that that would contravene in any way the provisions of mutual recognition?

Mr LOWE - Not at all.

Mr SQUIBB - Because whilst we have not formally come to a consensus on that I think there seems to be a desire to find a pathway which will enable what we are talking about to occur without it breaching mutual recognition.

Mr LOWE - Under the provisions of mutual recognition a person who had the type of special category general registration in this instance would themselves be voluntarily making a commitment to serve in that hospital. If a comparable position existed in a defined area of need in another public hospital elsewhere in Australia, it may be that that person would want to test themselves in that jurisdiction. I think that what has been recommended to you from the AMA is a very effective means of quarantining this category of people who have genuinely sought assistance because they are running out of time and I think that this is an effective means of doing it without violating the provisions of mutual recognition.

CHAIRMAN - What happens if an Australian-trained doctor goes into their area with their specialty? Should those people be able to remain or alternatively should they then have to leave because you have this situation where they say that an Australian doctor is there -

Mr LOWE - If they were not conditionally registered then they would obviously be able to remain. I mean that is the whole objective-

Mr SQUIBB - Under your recommendation, provided that the CEO of the hospital where they were working accepted them in preference -

Mr LOWE - Correct.

Mr SQUIBB - No, not in preference, sorry - continues to -

Mr LOWE - Continues to support them?

Mr SQUIBB - Yes.

CHAIRMAN - Do you think that is a fair recommendation?

Dr WALPOLE - I do. But on the other hand, looking at it from the perspective of academic standards and so forth, every college has what we call the 'practise eligible' track. That means that if you can demonstrate that your clinical practise is exactly the same as your peers most of them will accept that and give you fellowship. It is not automatic. It seems to me that with seven years to go to 2005 all those people really should be able to make a commitment to come up to that standard. Now whether that means they do the examination, present their credentials to the appropriate college, they should, if what Mr Squibb says is true that they are providing the level of service that is expected, then I cannot see there should be too much of a problem.

Mr SQUIBB - Except that in some cases, and we have evidence, it is not possible for a practitioner to continue in that area of need with the specialty they have, they need to leave that position and go elsewhere.

Mr LOONE - Because there are no training facilities available here in the State.

Dr WALPOLE - That is a problem in all rural Australia in that what do those people do about their continuing medical education? Mr Squibb used the words 'they can't be spared'; I would use the words 'they won't spare the person'. If you are going to have quality staff in your hospital then there has to be a commitment to their continuing education. It would not be beyond the bounds of reasonableness to send this person for a month, a year, to Melbourne or Sydney or something to let them get the skills that allow them to come up to the standard.

Mr LOONE - That would be feasible and practical but in the case of Dr Iastrebov - and I hasten to add that this is not a select committee into Dr Iastrebov, this is a select committee into registration. But to use him as an example, as I understand it, for him to come up to speed he needs to go out of the system for three years to go to a teaching hospital to get his qualifications. Now, a man of his qualifications and need on the north-west coast, they could not do without him for three years and there is no one else available to take his place.

Dr WALPOLE - With respect, that means they could not find anybody, which means either the terms and conditions of service or the structure of the hospital -

Mr LOONE - Other than another overseas -

Mr LOWE - I think also in relation to Dr Iastrebov, that is in accordance with the last advice he received. I do not know whether you have received evidence from the College of Anaesthetists in relation to this matter but it is my understanding that the college would be prepared to review that time frame through its - what is the word, Bryan?

Dr WALPOLE - Its a committee of its council.

Mr LOWE - Yes - that would actually inspect Dr Iastrebov on site and review that earlier decision.

CHAIRMAN - That to me in a number of matters I think would be good. One of the problems - and you get them everywhere - if I sat for a law exam now I do not think I would pass it if I sat it in commercial law because I have not done it for twenty years. Yet if I did it in the area that I know, I would hope that I would pass it. And I think that is the same with most medical practitioners.

Dr WALPOLE - That is why the colleges have the 'practise eligible' track but if you have graduated within ten years then it is not beyond the wit of that person to come up to scratch. There are many people passing post-graduate examinations now who are in their forties. We have mature-age graduates coming out of medicine at the age of thirty-five entering the normal track and there is plenty of evidence that they can pass.

CHAIRMAN - But if you are good in your field you are going to be busy, very busy. Therefore what you are doing is doing your work, doing your work with the expertise that you have developed over twenty years or whatever, and to suddenly cut off doing that work to be able to learn for the required standard to pass the examinations, I can understand why it is required but to me seems not the only way that people should be able to be registered as a fellow. I think peer assessment is probably the best way with situations like this because there is no better recommendation than the recommendation of your peers, I would have thought.

Dr WALPOLE - And we would support that.

Mr LOWE - In essence I think we are saying to you that the AMA is prepared to support a special statutory provision to safeguard the long-term future of a medical practitioner providing specialist services to a public hospital in Tasmania. If that individual then wants to move in their personal practice broader - that is, into private practice etcetera - then they need to understand that the pathway

for them to follow for that is via the college examination or alternatively the peer review assessment program. That needs to be separately recognised. Also, the hospitals concerned need to have an obligation to facilitate that course if that is their desire.

Mr HARRISS - Is there any potential for conflict with that recommendation of yours, given the health ministers' agreement, for a ceiling of two years to be applied to conditional registration? That is, as I recall, a national agreement that a ceiling of two years on conditional registration be applied.

Mr LOWE - That is precisely why I think you have to look at a pathway or a solution to this problem that moves away from conditional registration. I think that that has to be considered in this State's public interest.

Mr HARRISS - Has the question been asked of, I suppose, the Health Ministers Council as to whether proceeding with that recommendation would cause conflict -

Mr SQUIBB - I would have thought that was conditional registration.

Mr LOWE - I think we have to be very careful. The objective of the AMA in this recommendation is to preserve our public hospital system and I do not think that the Health ministers ever intended to do damage to the Tasmanian public hospital system in making that decision. But because it appears from the communication that has gone out from the Medical Council of Tasmania that it is very cut and dried at the moment, so far as those individuals are concerned, then I think that as legislators there is almost an obligation upon you to look to see if a statutory solution can be found. I mean we are looking at people who predate this moment. Anyone who comes in in future, I think the test that Dr Walpole has put forward it has to be very clear-cut, but we are dealing with the here and now. We are not dealing with a perfect human resource structure. In periods of enormous change in our public hospital system and funding process we are looking to try and keep a viable system afloat and it will not remain afloat unless these people can remain in it.

Mr HARRISS - Doug, your comments about the Medical Council's communication are right. They did seem to imply total inflexibility and in evidence we have heard since the communication seems to suggest it will still be sufficiently flexible to accommodate special needs.

Mr LOWE - We only have access to the correspondence that was sent out. I have not discussed it with anyone from within the Medical Council and we do not have the advantage of that knowledge.

CHAIRMAN - After 2005, if north-west hospitals desperately need an anaesthetist or intensivist, if a hospital in Launceston needs a cardiologist and there are none available within Australia to take up those positions, should we then be able to still get doctors in from overseas to take up those positions? Are you saying, 'Yes, we should be. But we should be on the basis that if they want to continue they have to go down the track that every doctor has in Australia and do the exam'?

Dr WALPOLE - The question of services in areas of need and not being able to attract people to do it means: have we got the critical mass of people there to support that practice? Have we got the infrastructure in place to provide that sort care? Is there consensus agreement between the Health department and the medical profession about the need for that?

If you look around Australia - and take cardiology, for example, cardiology is a team effort. There is no point having a cardiologist in a place like Devonport; it just will not work because they need a cardio-catheter machine and angioplastic facilities, anaesthesia and intensive care back-up and so forth, and a cardiologist is actually just the apex of a big triangle. All round the country where they shift up the technology scale we are finding that people like orthopaedic surgeons do not want to practise remote from, say, a rheumatologist, a physiotherapist, a gymnasium and some testing apparatus and a decent pathology laboratory.

I put it to you again, the problem on the north-west coast is they are trying to run two hospitals instead of one. They do not have the economies of scale to provide all the things that they want. If they had taken their own recommendations years ago and had one base hospital I think a lot of these problems would not have occurred. The AMA feels that quite strongly.

CHAIRMAN - So you are saying that 2005, which is the cut-off mark that you have mentioned, there should not be any conditional registration at all. If these areas are without doctors, well so be it, they remain without doctors.

Dr WALPOLE - I think the mechanism should be in place after 2005 to address it without the use of people from outside. In other words, there will need to be rural incentives, there will need to be the ability for people practising in smaller centres to network with people in larger centres or perhaps just people rotate on a roster.

CHAIRMAN - Do you not think we are looking at the ideal world as far as that was concerned? That would be terrific but in practise it does not happen because no doubt ten years ago, or prior to 1992, they would have been saying the same, that in seven years time, 1999, we should be in this position; but we are not in this position. I agree with what you are saying, but it seems to me that is the trouble with it.

Mr LOWE - With respect, I think one of the functions within your terms of reference that maybe this committee should take opportunity is to actually draw the Parliament's attention to the finite time scale that is involved in this issue and make firm recommendations into what should be the obligations upon the minister of the day and the government of the day to ensure that the impact of those time lines is fully accounted for in Government policy and particularly recruitment policy. I think this is a very timely warning for the Government to establish a far more proactive recruitment policy in the areas of specialist medical service than they have done in the past, and if it requires the establishment of particular fellowships etcetera or traineeships, for example, within some medical specialties to have younger qualifying medical specialists committed to our public hospitals, so be it. I think we have to become proactive in this area, not simply waiting for the fallout of the other States.

CHAIRMAN - What do we do with recruitment? I know everybody would like to know, but to get people out of the city area and into the country.

Mr LOWE - It is into the regional areas.

Dr WALPOLE - This is a problem in all rural Australia. We could go on endlessly about this but the economic rationalist approach of 'bigger is better'. The banks are shifting out of the country. What is happening to the ministers of religion? What is happening to the lawyers? What is happening to the accountants? What is happening to the nurses, the health professionals? We all have the same problem in rural Australia. And the doctors are moving out for the same sorts of reasons: spouse support, education, long hours on call, the fact that you need locum support and so forth, you need your month off period and you cannot get it. It is being looked at nationally but the whole of rural Australia is in this and the doctors are just a microcosm of a broader problem. It will ever be a problem getting a specialist work force into a town of less than 15 000 people.

So in the meantime may be what we give those people is access to those services somewhere else. It is outside the terms of reference of this committee but every small town is not going to have the range of specialist services they want for the foreseeable future but they need access to them. And that might involve a whole range of creative things like rostering, moving, peripheral clinics, a good transport system, aeromedical rescue services and so forth.

CHAIRMAN - Do you believe, like the teachers used to be on a contract, if they received money during their training, as you know, and then they went into the system and if there number was picked out they went Smithton, they went Rosebery, Tullah wherever. Obviously that has been spoken about, it would seem to me, in the medical sphere. Do you think something like that would assist these rural areas?

Dr WALPOLE - The evidence shows that the most likely reason that a doctor will go back to the country is the doctor came from the country and there are now rural incentives in place all around Australia so that people who come from smaller high schools can get some sort of positive discrimination on access to medical schools. The lateral entry program - that is, people who do not come from the higher school certificate or TCE - all have incentives built into them to take people who are community qualified from rural areas. That has been placed for - in New South Wales for about ten

or fifteen years and it is slowly having an effect. What we are looking here is fixing things up in the interim and I do not think that conscription is successful in the latter half of the twentieth century.

You find with the forces, more than half the people buy themselves out within two years, those who have bonds.

CHAIRMAN - So you think it is mainly incentives to get them back?

Dr WALPOLE - It is a whole range of structural issues in the country that need to be addressed. It is not just the doctors.

Most colleges have now a commitment to work towards rural rotation, so if you are going to be a physician, as a trainee you are now required to spend six months in somewhere other than a tertiary hospital - in other words, you actually need to go to somewhere like Launceston or Burnie.

Our graduates from Hobart, a number of them rotate to Burnie now so they get the feeling of taking more responsibility, of dealing with the rural population, of not maybe having the resources and backup they have in the city. Many of them relish that and what that has done is, for want of a better word, left some people behind in Burnie who went there for their three months or six months and liked it.

Mr LOWE - The other advantage, I think, that we have now that probably has not existed in the past, is the existence of a statewide hospital and ambulance service that does enable a statewide perspective to be taken in relation to some of the human resource issues. And the point that has been made by Dr Walpole in relation to training is a very valid one. There is now a lot of commonality being established to statewide waiting list policy in relation to others areas of rotation of staff. In medical education the Australian Medical Council accreditation committee was very firm that Launceston and Burnie had to play a major role in the education of under-graduate and post-graduate medical students. I think we have a structure now that is capable of probably being far more responsive and accountable than it has been in the past.

Mr HARRISS - Doug, at an earlier time in the process when Dr Iastrebov's situation has been considered, I think you made the comment that there is or somebody recognised that there is an alternative pathway for unconditional registration and that the Australian Medical Association would pursue with some vigour on Dr Iastrebov's behalf the pursuit of that alternative pathway. Where are we at with that specifically with Dr Iastrebov?

Mr LOWE - I mentioned to you earlier that it is my understanding that the College of Anaesthetists are prepared to have an inspection and interview Dr Iastrebov at his current location for the purpose of reviewing the decisions taken earlier by their censor, I think is the term.

Mr SQUIBB - That is a change of opinion by that body then because previously they refused to.

Mr LOWE - That is what has been conveyed to me. I would understand that as soon as the matter before your committee is disposed of I would assume that they would proceed down that pathway.

Mr SQUIBB - Just on that one. You indicated at a previous briefing with the full council that you would do all you could to assist Dr Iastrebov to examine these. Have you had the opportunity to actually meet with him as you said you would on site?

Mr LOWE - Yes, I have.

Mr SQUIBB - How recently was that?

Mr LOWE - The last meeting would be just prior to Christmas; in fact I helped him with his submission to this committee.

Mr SQUIBB - So you have met with him on more than one occasion?

Mr LOWE - More than one occasion. And I would want to add I have been in telephonic communication with him many times.

> **CHAIRMAN** - As far as you would be concerned, the best recommendations that this committee could be make seem to be: firstly, the recommendation that is on page 5 of Doug's report and secondly, a recommendation saying that the overseas-registered doctors here on conditional registration, let us say up until the 2005, should have a period of what, three months training at a teaching hospital?

Dr WALPOLE - That would be dependent upon the individual case but everybody is entitled to two weeks study leave and when there is somebody who requires some remedial work then there is a whole range of other provisions: there is special leave, there is sabbatical leave, there is long service leave that is granted after ten years but in fact it is possible for the hospital to second somebody from the staff for a period of time. In other words, considered like they are still working if they consider that they need them that badly and the Australian Medical Association would certainly support that.

CHAIRMAN - Let us say in the north Launceston needed a couple of specialists, Latrobe needed a couple of specialists, would the Royal Hobart Hospital have the ability to immediately take those four specialists in and give them this peer assessment over a period of three months prior to putting them back out to those hospitals?

Dr WALPOLE - I cannot speak for the hospital but, from a professional point of view, of course we would be prepared to enter into to negotiations about that. We all have a commitment to those colleagues. They have provided good and onerous service for a number of years and if we can assist in bringing them up to scratch then I am sure the profession would be right behind that.

CHAIRMAN - What about new ones coming in? Something happens to Dr Iastrebov tomorrow, they need a new anaesthetist or intensivist up at the Mersey Hospital, cannot get it in Australia because it would seem they advertised for around twelve months before they had Dr Iastrebov, so they get somebody in from overseas. It would seem that rather than just coming on the reference and the certificate there should be some assessment prior to putting him into Mersey, would he be able, or she be able, to immediately go into the Royal Hobart Hospital, have that assessment for a period of time; and secondly, how long should that period of time be?

Dr WALPOLE - That would be up to the professional colleges. It is usually something like three months or six months depending upon the person's background. I have taken responsibility for a number of those people, overseas trainees, to work with them for a period of time and provide them with a reference.

It is moderately onerous, it requires some off clinical time in order to do it, particularly to discuss performance review and their goals in the time with them and see that they meet them. But that is a normal professional commitment to one's colleagues.

CHAIRMAN - But it has not happened, has it? I do not whether I am being disrespectful to a person I have in mind at the moment but I understand there was a person from overseas who came in a speciality and it has caused some problems. I will not go into it any more than that.

Dr WALPOLE - I am well aware of what you are saying, Sir, and I would point out that one person left Royal Hobart Hospital because he was found out to be an illegal immigrant and he had been working at the hospital for two months, quite satisfactorily.

CHAIRMAN - But those problems would not arise if you had the screening of them by peer assessment for a period of time and I am trying to work out how long that period of time is going to be. Help me.

Dr WALPOLE - It is by negotiation between the student and the teacher. Some people require more than others. To actually work out someone's competence, I would say, probably takes at least three

months. They have to see a range -

Mr SQUIBB - That is not occurring at the moment, is it?

Mr LOWE - Perhaps the use of the word 'appropriate' might be - appropriate time period - because it will vary.

Mr SQUIBB - It is done on a curriculum vitae at the moment. None of this assessment at all.

Dr WALPOLE - No.

Mr LOWE - In fact there are very heavy responsibilities now on the CEOs of the hospitals under the new structure and I think there is probably far more scrutiny now than maybe there has been in the past. The responsibility on the CEO if there is a wrong decision made is fairly significant.

CHAIRMAN - Are there any other recommendations you think would assist?

Mr LOONE - Just one question I would like to ask Dr Walpole. From the evidence we have been receiving one forms the opinion that our hospital system could be in turmoil in the next eighteen months if these registrations are not extended. A lot of them expire on 31 December 1998 or March 1999 and they are saying that unless they come up to specifications they will not be renewed. Now from the evidence we get it will throw our whole system into turmoil unless some releasing of the strict regulations is made. Can you give me judgment on what you think will happen if these changes are not made? By what we are told -

Dr WALPOLE - I have not looked into it closely enough as to who they are and what they do. My experience of that is anecdote; I have not seen the data. There will be difficulties. I do not know whether 'turmoil' is the appropriate word but we either need transition provisions or we need six months of sitting down and working out how we are going to make those terms and conditions of service appropriate to Australian graduates but that would deny these people natural justice, I believe.

Mr LOWE - In respect to Launceston General Hospital there you would have Dr Bosanac, Director of Radiology, off the scene. It would appear as though would almost make the Launceston General Hospital's position intolerable.

CHAIRMAN - And Illes as well - is it Illes?

Mr LOWE - Yes. I was just looking at radiology in a hospital such as that, the importance of the radiology department.

CHAIRMAN - One of the other areas that you can see in what we are looking at as Parliament's ability or otherwise to step in and legislate. To me - and I have made it known clearly that I think it is a dangerous precedent for parliament to legislate on something that they have no real knowledge of and set ourselves up as a de facto registration board - can I just have your views -

Dr WALPOLE - Shades of Victor Richard Ratten.

CHAIRMAN - Yes, his name is mentioned every time.

Mr SQUIBB - Can I just add there. All we are doing is extending registration. Registration has already been granted.

CHAIRMAN - Yes, that is right. Can I get your views on that please?

Dr WALPOLE - On that you are just extending it?

CHAIRMAN - No. This de facto registration aspect that I have spoken about.

Mr LOWE - From my point of view, I think you have to avoid that at all cost because it has the potential to remove your credibility in this issue and with the impact of mutual recognition the one

thing we have to do is make sure that anyone who carries a Tasmanian registration does so with all the authority that there is possible.

I think that as legislators the area that you are entitled to be legitimately concerned is where there is a national policy or decision that without some refinement of law in this State is likely to adversely impact this State and I do not see that as a de facto registration authority at all. I think what you are saying is that these people are entitled to have their classification varied in order that they can continue to practise and so that they do not fall within the parameters of the policy that is currently causing them concern.

Mr SQUIBB - I think this recommendation actually will achieve what the bill set out to achieve. It was never seeking to get full registration which would enable recognition any where else in Australia because it said specifically in the bill, it named the four sites in Tasmania, nor was it the intention to ever get a provider number. So I think this recommendation, if it is adopted at any stage, will in fact achieve what the bill set out to achieve.

Mr LOWE - And we are pleased to help.

Mr SQUIBB - Could I just ask one further question of Mr Lowe, Mr Chairman? That is in relation to third line forcing. Has your association had any opinions on that or any discussions as to what effect a case to the ACCC may have?

Mr LOWE - Third line forcing in respect of what?

Mr SQUIBB - Medical practitioners where they are forced to be a member of a particular college in order to gain or retain employment.

Mr LOWE - My understanding is that third line forcing in respect to colleges has been ruled out by the -

Mr SQUIBB - Ruled out as in what is happening at the moment?

Mr LOWE - The way the colleges currently operate is not seen to be in violation of the Trades Practices Commission policy in relation to third line forcing.

Mr SQUIBB - Has that been tested or is that just an opinion?

Dr WALPOLE - No, it has not been tested.

Mr LOWE - I think that is an opinion.

Dr WALPOLE - There is currently correspondence underway between the Australian Medical Association and Federal Health Services because AMWAC is actually an arm of government coming under the Health ministers and that is in conflict with the ACCC. But our informal advice is that the activities of the colleges will not be seen in conflict. That is only informal though.

Mr SQUIBB - Is that likely to be formalised at any stage or tested, that you are aware of?

Dr WALPOLE - Well, correspondence is underway at present. You are probably aware that the whole Medicare program has been exempted from the ACCC.

CHAIRMAN - When people come out on conditional registrations and come out to practise at the Launceston General Hospital, the Mersey Hospital or wherever it might be, what concerns me a bit is that they are coming out with a belief, as I said at the outset, they are going to be registered, not ad infinitum is probably an exaggeration, but year in year out for a period of time. Are they made known through the Government or through the Council of the fact that when they come out they are to abide by conditional registration rules: public interest, area of need, if there is another Australian-trained doctor that goes into that area they have to leave?

Mr LOWE - No.

CHAIRMAN - It would seem to me that that would be a fairness aspect that should be applied with. Whenever they come they should be made known the facts upfront before they come to allow them to make that decision whether they come or not.

Mr LOWE - I would regard that as completely mandatory and I would be surprised if it does not take place.

CHAIRMAN - That is what I was wondering, does it take place?

Mr WALPOLE - I do not know.

CHAIRMAN - Right, I thought you were saying 'no'.

Mr LOWE - My response to that question is that I would be surprised if it does not take place because in all the discussions that I have been having in the six years that I have been in this job there is always the mention of the fact that you are looking at a year-to-year proposition and that in most of these positions there is a requirement that the position be advertised before accreditation will be reissued.

CHAIRMAN - I know they have said they have been told that but I just wonder whether it has been then followed up with a letter so at some stage they cannot come back - and some have indicated to us that they have been given a nod that they will be able to go on -

Mr SQUIBB - That is the key point, I think. In most cases with the evidence we have whilst they have been told that they have also been told that there are ways around that.

CHAIRMAN - And that is why I was thinking a letter should come.

Mr LOWE - Someone that is saying that is going beyond their authority, in my judgment, and they should be cautioned.

CHAIRMAN - Yes, but again a letter, I think, should be sent to them prior to them coming setting out the full facts then at some later stage they cannot argue that they were told this, they cannot argue in courts that -

Mr LOWE - I would actually be surprised if the Medical Council at the time of issuing conditional registration did not attach to that the reality of the situation vis-a-vis future registration application and, again, if that does not take place then I think it should.

CHAIRMAN - Thank you very much for coming and thanks for your input; it is much appreciated.

THE WITNESSES WITHDREW.