**THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON REGISTRATION OF OVERSEAS-TRAINED MEDICAL PRACTITIONERS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY 30 MARCH 1998.**

**Dr JOHN SPARROW,** CHIEF MEDICAL OFFICER, AND **Dr JONATHON BRUCE MULLIGAN,** DIRECTOR, HOSPITAL AND AMBULANCE SERVICES, WERE CALLED, MADE THE SOLEMN DECLARATION AND WERE EXAMINED.

**CHAIRMAN** (Mr Wilkinson) - Gentlemen, thanks for coming along. What we have to do by way of formality is ask you your full names and addresses and then the capacity for which you appear. If there is any evidence that you wish to be held in camera or in private, please let us know and we can discuss that rather than releasing it at some later stage. So if we can start with you first please, Jack.

**Dr SPARROW** - I am John Maxwell Sparrow and I am the Chief Medical Officer with the Department of Community and Health Services. I have a general liaison role with the Department of Community and Health Services on a number of medical work force issues.

**Dr MULLIGAN** - I am Jonathon Bruce Mulligan. I am the Director of Hospital and Ambulance Services in the Department of Community and Health Services. I am here to assist Dr Sparrow in his role as Chief Medical Officer and also because my division has responsibility for the major hospitals in the State which are, in the main, the employers of full-time specialist medical staff.

**CHAIRMAN -** Thank you. Jack, do you want to go through just briefly your submission to us and then we are ask questions, or what would you rather do? What do you feel most comfortable with?

**Dr SPARROW** - I contemplated that, Chairman, but I am not sure that it would be particularly helpful to the committee if I attempted to sum it up. I certainly hope it stands alone, and I think in my covering note addressed to you a month or two ago I, in fact, made some comments about noting that some of the information and comment in it was repetitive to some extent. But I felt it would be helpful to the committee - and indeed it was helpful to me in preparing it in what I hope is a reasonably logical form - to provide that general background information before specifically addressing the terms of reference.

My first chapter was just on the general comments about the Australian medical work force and then on to the specific role of AMWAC - the Australian Medical Workforce Advisory Committee - then some general comments on legislation and Commonwealth Government initiatives, and then to address the specific terms of reference around that framework. I believe it would be more helpful if I essentially offered to clarify or comment further on issues that are of particular interest to the committee.

**CHAIRMAN -** I have read the background notes that you have provided, going through the terms of reference, I think if we started from those terms - if you could - and then perhaps relate to each of those sections one by one.

**Dr SPARROW** - Chairman, I had a certain role to play in suggesting the original draft terms of reference and clearly the final terms of reference were modified to some extent. The terms of reference were certainly suggested on my part as being relatively wide and perhaps, to some extent, could be described as unnecessarily wide, but just to enable the committee to look at the issues in that very broadest context and not just in the terms of the relatively narrow definition in the legislation itself.

Again, I am not at all sure that it is terribly helpful to go through one by one and comment on the comments that I have made there, but rather to offer advice. I think there is not a great deal in the way of opinion offered, and that tends to be in respect of statements that have been made by other interested parties and commenting on the department's interpretation of those. But mostly it is based on the departmental advice that has clearly been given to the minister and the Government from the outset, that it would not be appropriate to support the bill for those various reasons that are elaborated there.

**CHAIRMAN -** What other options - and I know they start in paragraph 5(2) of your submission to us - it would seem on the face of it that Dr Iastrebov, and anybody else who comes to Tasmania, comes to Tasmania as a result of the need for practitioners like him to become involved where there is an area of need. What other suggestions can you think of to allow him to remain in Tasmania for an extended period than what is already granted to him?

**Dr SPARROW** - At the present time the medical council has indicated that his registration with conditions will expire at the end of December this year and as things stand at the moment his registration would not be continued after that time.

I think it should also be noted that it would be extremely unlikely in that event that he would be granted registration in another Australian State because the general two-year limitation on registration with conditions that has been supported as a principle by the Health ministers' conference, by the Australian Medical Council and by the various State and Territory boards, is an accumulative period. It is not a matter of being able to have temporary registration in Tasmania for two years and then moving on to the next State for another two years and so on. That is consistent with the mutual recognition principles. That is a somewhat negative comment and it is certainly a worse-case scenario.

What I would personally like to see happen would be for Dr Iastrebov to enter into serious discussions with the Australian and New Zealand College of Anaesthetists as to realistic and practical means by which he might undertake the examination and be assessed in due course by that college as having satisfied the conditions such as they would apply to an Australian medical graduate seeking recognition as a specialist anaesthetist.

It is not for me, of course, to give undertakings on the part of the Medical Council of Tasmania - and I am confident they will be giving evidence to the inquiry - nor can I give undertakings on behalf of the Australian and New Zealand College of Anaesthetists. Both of those bodies have certainly indicated, and specifically suggested in the correspondence - and copies of the correspondence have been attached - that they are, and would be and I am confident still will be prepared to take a reasonable view. Certainly the medical council has, in the case of other doctors in a similar position, indicated its willingness to not feel locked into that two-year period if the doctor is making a serious attempt to pass either a set of specialist college examinations or alternatively, the Australian Medical Council examinations and I would suggest that that particular matter be canvassed when you speak to the Medical Council of Tasmania and when you speak to the Australian and New Zealand colleges too. That is clearly, in my position, the preferred outcome.

Bob Walsh commented in one of his letters, and I believe a copy of that letter was addressed to all members of the Legislative Council, that it would be an unfortunate situation if Dr Iastrebov left at that time and the only option was to replace him with another overseas-trained specialist. None of us want to see that.

**CHAIRMAN -** Is there any way at all that he could continue to practise at the special hospital he is practising at now, the Mersey, and do that course that you are talking about? I know there has been some talk interstate recently where they are talking about allowing people like him to become registered but perhaps in a different way because of the problems that overseas doctors have when coming to Australia.

**Dr SPARROW** - Yes indeed. The issue of bridging courses and appropriate support and help for overseas-trained doctors to assist them in passing either the general Australian Medical Council examination or a specialist group was discussed as recently as the 19 March by the Australian Health ministers advisory council and there is a specific meeting that the Commonwealth has called, which is on Wednesday 22 April, to attempt to put that into practice.

To some extent, and I will ask Dr Mulligan to comment because it is clearly in his area, but our hospitals have attempted to provide support for overseas-trained doctors more in the way of assisting them to pass the AMC examination - that is, the relatively junior doctors - but also in the form of making concessions and providing what support they can to assist specialists through their respective specialist college examinations and I might say, with a great deal of success. We have had a number of overseas-trained specialists who have satisfied the college from a position in a Tasmanian hospital and that is not restricted just to the Royal Hobart Hospital, it is also applicable to the Launceston General and the North West Regional Hospital in relatively recent times.

My position is that the Tasmanian health system would do what it could to help and support but the first step, if you like, would need to come on Dr Iastrebov's part in indicating a preparedness to go down that route.

**Mr SQUIBB** - My question follows on from that, to ask what processes were involved in each of those two options. My understanding was that each of them would require him first of all to leave his current employment, the Mersey Community Hospital, because it would not be possible to pursue either the study or the assessment there. The second question is: obviously if he is not going to be registered again anywhere in Australia - and bearing in mind he is an Australian citizen - after 31 December this year, he has no means of livelihood.

**Dr SPARROW** - Could I deal with Mr Squibb's first question about the practical difficulties facing Dr Iastrebov. Certainly the colleges generally prefer accredited training positions, as part of the training, to be associated with one, and usually two, fellows of that particular college because specialist training is based so much on the peer training and peer review processes. So that is the desirable situation.

**Mr SQUIBB** - My understanding is that there is one of those currently at Mersey, albeit past retirement age.

**Dr SPARROW** - Yes, true. I am afraid I have not checked on the actual position at Mersey. I am not aware of it having changed; certainly that was the position at the end of January, but I have not checked it recently. There has been one very recent change that there is another - I might say Australian-trained - specialist/anaesthetist who has just taken up appointment at the North Western Regional Hospital so that the complement of fully trained specialist/anaesthetists for the north western hospitals has improved by one since the January time. It just seems to me that there is an opportunity there, with reasonableness on both sides - and certainly it exists on our side - to provide support from the North Western Regional Hospital and the Launceston General Hospital in terms of potentially rotational terms of those hospitals.

I cannot negotiate, as I have said before, on behalf of the College of Anaesthetists, but our experience is that the various colleges have been prepared to respond reasonably and look at any reasonable proposal that meets particular needs for a particular individual.

Mr Squibb, could I ask Dr Mulligan if he would like to elaborate on that, before I come to your second question about non-registration.

**Dr MULLIGAN** - Through you Mr Chairman - I can only reinforce what Dr Sparrow has said, that the availability of Australian-trained and recognised specialists in anaesthesia and in intensive care is such that we would be in a position to provide support but it would require Dr Iastrebov to submit, if you like, to the jurisdiction of the college, as we must, in training matters.

**CHAIRMAN -** All doctors who come from overseas in the same situation - I know we are putting the magnifying glass on Dr Iastrebov but it is all overseas practitioners that we are looking at - are they advised when they first come to Australia that if they need to, you can assist, or the medical council can assist them in any way in becoming fully qualified to remain in Australia? In other words, prior to coming to Australia, do they know the ground rules and do they know that the assistance is going to be available to them?

**Dr MULLIGAN -** I can comment on one aspect of that - and I am sure Dr Sparrow can fill in the gaps - but I think they fall into two categories. Those who are recruited to come to Australia to work as

doctors, certainly we appraise them of the registration requirements. In fact we would generally prefer not to recruit people whose registration will be limited but in those circumstances where we must, then certainly we do advise them of the limitations and that includes the more recent time line on limited registration appointments and we would also advise them of the options available to them to secure full registration. Having said that, mostly when we appoint people under those circumstances they are for limited tenure appointments and usually they would have to leave the country before they could gain permanent residency status. The other category of course is people who happen to have overseas medical qualifications but come here as part of the general stream of immigrants - and I am really not very familiar with what information the immigration authorities make available to such people, but perhaps Dr Sparrow is.

**Dr SPARROW** - Certainly now, Mr Chairman, doctors would be quite specifically advised about all of those current ground rules but in - and again returning to Dr Iastrebov's personal situation - some of those changes and policies have of course only come into effect since he was originally appointed to the Queensland hospital he worked at and some of it would not have been known to him at the time he first entered the country - indeed because it did not exist as general policy at that time - the two year limitation. On the other hand, he was quite strongly advised at that time by his Queensland employers to undertake the College of Anaesthetists examinations and that advice was in a letter dated - I am sorry, I will have to guess a little bit but I think it was September, 1995 or certainly thereabouts.

There has been reasonable time given by the various medical councils and medical boards so that the application of those new policies is not applied in a retrospective way so I think he is on an equal footing with anyone now and certainly, as Dr Mulligan said, any doctor entering the country now, it is explained absolutely clearly to him or her what those ground rules and requirements and expectations are.

**CHAIRMAN -** So the only difference there would have been that he was not told there would be a two year limitation?

**Dr SPARROW** - Because that did not exist as a requirement at the time that he originally came to Australia.

The second question was what happens to Dr Iastrebov in that worse-case scenario, that medical registration ceases at the end of December this year. I still view it as a worst case scenario but if that does happen it puts Dr Iastrebov, I guess, on a similar footing with a number of other Australian residents with permanent residency basis who are currently in Australia and have obtained medical qualifications overseas which are not recognised or registrable at this time. Of course that is another issue that has been addressed and is being addressed by the Commonwealth Government in a number of ways.

One of the ways in which that situation is being addressed - and it flows, I guess, from the fairly well publicised hunger strikes at the end of last year - is to offer 100 places in either the fourth, fifth or final year of one or more of the Australian medical schools for those doctors to undertake the final - the last one, two or three years - of the medical course and then if they satisfy the examiners there, they become registrable on the same basis as an Australian citizen/resident/young person who has completed the entire medical course with the only requirement being that they undertake a period of practice in a rural area of Australia for five years. But that scheme is being discussed at the moment. The medical schools and the various State governments have indicated their support in principle for it and all indications are that it will be introduced at the beginning of 1999.

**Mr SQUIBB** - And that would include specialists as well as GPs?

**Dr SPARROW** - Some of those doctors would claim overseas specialist qualifications as well.

**Mr LOONE** - The discussion has broadened since I was going to ask a question but I was a bit concerned earlier on that we were heading down the track that this was purely and simply about Dr Iastrebov. That is not case, he is only being used as an example, and our concern is for the future registration of foreign doctors in the case of places like Latrobe where they may be left without a specialist. The discussions had broadened since then but I think it is pretty important that it does not go

across to the public or to people coming to give evidence, that we are only here talking about Dr Iastrebov.

**Mr HARRISS** - I had a couple of questions. One revolves around a finding of the Human Rights and Equal Opportunities Commission's deliberations in 1995, Dr Siddiqui - and you are probably well familiar with that - and that is that the Commission said that 'in its present form the system governing the admission of overseas-trained doctors to medical practices in Australia is grossly unfair' and so on. That essentially is a Federal Government matter which the coalition is taking account of. How then does that assessment by the Commission impact State by State, recognising that the coalition also went on to say that 'subsequent to that decision' or that assessment by the Commission 'that registration is nonetheless a State by State issue under each medical council in each State'. How then are we progressing - in Tasmania, I suppose - subsequent to the finding of the Commission in that doctor's case?

**Dr SPARROW** - I would like to start the response to that by saying that all State medical boards, medical councils, agreed some years ago to accept the examination conducted by the Australian Medical Council as the general qualifying examination for overseas-trained doctors. It is absolutely correct that the medical boards, through the various State acts, are the only bodies that are responsible for medical registration but it was clearly impractical and clearly created an opportunity for significant inconsistency for each board to attempt to set up its own examination and assessment processes. So the medical boards decided that the Australian Medical Council, on which of course they are all represented through the chairmen of the State boards, was the appropriate body to achieve consistency in that process.

The actual procedures for admission to the Australian Medical Council examination were the issue that was fundamentally the difficulty in the Siddiqui case. It was not the difficulty or the nature of the examination itself, it was the fairness or otherwise of the processes for accepting an overseas-trained doctor to undertake the AMC examination. The AMC at one stage had imposed a quota on the number of overseas-trained doctors that it would assess each year and that did not meet the expectations of the number of doctors who were gaining entry to Australia and some of them were precluded from the examination and they considered that they were being precluded unfairly.

The quota system and the various ground rules and the administrative procedures adopted by the AMC have been extensively revised as a result of the decision in the Siddiqui case and the particular criticism that Dr Siddiqui made on his own behalf and on behalf of other overseas-trained doctors is not a current criticism of the process or the fairness of the process.

Dr Mulligan just commented to me that the specialist avenue has come in since that time and that is a relatively new and more formal approach than existed before, that all the medical acts in each State and Territory now have the provision for registration with conditions and a common condition is that an overseas-trained doctor with recognition as a specialist, in whichever specialty area, is given registration; that the registration is limited to practising in that field -

**Mr SQUIBB** - And that is not full registration?

**Dr SPARROW** - The concept is. I think I used the analogy that a neurosurgeon, for instance, could not practise as an anaesthetist, nor would they want to; specialists only practise in their area as in some cases relatively broadly defined. So in practise it does not impose any restrictions on what a doctor would want to do.

**Mr SQUIBB** - But the Health minister's conference in 1991 agreed that full registration was registration without the conditions.

**Dr SPARROW -** Yes, they probably did.

**Mr SQUIBB** - The problem seems to be, what are conditions?

**Dr SPARROW -** Yes, the discussion at that time was certainly much more in terms of the basic qualification, the AMC examination, because that was the thrust of the discussion. That was why Dr

Mulligan suggested that I mention the second route of the registration with conditions in the case of a specialist, the only condition being practised in your own specialty.

**Mr SQUIBB** - Can you tell me the difference - and I use Dr Iastrebov as an example now - between his current registration with conditions and the type of registration proposed in the bill with conditions? I thank you for the copy of the Solicitor-General's advice; I must say I understand that there is contrary legal advice and you are probably not in a position to discuss that at this particular point of time but as the department sees it, could you explain the difference between those types of conditions?

**Dr SPARROW -** Fundamentally I do not think there are any significant differences. Basically as I understand the -

**Mr SQUIBB** - How is his current registration exempt from the provisions of mutual recognition?

**Dr SPARROW -** It is not, as it stands at the present time -

**Mr SQUIBB** - So he can be registered anywhere in Australia at the present time then?

**Dr SPARROW -** At the present time. But that condition that applies here would have to translate to another State too because under the mutual recognition agreements and legislation registration if it has conditions attached, the conditions are transferable as well.

**Mr SQUIBB** - And the condition is that he is limited to the Mersey - for a period of time.

**Dr SPARROW -** At the present time, yes.

**Mr SQUIBB** - So if he was granted by this State, registration, instead of using the words 'at public hospitals within this State', if the words, 'Mersey community, Royal Hobart, Launceston General and North-west Hospital' were used rather than the words. 'in this State' does that make any difference?

**Dr SPARROW -** There is one other aspect of Dr Iastrebov's registration with conditions that it does prescribe the specialist field in which he is at the present time.

**Mr SQUIBB** - And assuming he is sticking with that specialist field.

**Dr SPARROW -** No, as I see it there would be no legislative barrier between now and the end of December provided that the Secretary of the Department of Community and Health Services would be prepared to certify that the Royal Hobart Hospital is an area of need in respect of a specialist anaesthetist and at the present time, I do not think that the Secretary would be able to declare that the Royal Hobart Hospital is an area of need. I believe that at the present time the Royal has a full complement of specialist anaesthetists.

**Mr SQUIBB** - Should that situation change or if the Royal Hobart Hospital was left off that list and registration was granted on the basis of need and he was granted registration with conditions and those circumstances changed in the future - for instance, the Launceston General may in fact no longer be an area of need - once he has been granted registration. is that affected by circumstances which change after that granting?

**Dr SPARROW -** No, but the granting of registration would be only for a finite period of time, the 31 December 1998 condition would clearly still apply.

**Mr SQUIBB** - No, perhaps I am looking past that, I am looking at legislation which would enable him to be granted limited or conditional registration.

**Dr SPARROW -** That legislation would clearly be in conflict with the general agreement that has been reached by the various medical boards with the approval of the Australian Health Ministers' Council that the two year period should be the determining factor.

**Mr SQUIBB** - That is for full registration without conditions; I am talking about registration with conditions.

**Dr SPARROW -** Yes, I am sorry I must be appearing a little bit dull, Mr Squibb, I am not quite sure that I am on the same train of thought as you are but -

**Mr SQUIBB** - You are probably talking along the lines of legislation as it currently exists. I am looking at proposed legislation which would enable this State to provide registration, with conditions which would not be in conflict with the mutual recognition legislation.

**Dr SPARROW -** Certainly that position would not be opposed in principle by the department. I guess that I have already implied that that opportunity is there in that if Dr Iastrebov came up with a reasonable proposal that met with the general approval of the College of Anaesthetists, I have indicated or suggested that I believe the Medical Council of Tasmania would be generally supportive in extending registration to enable that route to be followed.

**Mr SQUIBB** - But as an option to that, what would the department's opinion be if legislation could be enacted which does not conflict - which would enable Dr Iastrebov to achieve what he is seeking, provided it was not in conflict with the mutual recognition provisions.

**Dr SPARROW -** I can only answer that at the personal level because it is somewhat of a hypothetical question as far as the department - and much more importantly the Government's and the minister's - position is concerned but certainly from my personal perspective, an approach for legislation that did not conflict with mutual recognition agreements and ministerial council agreements and such like would not be opposed in principle.

**CHAIRMAN -** Talking about the Tasmanian rural district at the moment, is the Tasmanian rural district in your opinion, or both of your opinions, in need of general practitioners?

**Dr SPARROW -** Undoubtedly. At the present time and I think I quoted seventeen positions at the time that I prepared the submission and that is, of course, a somewhat changing picture but in the meantime there have been one or two other doctors who have moved and others who have suggested that they would like to retire or move on. We would still have at least that number of positions at the moment that are significantly difficult to fill in rural Tasmania.

**CHAIRMAN -** Do you find that that number is increasing as more people seem to try and focus on the cities as opposed to the rural areas from twenty years ago, fifteen years ago, ten years ago?

**Mr SQUIBB** - Rural and regional.

**CHAIRMAN -** Yes, rural and regional. Is the number of doctors in rural and regional increasing as far as needs are concerned over those years?

**Dr SPARROW -** In terms of general practice it is still a problem but there is certainly encouraging signs that some of the initiatives that have been taken to encourage the recruitment of doctors to rural areas are taking effect. Equally importantly, so are the measures to encourage those doctors to stay on once they get there.

The unfortunate aspect of it is that those sorts of changes take a considerable time for their impact to be fully felt and I think in the case of anaesthesia, for instance, although all States and the College of Anaesthetists and the hospital systems and the State Health departments have been very supportive in terms of increasing the number of training positions for specialist anaesthetists. The payback period is not overnight or next week. In that case it is acknowledged as 2001 or 2002, I think, before the full impact is felt and that is the case with most specialist training, simply because specialist training is a fairly long and demanding procedure taking five or six years in all.

In the case of general practice, some of those moves have been directed more towards medical students and indeed right at the outset of the selection of medical students, or the selection of people into medical courses, who have a rural background because there is certainly plenty of evidence now that those people are ultimately more likely to take up rural general practice or indeed rural specialist practice in due course. But again the payback period is not a particularly quick one and the final aspect of it is that strenuous efforts, and they are strenuous, that are being made to incorporate rural and

community terms in the hospital experience of all medical students, particularly in their later years of their course and in those junior years after they first graduate. Again on the basis that so many of them have never experienced the advantages and the gratification and there are considerable plus points in terms of rural practice and that that is much more likely to encourage a number of them to take it up.

**CHAIRMAN -** There is talk about them being paid by the Government more money to go into those areas; other, let us say, incentives, to get them into those areas. Do you believe that if those incentives were acted upon, there would be less need to get the doctors from interstate. It seems an obvious answer to that.

**Dr SPARROW -**Yes I do, and the incentives that are available were perhaps a little bit bureaucratic and tight at the outset and progressively there is more freedom to look at the particular needs of an individual doctor in an individual community. There are some examples in Tasmania where the department has worked very closely with a particular local community and the community has contributed something - for instance, accommodation and a facility to practise and just general community support of the doctor and their family. The department has been able to supplement that with professional opportunities and further training and such like and that is proving to be far and away the most satisfactory way of moving.

**CHAIRMAN -** It appears one of the major downfalls of a doctor going to a country area is that he is on call twenty-four hours a day, seven days a week, and just does not get any rest at all and he cannot take holidays because they find it difficult for people to take over whilst they are on holidays. I know that a number of doctors have left country areas because of that and no doubt you would be aware fully of that as well. Is there anything being done to allow doctors to take a break or allow some special relief to come in to give those doctors a break?

**Dr SPARROW -** Yes there is. There is some specific money available for employment of locums for rural areas and we have had very good service from a doctor who was appointed for that particular purpose a couple of years ago but clearly one general practitioner, albeit very enthusiastic and experienced GP, cannot provide that sort of coverage for every rural-based doctor in Tasmania and it is not, unfortunately, that the rural general practice locum appointment has not been one that we have been rushed with applicants. But there is money to provide that sort of support and certainly it is correct that that is a significant concern expressed by a number of doctors. The longer that I stay involved and interested in the area, the more I accept that it is very much a matter of individual horses for courses and you do not get one common list, and certainly not in priority order, of what are the real concerns about rural general practice in Tasmania. It differs doctor by doctor.

**CHAIRMAN -** How often have you found that the overseas doctors that have travelled to fill a position - like around the west coast, for example, or on the east coast - once they get the full registration, they remain in that area for a short period of time and then either move interstate or move into the city.

**Dr SPARROW** - Two of the doctors who were granted full registration through the Medical Practitioners Act in 1996 have subsequently moved on and one has partly retired but he indicated that he may retire within a relatively short time frame. Another one has certainly left that rural part of Tasmania and left it relatively soon after the legislation passed, and is practising in another State now. The other two are still in general practice in the communities they were in at the time.

**CHAIRMAN -** Do those doctors give a special undertaking to you, or do they give an implied intention anyway, prior to getting this full registration that whatever the case they want to remain in the area; they have accepted the chance that they have got in the area; they have grown to like the area and therefore they do not wish to move. Have they given you that undertaking?

**Dr SPARROW -** Certainly that was the expectation. In the case of those four doctors a couple of years ago, I have already commented earlier that the new arrangements for 100 places for overseas-trained doctors to finish a medical course in Australia, the condition of that would be that those doctors practise for a period of five years in a rural location. But there has already been pointed out the considerable practical difficulties of enforcing that which is given as an undertaking and presumably with good intentions at the outset but if it is not followed through, there is very little in the way of

punitive action that can be taken. One of the potential measures to address that is for the Commonwealth to provide what is known as a geographically qualified provider number for Medicare purposes and of course that is a proposal that is very much an ongoing consideration at the moment. It is not a move that is generally popular because it amounts to civil conscription and there is the potential for it being challenged on that basis but it is nevertheless something that is a real way of addressing that concern.

**Mr SQUIBB -** Could I just ask what happens in those situations where a young GP, for instance, will go to one of those areas, take up a geographic-based provided number; if he wants to go back to the city, how does he get a provider number at a later stage.

**Dr SPARROW -**That is a very practical problem and I do not believe that there is any answer to that yet and clearly I think that no one would be attracted to a concept that said you can only practise in a rural community for ever and ever -

**Mr SQUIBB -** Unless they can see a step beyond.

**Dr SPARROW -** Yes, indeed. I think that one of the approaches that is being taken more and more and particularly as careers in the medical profession, as well as across the community generally, become much more mobile that there would be a reasonable expectation that every doctor, for instance, worked for three, four or five years perhaps in a rural community and if you like everyone then would have done their share towards rural Australia and they can take up practice later on. An obvious major difficulty with that is the way that the system, particularly for specialist training, is structured at the present time. It is based so much on major teaching hospitals in metropolitan areas, that young doctors, with all of the potential and all the interest, to take up a specialist career would view that as putting a barrier in the way of them entering that specialist career in due course.

The colleges are generally very much aware of that and are supportive of it and there are now, for instance with the College of Surgeons, specific training options that are available for rural surgeons with a more general background, with some orthopaedic, some neurology and some general surgery. The other colleges, bit by bit, are working towards recognising and designating positions in rural areas because they are well aware as the rest of us that, particularly major provincial, cities have huge difficulties in maintaining specialists in many fields.

**CHAIRMAN -** Do you know of any other place in the world where a council like ours can give registration to Dr Boyer, whoever, without expertise in the area?

**Dr SPARROW** - No, I do not know of any other jurisdiction. I am not aware, personally, of any other parliaments that have taken that step.

**CHAIRMAN -** Do you know of any State in Australia where that step has been taken? In other words, an overseas doctor comes to Western Australia, practises up at Broome for two years and then says, 'I don't want to go through the system' but goes to a member of parliament or members of parliament and endeavours to get legislation put forward.

**Mr SQUIBB -** Tasmania has already done it.

**Dr SPARROW** - No, Mr Chairman, I do not. I hesitated when you asked the question in the first place because there was some advice that was provided several years ago that that had been the case in Western Australia. But I was certainly unable to substantiate that that was the case and certainly not through an act of Parliament, although there may or may not have been some special consideration given to overseas-trained doctors by the Western Australian medical board at that time, but not to the extent of legislative action.

**CHAIRMAN -** There is some argument, as you know, that they say, 'It's a bit of a club to get into the specialist field' - the anaesthetics, the orthopaedics, or wherever - and as a result of that 'club' mentality that people would argue - and I am not one of those, but some people do argue that - they say it is very difficult, nigh on impossible for overseas doctors to become a specialist and get unrestricted ability to practise within Australia.

**Dr SPARROW** - That has been said, and probably with some justification in years past, and perhaps with more justification in the case of one or two specialist colleges than across the board, but there is abundant evidence now that other doctors with overseas training, and including specialist training, have successfully passed the Australian College examinations. I do not think it is appropriate to name them but in fields such as ophthalmology, indeed in anaesthesia, in general medicine and in psychiatry, are just examples that come to mind within the last year or eighteen months that overseas-trained doctors have satisfied the Australian colleges.

I would also like to add that I represent Tasmania on the Medical Training Review Panel and that is a committee that was established by legislation when the Commonwealth amended their legislation relating to Medicare and so on in November, 1996. The presidents of the various specialist colleges are all members of that panel which is, needless to say, a fairly large one but the colleges, as represented by their presidents, have indicated their support for the general principles. The only other comment in that area is that the various specialist colleges have been very active participants in the work of the Australian Medical Workforce Advisory Committee in studying and looking at the work force requirements in various specialist areas and have willingly agreed to increase the number of training positions in those various specialties and to make those available, of course, to overseas-trained doctors as well as for Australian-trained doctors.

**Mr HARRISS** - Recognition of prior learning is a well recognised principle, of course, and I note from your submission that you have made a comment in section 57(10) about the wide recognition that specialist training standards in places like the USSR were on the whole considerably inferior to Australian standards. Does that comment apply as strongly to the field of anaesthesiology or is it a broad statement about specialist fields generally?

**Dr SPARROW** - It is certainly a broad statement about specialist fields generally and it is extremely difficult to make a general statement that stands up across the board. I believe that the colleges now individually approach their counterpart, if there is a counterpart - and there is not necessarily in every country around the world - but they, through their own sources, seek more information about the various courses of training available.

Some years ago, because there was so much subjectivity in it at the time, the Commonwealth established what is known as the National Specialists Qualification Advisory Committee of Australia and that committee produces a publication called 'Recommended Medical Specialties and Qualifications' and just by way of example, when you turn to anaesthesia which is obviously a recognised specialised area, under the list of accepted specialties and qualifications it lists 15 bodies awarding qualifications ranging from Australia, New Zealand, Australian universities, the English college, Irish college, the American board, the Canadian college, the South African college and several South African universities and specifies that the qualification awarded by that particular organisation is acceptable in such and such circumstances. In some cases it goes right back to 'if obtained before 1974'. This publication and this committee examines every specialty in that light and looks at the recognised qualifications awarded throughout the world and mostly that is obviously the Western world and it is far more difficult to comment on what standards apply in the Eastern bloc and certainly in the Asian countries.

**Mr HARRISS** - Can I then, Mr Chairman, return - just for my own clarification because I am not completely clear on the matter yet - to that matter of the Human Rights and Equal Opportunities Commission's decision or assessment. You made a comment, after Dr Mulligan shared something with you, that that was back in 1995 and things have changed to improve the situation. Precisely what has changed which might make the Commission reconsider that assessment?

**Dr SPARROW** - The change is that the medical acts of each State and Territory now recognise the conditional registration to practise only in a particular speciality for a person whose qualifications have been recognised in that specialty. That is a relatively new initiative.

**Mr HARRISS** - Just finally, Mr Chairman, the matter of a parliament delivering registration to any practitioner, what are your views then because, as I understand it, the Medical Practitioners Registration Act delivers to the relevant medical council the authority to deregister if a person is found to be incompetent?

If after a process of, one would hope extremely thorough assessment by a parliament - in this case the Tasmanian Parliament - to deliver registration to anybody, doesn't the Medical Council then have ultimate authority to assess the competence of any of those practitioners and to subsequently deregister if found to be incompetent?

**Dr SPARROW -** Yes, it does. The provisions of the Medical Practitioners Registration Act still apply. Those provisions, of course, are not related simply to incompetence. The power to register a doctor still rests with the Medical Council under the provisions of that act but with the particular act in question, I believe that certainly the intention of the wording appears to be that provision overrides the power of the Medical Council.

**Mr SQUIBB** - Through you, Mr Chairman - I will just follow on from Mr Harriss' question before last - in the case of those that have a qualification from one of those, I think sixteen institutions that you referred to, would they be treated as being the equivalent of an Australian and New Zealand-trained specialist or do they then go through a separate process. For instance, a South African-trained doctor, what would his or her process be?

**Dr SPARROW -** I mentioned, and probably only in passing, that there time lines set on some of those. The University of Cape Town which is a typical example, the comment is that if that qualification is obtained before 1 January 1975 and subject to approval of training by the Australian College. So a South African doctor who had obtained the Master of Medicine in Anaesthetics qualification from Cape Town prior to January 1975; in other words had been practising as an anaesthetist for 24-25 years, would still have to have their training and experience approved by the Australian College before they were registered.

That would, in my experience, obviously be undertaken on an individual basis but there have been examples where specialists with substantial overseas experience at a high level in countries with comparable medical conditions and so on have been registered, have been accepted by the relevant specialist college without any further request or requirement to pass the examination.

**Mr SQUIBB** - Finally, Mr Chairman, the Australian health ministers have resolved that there is to be uniformity between States in the form of the mutual recognition. Is there a reason why the various colleges have not adopted uniform procedures for assessing qualifications and registration? It seems to be much easier for an orthopaedic surgeon to be accepted than what it does for an anaesthetist.

**Dr SPARROW -** Yes, it is a very fair question, it is very difficult to explain it without sounding as though I am fudging the question a little bit. It is perhaps considerably easier to assess a person's surgical qualifications and experience than it would be, for instance, to assess a psychiatrist where the inter-personal relationship and the ability to communicate in the language become much more prominent factors rather than the technical skills.

**Mr SQUIBB** - That is if you went down the path of assessment rather than examinations, I guess.

**Dr SPARROW -** That normally is a part of the process of course and I commented earlier that the colleges would normally expect someone who is being assessed to work alongside a couple of college fellows for a couple of years so that they can make a practical assessment of the person's skills and experience. That clearly forms a part of the assessment process.

**Mr SQUIBB** - My understanding is that in some colleges it is an option. My understanding in the case of an anaesthetist, and Dr Iastrebov in particular, that that second option is not really available.

**Dr SPARROW -** Yes. I reproduced from some information the procedures adopted by the College of Anaesthetists and the Medical Training Review Panel that I mentioned earlier has recently looked at the processes adopted college by college to see whether there are shortcomings and difficulties with them.

Again, I believe that I made the comment somewhere in this submission that by and large the colleges at the national level had adopted processes which seemed fair and appropriate and equitable but sometimes they were a little lost when it got down to their translation at individual State branch level.

That may be an issue of concern but overall I believe that the approach taken by the College of Anaesthetists is considered to be a fair one for assessing a person's experience and competence to practise in that field.

**Mr LOONE** - Mr Chairman, the main purpose of this committee is for us to endeavour to find ways to retain medical practitioners, whether they be specialists or GPs, in the State. In the case of a specialist, and I have to keep referring back to Dr Iastrebov where he is a proven specialist and there is ample evidence available about his qualifications or the quality of his work why would not it be practical for his peers to judge his registration rather than him have to virtually go back to school and be taken out of the system for up to three years to complete studies that he is already fully qualified for, just to meet our medical requirement. Why would not it be practical for his peers to judge his ability?

**Dr SPARROW -** I am not convinced that any of us are in a position to say that the experience and the training that he has had is fully appropriate. I think that only his peers through the relevant college are in a position to make an informed judgment on the relevance and the level of his formal training and the experience that he has had.

**Mr LOONE** - I just used him as an example, I do not mean him totally, I mean right across the board.

**Dr SPARROW -** Sorry, I am answering in the ... but attempting to answer in the general sense too, Mr Loone but it is easy to use a particular field and a particular example.

I think that that is one part of the overall assessment process but it is not all of it and again the comment is made that Australia has a very high standard, some people have criticised it from time to time as being too high but it is a proven system that the relevant specialist college is far and away best place to provide that sort of assessment and putting aside the concerns that the colleges have not always in the past been totally objective about that. I believe that they are looking at that responsibility very seriously and carefully now and certainly not making judgments that are just designed to protect their own patch. You and I and other members of parliament, and Dr Mulligan, are the first to hear when someone is treated by a specialist or a general practitioner and they believe that that treatment is not up to scratch. I think that collectively we have got a real responsibility to do whatever we can to maintain those standards.

**Mr LOONE -** Just one other short question. It is generally recognised that we have got a shortage here, whether it be specialist or GPs, and cases like the north west coast there are a number of shortages. Is the department totally happy with the position you have on regards registrations or has the department any ideas on improving that position.

**Dr SPARROW -** My view is that the changes that are being made will collectively make a huge difference in several years time. Fortunately it will not be necessary for us to be having these sorts of discussions because the shortages will by and large be a thing of the past. But that is looking still several years down the track before we get to that fortunate situation in all specialties and in terms of rural general practitioners that the Chairman concentrated on.

**Mr LOONE -** The department is happy with the registration situation at the moment; they do not see any improvement to be made to that?

**Dr SPARROW -** Certainly again I can only comment personally but I have not proposed and would not be proposing any changes to the legislation at the present time to address that particular problem. I think that the various approaches that are in place are working and still looking very optimistically able to work towards that ultimate end.

**Dr MULLIGAN -** Mr Chairman, I wonder if I might supplement Dr Sparrow's response to that because I think there is another side of this coin and that is the reputation and any impact, any change that might have on our ability to recruit, because we know that one of the things that specialists value in looking at possible new positions is the standard of practice within those institutions. I think there has to at least be some recognition that any interference with the registration and what might be interpreted as the standards applying to the assessment of medical practitioners in our major hospitals

might rebound. I think we have to make sure that we protect the very high standards which we have at present.

**CHAIRMAN -** So in short you are saying that people will not come to Tasmania if they believe that the standards are being eroded by, let us say, registration through the back door as opposed to the normal process.

**Dr MULLIGAN -** I am not in a position to assert that firmly but based on my experience as chief executive of two teaching hospitals in two States, that certainly the thing that aspiring new appointees to specialist positions want to satisfy themselves about is the standard of practice, what reflection on their reputation might follow and, if you like, the standard of their colleagues.

**CHAIRMAN -** And how would that flow to the medical school at the University. Do you get the same type of flow on or are you scared of the same type of flow on is probably a fairer question.

**Dr MULLIGAN -** I guess I would not be so bothered about that except to the extent that it might bring into question the standard of teaching in some disciplines.

**Mr HARRISS -** Just following on from that, I note from your submission and it reinforces what you just said Dr Mulligan, that regardless of the problems the professional standards must be maintained because Australia does have a high reputation for quality medical delivery. What account then is taken of a display of competence by a medical practitioner who is operating under conditional registration. Again, it is this matter of recognition of prior learning, I guess. During a period of conditional registration there must be some opportunity or some process of assessing the person's competence and therefore relating it to recognition of prior learning during that period of conditional registration.

**Dr MULLIGAN -** I think Dr Sparrow is much more expert in this field than I, but I would like to just at least make some response to your question in that I wonder if the committee members are familiar with the change that has occurred in the focus of training and recognition of Australian specialist qualifications. Many years ago the focus was on an exit examination and those who jumped the hurdle were recognised as being competent. The shortcomings of that system were pretty obvious that it had a certain hit or miss element, had a very high failure rate, but did not take a lot of account of the experience and the training that people had had, hence the turn to very structured training under supervision through a range of experiences and practice settings, combined with examinations. So both a supervised training experience and an academic hurdle to be passed. I think the difficulty about assessing the experience of other people, or at least people trained in other places, is often the absence of reliable information about the range of experiences they have had and the sort of supervision and training they have had during that.

In the absence of that, to rely only on an examination brings up all the flaws of the past. Of course there is an argument that under supervision it should be possible for experienced people to make a general judgment about the level of competence and that raises the question of peers which was being addressed earlier in this discussion but Dr Sparrow knows much more about the detail of registration arrangements.

**Dr SPARROW -** I do not think that I can really add usefully to those comments Mr Harriss, except to say that they provide yet another very good substantiation of encouraging these people into the formal college processes because they are then subject to that sort of ongoing assessment and training and experience at the hands of the experienced peers who have undertaken that role for quite some time. It is done far more satisfactorily at that level through the formal college process than it is in the abstract sense by a medical council.

**CHAIRMAN -** Gentlemen, time is marching on. Thank you very much for your attendance today. If I can just propose one last inquiry more than anything else. There seems to be a number of good proposals being put forward, it would seem, by the Health ministers' conference. Are we able at all to have a look at those proposals or alternatively would we be able to get a summary of the proposals; that might be easier.

**Dr SPARROW -** Again, Mr Chairman, my hesitation is only that I was just trying to think if there is one single document that sums up all of the initiatives that have been taken. I attempted to comment briefly on them in my submission, but certainly I will attempt to find something that talks about those initiatives in a more general sense and in the same broad perspective.

**CHAIRMAN -** It would seem it might be of assistance - it certainly would be of assistance to me - in the face of what we are doing. There have obviously been a lot of ideas put forward at that conference and if we could get hold of it in a summary form, or in full if that is easier, it would certainly be of great assistance, I believe, to this committee. Thank you very much for coming along, much appreciated.

**THE WITNESS WITHDREW**.

**Mr PETER ROSS JONES** WAS CALLED, MADE THE SOLEMN DECLARATION AND WAS EXAMINED.

**DEPUTY CHAIRMAN** (Mr Loone) - Thank you, Mr Jones, for making your time available to come and meet with the committee this morning. We would like to make a couple of things clear to you: are you quite happy to give your evidence in committee or in public?

**Mr JONES** - Either way - in public, if that is the case.

**DEPUTY CHAIRMAN** - We would like you to make your presentation to us and then the committee members will then ask you a few questions, if that is okay with you. If you are happy, you can go ahead.

**Mr JONES** - Yes, thank you. Mr Deputy Chairman, firstly, thank you for permitting me to come here. Has each member of the committee a copy of my submission? I really do not need to add much to that. It is a very simple proposition that brings me here. There is a shortage, or a lack, or an absence of doctors in country areas. It seems that Australian doctors will not take the jobs and therefore I believe it is right for the community through its legislative branches to open the doors for any who will take those jobs and that means South African doctors, Hungarian doctors, Polish doctors; it does not matter who they are. I believe the people who take the jobs should be allowed to provide medical treatment and that their deeds should be their references and I think section 3 of your terms of reference - one throw-away line - 'the established procedures'.

During the Korean War there was a Canadian army medical officer who did some rather brilliant repairs to head injuries caused by military operations. After the war he set up a practice in Toronto. He would still have been a brilliant brain surgeon if he had not fallen foul of the tax department - they discovered he had never been a doctor at all. So one wonders about qualifications but nonetheless if I had known he had no qualifications and I had had my head shot off, I would not have wanted to go to him. My proposition that there is a shortage of doctors, nobody will take them and we have to find doctors who will.

**Mr SQUIBB** - I note that Mr Jones is from Orford; is it a particular problem in this area?

**Mr JONES** - Yes, it is. I have only been in Orford for two years but until about three years ago I understand there were six doctors in that general area: Orford, Triabunna, two in Bicheno and two in Swansea. The situation at the moment is that there is one in Triabunna, who is grossly overworked. In fact we tend to avoid going to the doctor because we know how busy the man is. There is one in Swansea who went there ten years ago, I think, to retire and has finally pulled the pin from the end of

June - quite soon. So there are no doctors between - I am not sure what the situation is at St Helens but that is some very long distance away. The doctors in Sorell, by story, have closed their books and will not accept more patients. So the people of Orford, Triabunna, Buckland and Swansea, what do they do?

**Mr SQUIBB** - That was going to be my next question.

**Mr JONES** - Well, I do not know what they do.

**DEPUTY CHAIRMAN** - Do you think that a policy could be developed whereby an overseas doctor with the correct qualifications be allowed to come into this State as long as he works for five or ten years in a given area and then be given open registration? Do you have any suggestions along that line?

**Mr JONES** - Yes. In the very end of my submission I felt that perhaps it was necessary for a doctor to have his qualifications - I think the term is 'validated' -

**Mr SQUIBB** - That is what you have used.

**Mr JONES** - Yes. Part of the process should be that they work for a specified period, therefore, Orford, for *x* years. But I got to thinking about that and I do not really see - well, it would depend on the numbers we could attract. There are about nine or ten little centres of population that have no doctors. So if we brought in - somehow or other, by a magic wand - nine or ten doctors, we could place them in those nine or ten places. But then how do prevent them from coming into Hobart? The answer seems to me that you do not fiddle around with five or ten, you bring in fifty - not so much bring in, open the doors. I am quite a ruthless man in some ways, there is only one way to bring sanity to the present situation and that is to swamp the market and to starve out into where the work is, those people who enjoy living and working in cities. There is not a lot of difference between a doctor and a plumber or a farmer, everybody provides a service, and that service can be traded as a commodity. So I would let in every doctor in the Western and Eastern world who wanted to come into Tasmania -

**DEPUTY CHAIRMAN** - You would maintain the standard required; you would not want to lower the standard for those coming here to work?

**Mr JONES** - I do not know what the standard is. Twenty years ago, if I needed a heart replacement, would I have been able to get it done by a man named Christian Barnard, who had South African qualifications, assuming we would let him into the country? So what are qualifications?

**DEPUTY CHAIRMAN** - The Australian Medical Association have certain standards that you must meet before you can enter the Commonwealth.

**Mr JONES** - Yes, and I do not see a lot of difference between the medical councils and the maritime unions of Australia; both enjoy a monopoly and they are milking it to the best of their ability for the benefit of their members.

**Mr SQUIBB** - Mr Jones referred earlier to the doctors who were currently on the southern end of the east coast, are they fully registered or are they -

**Mr JONES** - No, I do not know. It is appropriate to mention a name - no, I will not do it. The present medical practitioner in Triabunna - who serves Triabunna, Orford - was of South African nationality. I do not know what his qualifications are or where they were gained but the man has a very good reputation and I think that reputation is all important. I can think of some medical practitioners in another part of the State and as one man said, 'So and so doctor is a damned good doctor to go to as long as you're not sick'. One does wonder: how do I, as a farmer, judge the expertise of a medical practitioner? I suppose I learned to judge the competency of veterinary surgeons because I employed them from time to time, so I suppose I could make my own assessment of the quality of the service provided by a medical practitioner. But I do not know what exactly is meant by 'qualifications'. After all, there is a whole world that is treated by doctors who have not enjoyed the benefits of being registered under the qualifications here and people seem to survive or not survive as providence disposes.

Is a Russian doctor going to be any less competent than an English doctor who can enjoy I think, almost automatic registration here? Is a German doctor any less qualified? I do not know you see but one of the points I made, Sir, is that it is probable that any doctor is better than no doctor and not everybody needs a brain surgeon or a heart surgeon. It just so happened that yesterday my wife dropped a pair of scissors and stabbed her ankle. She ought to get a tetanus shot and it just so happened in the same day I walked into the tow bar of a car outside a church and I knocked my shin and I really ought to get a tetanus shot. Well, because I am here today we are putting that off but we ask ourselves, would we worry the doctor in Triabunna for a needle? But it does not need to be a qualified brain surgeon or a heart surgeon or an orthopaedic surgeon to say, 'Yes, you really ought to have a tetanus shot' and poke a needle into us. Any doctor is better than no doctor when there is none.

**Mr SQUIBB** - Through you, Mr Chairman, is there any indication Mr Jones of how many people from this area where you live would adopt the same attitude, rather than going to the doctor at Triabunna would come to Sorell or even more so to Hobart? Is there much evidence of that that you are aware of?

**Mr JONES -** I do not know the full evidence but there are some people who cannot get on the books of the Triabunna doctor, this is what they tell me; he will not take any more patients. We were fortunate when we went there that we went to the two doctors that were there, one left. No I cannot help you there.

**DEPUTY CHAIRMAN -** Well, Mr Jones, if you have no other evidence to give we would like to thank you very much for attending today. Your comments certainly will be noted and when the committee is making its report they will be taken into account. Thank you very much for your attendance.

**Mr JONES -** Thank you, Mr Deputy Chairman, and thank you for taking the time to see me and to hear me and may I also thank the members of the staff that I have had brief dealings with, the courtesy and helpfulness of them is notable.

**THE WITNESS WITHDREW**.

**Mr VICTOR JOHN McLAGLEN**, RETIRED POLICE OFFICER, WAS CALLED, MADE THE SOLEMN DECLARATION AND WAS EXAMINED.

**DEPUTY CHAIRMAN** (Mr Loone) - Thank you for appearing before the committee Mr McLaglen and giving your time to meet with us this morning. Before you address the committee you might just mention your name and your address and your occupation and if you would like to make your presentation to us, the committee will follow up with any questions that may arise.

**Mr McLAGLEN -** Thank you, Sir. My name is Victor John McLaglen. I am a retired police officer and formerly served in the South Australian police force. I retired from South Australia to Tasmania five years ago almost to the day; I arrived here on 25 March, 1993.

I believe all you gentlemen would have a copy of my submission. I only have a few things to add to that submission. Firstly, I did not advert in my submission to the fact that Dr Girgis - perhaps I should mention at the outset that I am interested in Dover because that is close to where I live, that is where I would normally receive any medical attention I require. As stated in my submission there have been numerous doctors since I have been there. There has been a relentless procession of temporary appointments; some of them, as I have stated, of quite dubious quality which in some cases has led to quite life-threatening situations. Perhaps one of the problems being that the temporary doctors are not familiar with their patients' histories.

To give an example of that, my wife, for instance, suffers with hypertension and she attended one of the temporary doctors with her blood pressure and upon coming out of the surgery I asked her what her blood pressure was and she said, 'I don't know, he hasn't taken my blood pressure'. So the matron that was present at the time immediately took my wife and took her blood pressure which was some horrific 216 over 110. So the matron advised that she go immediately to see another doctor and so it meant travelling then to another town and seeing a doctor at Geeveston where her medication was immediately doubled.

That is the sort of thing that can arise with temporary appointments of short duration. I think in all in the five years I have been there, there have been either twelve or fourteen temporary appointments and I do not think that this is fair to any rural community to have this situation. There have been periods of course when there has been no doctor at all to service the Dover area and people have had to go to Huonville or Geeveston where they grossly overload the doctors in those locations.

There have been several other instances of quite life-threatening situations. One of my neighbours attended with pains in his chest - he had had a triple by-pass - and without even putting a stethoscope on him or making any actual physical examination, the temporary doctor decided that he was suffering from indigestion and sent him with a prescription for some antacid. A few hours later he had to be whizzed off to Hobart with a severe heart condition - I think it was about four and a half hours later. No rural community should have to tolerate that standard of medical practice and the only way it can be redressed is by having a permanently appointed doctor.

At the moment we have a quite marvellous temporary appointment, Dr Khayrat Girgis, who is an overseas-trained medical practitioner. He obtained his degree at the University of Cairo and then subsequently obtained a post graduate degree in ophthalmology at the Dublin University.

Dr Girgis has served a number of years in Africa doing exactly the same job as Fred Hollows, mainly corneal transplants and attending to other eye ailments, plus general practice in Zambia and other countries. Of course we hold up Fred Hollows as virtually a national hero and yet Dr Girgis, who was doing exactly the same thing, is finding it impossible to get permanent registration here, I would say. I have not broached the matter directly with him, I have skirted around it but he obviously is a little bit reluctant to be absolutely forthcoming on the matter and of course when I saw the terms of reference and obtained the legislation adverted to in your terms of reference, I only had to look at the Medical Practitioners Registration Act to see that you have certain punitive provisions enforcing secrecy in certain parts of that. So my ex-policeman's mind immediately suggests to me that Dr Girgis must be under some sort of agreement by which he is not able to come out in the open and address the matter of obtaining a permanent conditional registration.

That is all that we, the people of Dover would like to see - a permanent, conditional appointment of Dr Girgis to the Dover practice; conditional that he stay there for certainly a period of at least seven years.

I do not think that these appointments of overseas medical practitioners should be allowed where they are only going to be of extremely short duration and then they want to go to the cities because that does not alleviate the rural problem.

The problems in rural areas of course, as you are aware, is not confined to Tasmania. Throughout Australia, rural communities are having great difficulty in obtaining medical practitioners, and you would be as aware of this as I am. I think that we should redress it by allowing overseas-trained medical practitioners to fill these positions providing they are willing to take them up on some sort of permanent basis and I would suggest that a minimum period for such a basis would be at least seven years.

I have in my file here a little article from the *Mercury* of Tuesday 10 March this year in which it says 'Tassie population push to target wealthy retirees going grey' an apparently the State is trying to entice retirees to this State because retirees are excellent for the economy and that they are not seeking jobs, but they create jobs. But you would have to understand that most retirees who come to this State would be seeking a rural location for their residence because if they were seeking a city residence, cities on the mainland - without wishing to put anybody's nose out of joint - have far more to offer than the cities do here, both culturally and in the way of services and so on. So if you want to attract these

people to Tasmania, then you have to ensure that they have the services that elderly people will require and those of course are efficient medical services in rural locations because that is where they will be going.

The other thing that I would like to say is that the population of Dover, the whole Dover community, is a most supportive community. It is a self help community; as an example, Multicap when it was getting off the ground, received donations well in excess of $50 000 from Dover and remember there are only 800-odd people there. There have been numerous instances of excellent fundraising. The actual medical centre there, or I should say the multi-purpose centre at Dover where the doctor's surgery is located presently - it is also the hospital and medical centre of course - was, I think, 50 percent financed from local donation.

If we can get a permanent medical practitioner there of the calibre of Dr Girgis, the community will immediately get behind the centre and start to provide equipment. We do not have an x-ray machine for instance; we used to have an x-ray machine but for one reason or another, the x-ray machine was lost because no-one was actually using it any more.

That means that if people break a limb in our area, it cannot be set in the actual area. They have to be transported to Hobart, usually in considerable discomfort, to have these things done. Dr Girgis, in his African practice, has performed all these functions; he has set many limbs. As I say, we, the community, will immediately get behind the medical centre and start to do fundraising and provide equipment, but we have to have a permanent doctor first. We are not willing to make great effort and raise lots of money for equipment that then is going to simply not be used because we have do not have a permanent doctor. So everything relies in our case on the permanent appointment of Dr Girgis and I think this committee is able, through its recommendations, to pave the way for such a permanent conditional appointment. Thank you Sir.

**DEPUTY CHAIRMAN -** Just while you are talking of Dr Girgis and him being an expatriate of South Africa or Egyptian by nationality, you obviously would have talked to him and him being someone who has come to this country to further his profession, what would his feeling be if he got full registration on those terms that you suggest. Would he accept that? Have you spoken to him about a situation like that?

**Mr McLAGLEN -** I am absolutely sure that he would. He is saying 'I would love it, but I am sorry but I can't really speak to you about it', which is why I am left with the feeling that he has probably signed something with the practitioners' board here, the registration board, and he feels that it is not proper for him to advert to it.

**DEPUTY CHAIRMAN -** I note from your submission where he is living in Dover and his family is back in Sydney -

**Mr McLAGLEN -** His wife is an epidemiologist. She was the epidemiologist who actually traced down the last severe food poisoning outbreak in New South Wales to the oysters. If he had a permanent appointment here, then his family could come here. His wife being an epidemiologist would find work here in no time at all because having a view to our clean foods initiatives here in Tasmania, she would have no problem at all in finding work in that area.

**Mr SQUIBB -** If he was to receive full registration, could the reverse happen? Could he go back to Sydney?

**Mr McLAGLEN -**That is why it should be conditional; that is why it would have to be conditional. I do not think so because he tells me that he has many medical practitioner friends in New South Wales and in Queensland and, as you probably know, just a few months ago they did a protest march against failure to gain registration -

**DEPUTY CHAIRMAN -** They went on a starvation diet, didn't they? A hunger strike?

**Mr McLAGLEN -** They went on a hunger strike, yes. He says he cannot understand why so many of them flock around the cities when that is not where they are really needed and he has friends that have

gained their full registration and in the various clinics in Sydney, there is a dearth of patients. The whole thing is not working properly. He has friends he tells me that sometimes only see seven or eight patients a week, whereas here, Dr Girgiss does that in a couple of hours. I mean it is only time constraints that he does not see more.

**DEPUTY CHAIRMAN -** Talking of the Huon area, how many doctors are there in the Huon area at the moment?

**Mr McLAGLEN -** Well, first of all when we say the Huon area, we have to be a little bit circumspect here. The Huon area covers a very large area of course, geographically, and do not forget you are going to the very southernmost tip of the State, you are going down to Cockle Creek. Although there are only, I think, nine people who reside there permanently, down at the southernmost tip, you have an awful lot of holiday makers who go there and funnily enough it is holiday makers who seem to get into more trouble requiring medical attention than permanent residents. But then you have Dr Climie and I think three other doctors at Huonville; you have a doctor at Geeveston but I think all of these are being worked to capacity.

**DEPUTY CHAIRMAN** - Do they use a roster system for the Huon so that they have time off.

**Mr McLAGLEN -** I have no idea because I have nothing to do with them, I am sorry. I know that the Franklin hospital - the acute care beds there - as I understand are about to close because the doctors are not willing to service them in out of hours times. Whereas Dr Girgis - our acute care beds in Dover are constantly in use, he turns out all times of day and night. This is the problem that he is a community's dream doctor, which is why we are so anxious to hang on to him. He is always available any time of the day and night and he is just so competent that the whole thing really is ludicrous.

As you know, there was considerable consternation at the last examinations where overseas-trained medical practitioners were seeking to get their registration in Australia, in that 82 per cent of those sitting the examination failed on one question. Dr Girgis apparently was one of these people that failed in that question, which was a gynaecological question, which I understand from other medical practitioner friends of mine who have been in practice for many years that they would have been very, very hard put to have answered themself because it went into the throws of really specialist practice. It would have been outside the normal scope of competence of a normal general practitioner, bearing in mind that Dr Girgis previously passed the gynaecological paper in the examination - it just seems a bit strange.

It seems like the examinations, and indeed this is Australian medical practitioner friends of mine that say it definitely does savour of trying to keep overseas-trained medical practitioners out of practice here in South Australia (sic). It seems quite frankly like the previous witness said that the medical councils seem to be run in a manner tantamount to the wharf workers and this is not right. I think we should be fair in the matter and I think that committees like yourself, by your recommendations and then the appropriate legislation being brought in, can redress the matter and I earnestly beseech you to do so.

**DEPUTY CHAIRMAN -** Mr Harriss, have you a question?

**Mr HARRISS** - I take it during your submission to us today that you were referring to a specific section of the Medical Registration Act when you presumed that Dr Girgis was sworn to some sort of silence on the matter?

**Mr McLAGLEN -** As soon as I saw it, I immediately began to think, 'Ah, this is why he always steers around it'. Yes, there is a section in the Medical Practitioners Registration Act, it would be under division 2, Powers of the Council, it would be under division 8:

> 'A person must not -
>
> report otherwise disclose any proceedings of a committee of assessors or the Tribunal contrary to an order of that committee or the Tribunal; or

report or otherwise disclose any information in respect of the proceedings of a committee of assessors or the Tribunal contrary to an order of that committee or the Tribunal.'

**Mr HARRISS** - What section are you reading from?

**Mr McLAGLEN -** This is section 74,Failure to comply with orders. Frankly, I do not think provisions of secrecy have any place in such legislation. I think secrecy has a place in military and crime intelligence but not much elsewhere. I think it creates far more problems than ever it solves.

**Mr HARRISS** - That is merely a presumption on your part?

**Mr McLAGLEN -** That is a presumption on my part. Yu would have to actually call Dr Gurgus before you to ever find out if such was the case.

**Mr HARRISS** - That is fine, it is just that we certainly have copies of that piece of legislation and I was interested for a reference.

**Mr McLAGLEN -** Yes, well unfortunately most people - the general community - cannot really read legislation. First of all you have to take the trouble to get it -

**Mr HARRISS** - It is not the most compelling reading, is it?

**Mr McLAGLEN -** And it is not the appealing reading; you have to know how to read an act of parliament to understand it properly.

**DEPUTY CHAIRMAN** - Mr McLaglen, thank you very much for your attendance today and your comments will certainly be taken note of and will be considered when we make our report; we thank you for giving your time up today.

**Mr McLAGLEN -** I thank you very much for giving me the opportunity to attend.

**THE WITNESS WITHDREW**.

**Dr JAMES KEITH BRODRIBB,** CHAIR OF THE TASMANIAN STATE COMMITTEE OF THE ROYAL AUSTRALIAN COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS WAS CALLED, MADE THE SOLEMN DECLARATION AND WAS EXAMINED.

**DEPUTY CHAIRMAN** (Mr Loone) **-** Thank you for coming to see us this morning Dr Brodribb. We appreciate you are a busy man and we are pleased you are able to give your time. Normal procedure is that if you would state your name and occupation for the *Hansard* purposes and then go ahead with your presentation to us and when you have finished your presentation the committee would like to ask you any appropriate questions, so if it is okay, you can go ahead.

**Dr BRODRIBB -** James Brodribb, medical practitioner. My role is as Chairman of the Tasmanian State Committee of the Royal Australian College of Obstetricians and Gynaecologists. We responded

to a letter from Ms Mezgailis regarding the terms of reference for the committee looking into the registration of Dr Iastrebov and there were -

**DEPUTY CHAIRMAN -** Excuse me, could I just correct you a little bit there. This is not a committee investigating Dr Iastrebov; this is a select committee to look at the registration of foreign-trained or overseas-trained doctors. Dr Iastrebov probably is the reason it was instigated, brought the problem to light, but it is not to look into Dr Iastrebov's problem.

**Dr BRODRIBB -** In relation to the Medical Registration Bill, yes.

There were some issues that we felt were important that perhaps we should have some input into, particularly in regards to the issue of looking at the registration of overseas-trained medical practitioners. There have been instances in the past, probably the most notorious in the 1930s of a medical practitioner being registered perhaps against the will of the medical profession. We were aware of the circumstances surrounding Dr Iastrebov and the difficulties related to his registration and the dealings with the College of Anaesthetists. We, in the College of Obstetricians and Gynaecologists, would have concerns in regards to overseas-trained medical practitioners being registered to practice certainly within Tasmania, but I think from the college's point of view, in Australia, where the circumstances were such that the qualifications of such a practitioner were seen by the college to not come up to the standards that the college itself has set for local postgraduate trainees.

We recognise the difficulties inherent in the provision of medical services and particularly specialist medical services in rural communities and within the College of Obstetricians and Gynaecologists we recognise that there has been a 25 per cent reduction in specialist obstetricians throughout Australia practicing in the rural community in the last five years. We recognise that it is important for rural communities to have access to specialist practitioners but at the same time we feel that it is appropriate that such practitioners at least match the standards that the Australian College require of its own trainees, otherwise it would seem to be a discriminatory act against people in rural communities to have practitioners who are seen by the Australian college not to come up to standards.

In relation to overseas-trained medical practitioners, the College of Obstetricians has a well-documented process of assessment and I am happy to provide you with a copy of the college's documents that contain not only the assessment and training protocols for overseas-trained practitioners but also for local postgraduate trainees as well. I think it is fairly clear for any specialist who has worked overseas to realise that the standards of medical practice that we maintain within Australia is the equal of anything that exists elsewhere and in many respects probably exceeds that. The climate certainly with regards to obstetrics and gynaecology, particularly the medical and legal climate, is one that necessitates the maintenance of the highest possible standards. We feel that the present system that exists, where the medical council has been provided with the responsibility of assessing and recommending the suitability of medical practitioners to practice within the State, is a good system. It does maintain standards at the highest level. Whether the community wants those standards to stay at that level is a community decision, but certainly from a medical point of view we would want those standards to stay at the highest possible level.

In obstetrics and gynaecology there is a requirement, indeed there is an imperative from our patients, that our standards are the highest. They will not accept poor standards and the rising area of concern of litigation lends support to the notion now that we have to maintain those standards. The college has an ongoing continuing medical education process that is a fairly wide ranging and all-inclusive form of continuing education that does not require examinations but requires continuing training in the areas that that practitioner practices in. In other words, if I am practicing purely as an obstetrician and I never practice for cancer surgery then it would not necessarily be expected that I am up-to-date with the most recent literature and knowledge in regard to cancer surgery, but I certainly would be required to know the basics very well and I would need to know how to make the diagnosis and it is the same with all areas, whether it be perinatal medicine, cancer or any of the others.

Our college would hope that the Parliament would see fit to continue to process of vesting the medical council with this responsibility and acknowledging situations where, in spite of needs in various communities, that people who do not match the standards of the colleges - and I talk from the point of view from the College of Obstetricians and Gynaecologists - that if those standards are not maintained

that these people should not be registered as specialist medical practitioners in accordance with the various guidelines set down by the college.

**Mr HARRISS -** Are there examples, Doctor, within RACOG, or that group having recommended to the Medical Council of conditional registration within your profession?

**Dr BRODRIBB -**Yes, conditional registration is recognised but it is usually provided with a time limit and people who are registered in that fashion would be required within a period, probably of two years, to have made arrangements with the appropriate college and from my point of view with our college to have sought assessment to their suitability to be registered as a specialist under the fellowship of our college.

**Mr SQUIBB -** So the procedure that is used for your college is an assessment rather than an examination?

**Dr BRODRIBB -** Can I give you a copy - this is really just a thumbnail sketch of the document. Perhaps if I talk my way through that diagram it might be helpful.

In normal circumstances the Australian Medical Council would have an application made for specialist recognition and there are two scenarios there: one is that they have not passed their Australian Medical Council exam or the person was not an Australian medical graduate.

**Mr SQUIBB -** Is that Australian or Australasian?

**Dr BRODRIBB -** At the moment Australian.

**Mr SQUIBB -** So you differ from most other colleges?

**Dr BRODRIBB -** We are just about probably to amalgamate with New Zealand, so that is in the process at the moment. This will apply equally to the Australasian college when it applies.

If they have passed the AMC exam or they are an Australian graduate who may have attained their postgraduate training overseas, they would apply to the Royal Australian College of Obstetricians and Gynaecologists and would undergo an assessment process. For people who are not Australian graduates and have not passed the AMC exam, they would be referred to the RACOG for assessment with two criteria: one is that they had permanent resident status or they had applied for migrant entry; the second one is that their primary medical degree should have been obtained from a medical school that is listed in the World Directory of Medical Schools. This, I daresay, is to protect people getting medical degrees for rather spurious efforts.

They would then undergo an initial assessment and that would be by the State Chairman of the Overseas-Trained Specialists interview panel and each State has been asked to provide representatives on this panel. As a result of this initial assessment, if the person was found to be of equivalent standard or close to the standard of the college they would then go to a more formal process of review with the Postgraduate Medical Education Committee and depending on that a decision would be made that they are either suitable and therefore could apply for fellowship or they may not be quite close enough but it is felt that with some short-term training, probably of a duration of two years, plus doing the membership examination, if they pass those they would then be invited by the college to apply for fellowship status.

If they were not seen to approach the standards required by the college, they would then be invited to enrol in the formal training program which is six years duration. Dependent upon the performance there they would then either pass the examinations, the assessment process; if they did they would be asked to apply for fellowship and as a result of that process the Australian Medical Council would then be informed of their suitability.

**Mr HARRISS** - And at the point of your initial assessment by your State chairman, are there any provisions for what I might term as appeal rights by an aggrieved person if the assessment at that stage is a negative?

**Dr BRODRIBB -** I have been through the document and I wondered about the same thing. I have not seen anything documented that indicates a appeal process. I know that the college adheres to the process of natural justice and would certainly recognise the right of someone to have a review process going on. Now, I am talking informally here and not necessarily what is in the document.

**Mr HARRISS** - Yes.

**Dr BRODRIBB -** There are actually - I discovered four pages missing from this document, which was pointed out when we were copying it. It may very well be in that, that I overlooked it.

**Mr HARRISS** - That is fine.

**DEPUTY CHAIRMAN -** Any further questions?

**Mr SQUIBB** - I was mainly concerned about the procedure adopted by this particular college because it appears, as I have said previously, that they vary from college to college.

**Mr HARRISS** - Mr Chairman, in terms of our term of reference 3, we are to consider the procedures utilised by the AMC and the MCT and so on with particular emphasis of medical qualifications gained other than in Australia or New Zealand. That is giving this committee pretty broad scope to consider a whole range of issues and maybe even to come out with recommendations which may, for want of a better term, offend any one of the colleges or the Medical Council or the AMC. Now, obviously I cannot pre-empt anything, we are in the very early stages of taking evidence but if the committee was to recommend a new process which is contrary to the views of, in this case, your college, where would that leave the registration process for your profession in Tasmania?

**Dr BRODRIBB -** The registration process is going to be determined by Parliament if that happens and you may very well be taking on - if I read into this - an alternative way of registering. We cannot step in the way of that. I think the view of our college in regards to this in whatever happens is that this is the maintenance of standards issue, which I think is what the whole of the college's structure is, is that the standard of care provided for women either in childbirth or women's diseases is of the highest possible standard. I think that the issue that is important is where this process might lead to a form of recognition of specialist status that may allow people to practice who may not fulfil the criteria that this college thinks is important to maintain those standards.

**DEPUTY CHAIRMAN -** How would you view the position - this is something that is being raised and I hear it in my electorate and I guess the other members do the same - where an overseas-trained doctor arrives in Australia and he is given temporary registration for three years. He has obviously be assessed and believed to have the right qualifications to practice in a particular area for this given time. Now, at the end of that three years he does not have the right qualifications to achieve specialist registration and then is told that he has to go back to school or back to university and study for three years and he is taken out of the system. Over that three years of temporary registration he has had an exemplary record, he has met all the standards that are required and for all intents and purposes he has measures up. Why is it that it is not possible then for a panel of, say, his peers in the particular area of which has expertise, to sit in judgment of him for his registration as a specialist rather than be lost to practising for three years? Did I make myself clear?

**Mr SQUIBB** - Only to be replaced more likely by another overseas -

**DEPUTY CHAIRMAN -** To be replaced probably by someone of less qualifications?

**Dr BRODRIBB -** I recognise the difficulty and I recognise the fact that this situation has arisen in Tasmania in the past. I can only say that, firstly, I do not fully understand the process of temporary registration with, say, the Tasmanian Medical Council. I do not know what criteria they use. It is an area which I am sorry that I did not speak to one of the members of the Tasmanian Medical Council.

The answer is that in terms of the college is that if a committee of his peers has been asked to review his performance and his training credentials, because temporary registration is not necessarily related

to our particular college, that is a decision made by the employing authority and by the Medical Council.

**DEPUTY CHAIRMAN -** But to have achieved that temporary registration he must have met pretty stringent qualification standards.

**Dr BRODRIBB -** I can understand that. That is why I say I do not understand what the Tasmanian Medical Council's requirements are in regard to temporary registration.

One of the difficulties is that often people will practise in isolation from most of their peers so that the situations where this has arisen has often been where people have been out in rural communities. Within certainly the greater Hobart area and the Launceston area it would become very clear very quickly as to whether someone was of suitable standards because we work with our peers all the time.

I cannot give you an answer to that because I think there are issues related to temporary registration that I am not aware of. Our view though is important in the sense that the college would recognise that they have a two-year period within which they would have to apply for registration or fellowship registration and assessment I do not think at the moment, in terms of obstetrics and gynaecology, that I can think of any instance where that has arisen so we have not had practical experience of the difficulty.

If a committee of peers rejected that person's qualifications then my interpretation of that would be that there would be very sound reasons why they have done it. The difficulty would be the isolation that most of these people practise in. If I think of the general practitioner episodes that have occurred in Tasmania where they are usually solo practitioners in rural communities.

**Mr SQUIBB** - Just generally, I am not speaking necessarily in regard to your specialist college, several witnesses, albeit community witnesses, have promoted the idea of a permanent conditional registration. I guess an extension of these two or three-year temporary ones that we have at the moment. If a way could be found around the alleged conflict with mutual recognition, what would your opinion be in regard to the granting of permanent conditional registrations?

**Dr BRODRIBB -** I think that is fence sitting, that is the first thing. People are either suitable or not suitable. I think one of the processes that I would see personally is that if you are going to have conditional registration it is conditional on a number of conditions and one of those would be supervision. I think this is where the issue of suitability of the practitioner will rapidly become clear if there is a supervisor for this person, a ... counsellor or whatever we call that person, but I would have thought that conditional registration is conditional upon conditional supervision.

**Mr SQUIBB** - I am not sure that it is fence sitting because the situation we have at the moment obviously, as Mr Harriss pointed out earlier, people are receiving conditional registration.

**Dr BRODRIBB -** I well understand that. Are you talking about permanent?

**Mr SQUIBB** - Yes, making those positions permanent but still applying conditions so that it is never regarded as being full registration.

**Dr BRODRIBB -** I personally have difficulties with this. I think that if you recognise that someone has the ability to practise and continue to practise and to continue to practise in the area of their expertise without receiving the negative comments from the particular college then I think it would be very hard to understand why that person is not receiving full recognition.

**Mr SQUIBB** - But some colleges require more than just peer assessment to grant that full registration. It is a matter of doing examinations which are not possible from the particular location in which their temporary registration employs them.

**Dr BRODRIBB -** I think it is incumbent upon the person who is actually the medical practitioner to make it their business to do it. After all, it is in their interests to do it. It is exactly the same as the rural practitioners have in my college. They must fulfil requirements for continuing medical education and

that means that they leave their community, probably without an obstetrician, to attain the appropriate recognition points to continue as a specialist. This is recognised as a major difficulty within the college to the point that people leave rural practice and it has been addressed by the college in an attempt to provide short term locums for these people to get away, even to do some more training in hospitals should they need to do it. At the moment that is not a problem because they are a very competent group of people but I think it is incumbent upon the medical practitioner to make those facilities available. After all, it is in that person's interests to receive recognition as a practitioner in either general practice or in a specialist medical practice. I do not think that it is the community's responsibility. I think it is the individual practitioner's responsibility in exactly the same way it is for a practitioner who is training as a specialist to go through the required training programs or assessment programs. The program does not go to them, they go to the program.

**DEPUTY CHAIRMAN -** Well, Dr Brodribb, thank you very much for your attendance. We appreciate you making yourself available and we assure you your comments will be taken into consideration when we make our report.

**THE WITNESS WITHDREW**.

**Mr GLENN GRAEME DOYLE**, MANAGER, COMMUNITY SERVICES, HUON VALLEY COUNCIL WAS CALLED, MADE THE SOLEMN DECLARATION AND WAS EXAMINED.

**CHAIRMAN** (Mr Wilkinson) - Glenn, thanks for coming along. Could I ask that you state your full name and address please?

**Mr DOYLE -** My name is Glenn Doyle, I am the Manager of Community Services for the Huon Valley Council, my residential address is 27 Braeside Road, Franklin.

**CHAIRMAN -** As you know, we are here to take evidence in relation to the Overseas Medical Practitioners Bill. You have sent a report to us. We have been through that report and please give your evidence in any way you feel most comfortable.

**Mr DOYLE -** Firstly, can I record an apology for Mayor Greg Norris who is out of the State at this time. I guess that the majority of what I have to say probably comes in under clause 9 of your terms of reference because I acknowledge that council's primary concern is the recruitment and retention of doctors to rural areas and it is hard, if not impossible perhaps, for us at least to differentiate between that dilemma and that of overseas-trained doctors and the registration that goes with that.

Can I also say that I am a non-medical person, my sole experience with doctors was visiting them, until becoming involved with the multipurpose health centre at Dover and what that has brought forward.

I think a Dover resident appeared before you this morning, Mr Chairman, and gave evidence with regard to Dover. As I go through perhaps there will be some of that information I might touch on and for the purpose of accurate record make comment on.

Dover, like many rural areas in this State and in fact the country, has had its difficulties in as much as there was a doctor who served at Dover for donkey's years and when that doctor decided that it was time to have a spell, finding a replacement has not proved that easy. Dover was fortunate to obtain funding for a multipurpose health centre and contained within that centre was a doctor's practice and because council own and manage that facility council had an interest in the recruitment and retention of doctors and it is certainly something that the community have been very concerned about.

On the local government front generally, I have fairly close contact with five of my colleagues in other council areas who are increasingly becoming more involved in the rural doctor issue and overseas trained does touch on that. We are well aware of the circumstances on the mainland and also local government's involvement in playing a role.

As far as overseas-trained doctors are concerned we find that if, having identified a vacancy - whether it be in a rural area or an urban area - the Internet seems to be the best way to publicise that vacancy and it does attract overseas interest.

The difficulty we have is with the imbalance of provision of doctors, as we are told that exists across the nation, and I guess that the Huon Valley, to some extent, is representative of that. The Huon Valley in itself has ten doctors and in looking at it from the outside you would think, well, that is plenty. The difficulty is seven of them are based in Huonville and there are then three solo practices: one at Dover, one at Geeveston and one at Cygnet.

The Dover is the one that is at issue and I guess the main subject of my submission to you, but both Cygnet and Geeveston have solo practices with doctors who are heavily worked and there is a fear that at any time those practices could also become vacant.

There is a preparedness to some extent for the doctors to work collectively and support each other but there is a limit to how much that support will go and we find that in the area of Dover in particular it is too far away for them to appropriately service after hours calls. So there is some degree of working together within the medical fraternity in an area like ours but it has its limitations.

We also find that the changes that Dr Sparrow has probably given you better information than I on, with regard to trying to sort out this overseas-trained doctor business has made it more difficult. We had experience recently of negotiating and, as my submission says, with a chap who was practising in New Zealand, having obtained his initial registration in South Africa. The process that is involved now in negotiating to get somebody in on a temporary work permit and temporary registration, let alone permanent registration, is horrific and I think designed so as to try to encourage those practising in the city to actually go into the country. To give you an example, Mr Chairman, it is necessary to obtain a work visa, it is necessary to obtain obviously registration, it is necessary to obtain a ministerial exemption under the legislation so that a provider number can be allocated. A provider number is necessary so that the doctor when coming in can get access to Medicare.

That is very much an interesting process and very individualised in as much as none of the four sections tend to talk each other and you find yourself going from one to the other.

**CHAIRMAN -** Is that the point three, if I can just cut in, when you say the ministerial exemption for provider number; is that what you are saying, that is the difficult part, you find one service going to another and then back to the other one?

**Mr DOYLE -** Yes, very much so.

**CHAIRMAN -** So it is not the work visa or not the registration, it is mainly number 3.

**Mr DOYLE -** I think it is collective.

**CHAIRMAN -** Right.

**Mr DOYLE -** Very few of each of them know what the other's role is and if you persevere for long enough and are happy to meet the cost of long distance telephone calls to Canberra you can generally track down somebody that has a handle on it but it is not easy and the tendency for conflicting information is horrific. As I say again, I am only talking about trying to secure someone for perhaps two years on a temporary work visa. So there is an opportunity there, I think, for an enormous amount of streamlining at a Federal level to make it easier for communities.

With regard to a person like the current incumbent at Dover, there was a cloak of secrecy referred to this morning and I tend to think that is not in any way a legislative requirement but more a choice by

the incumbent. I think if you were a doctor, perhaps a highly credential doctor overseas, the last thing you would want is for your local community to be knowing that you are having difficulties passing an exam, in a current situation; none the least it could have a direct impact on your business, particularly in a small community. So I think that is a point worth noting.

For the record, there has been some nine doctors at Dover, not fourteen, and Dover has not been at any time without a doctor apart from the occasional weekend break which might be taken. I would suggest to you that is through the efforts of council rather than anything else but I would like to make that point.

**Mr LOONE** - Did you say there was nine doctors over a period of five years as the other gentleman -

**Mr DOYLE -** Correct, yes.

**CHAIRMAN -** Who takes over the position when a doctor is away on holidays? Does the fellow from Geeveston go down or do you get somebody from Huonville or do you have to get somebody from town to do that?

**Mr DOYLE -** Currently, as the present chap is a self-employed practitioner receiving albeit support, he makes his own arrangements with regard to a replacement locum. In fact he is in Sydney at the moment with his family and undertaking his fourth attempt at the Australian medical exam as we speak - that is the first component. He arranged for the engagement of a locum to cover himself in his absence. If he had not been able to take that step council would have become involved in getting a locum in.

The other doctors in the valley do not consider that they have the capacity to actually extend themselves into Dover so it is necessary to bring someone in from outside.

**CHAIRMAN -** And paying for the locum, does he do that himself or does the council help?

**Mr DOYLE -** A mixture of each, council has in the past helped. This time he is meeting the costs with some assistance from the Tasmanian Rural Doctors Incentive Program which, I might add, is the only assistance available to him. If I can I would like to touch on the Rural Doctors Incentive Program in a moment.

The difficulty that our chap has faced is that he tells me that he considers the goal posts change. As I have said, he has unsuccessfully sat the AMC a couple of times and finds that it is becoming more increasingly difficult to actually pass it because it is perceived at least that it is purposely made more difficult so as the number of provider numbers in the country are lessened to try and encourage doctors back into rural areas. That is his determination. I take his word on that.

The other thing we have found is that previously, on the two earlier occasions when he has attempted the exam at Dover, he has been in practice trying to maintain a practice, provide after hours and study. That is why this time we supported him in taking a break to see if he could get it under his belt.

The other issue with overseas-trained GPs - and there is some confusion in my mind - I understood from the Tasmanian Medical Council that there was a two-year limit in which overseas-trained GPs would have to secure at least the first component of their AMC and that limit was to expire - a two-year limit or by 31 December 1998 - and council have the present incumbent contracted to that December 1998 timeframe. I notice in the submission put to you by Dr Sparrow there is some different information there and I will need to pursue that because there is a suggestion there that they do in fact have until December 2001, so that could give us some breathing space for us.

But there is no doubt about it when you put a position on Internet, overwhelmingly the people who express the most interest are overseas-trained and can I say to you the ones that seem most interested in coming to serve a community without necessarily investigating the financial aspects first, are those that come from overseas.

**CHAIRMAN -** Any special country?

**MR DOYLE -** No. We have had interest from certainly Egypt, some from England. Not a lot of interest from America. I do not recall any American interest, but otherwise just general. A lot of inquiries that do not proceed when they are referred to the respective authorities to see what is involved, but there is no doubt if I get interest from an Australian-registered GP, there is much more economic investigation done in the first instance.

I am not sure if there is anything I can directly add as far as overseas-trained are concerned other than that information and that that is in my submission but if you would permit me, with regard to rural doctors generally - and I know you people represent rural areas that are suffering various forms of decline. It is certainly the case that a community might be prepared to see its banking facilities go and maybe even its council but they will scream blue murder if somebody takes away their doctor and so it is a situation that is a real one and in Tasmania probably one that we do have a hope of fixing because whilst it is rural to us and isolated to us, it not in the mainland context and I think with some appropriate consideration, Tassie could be a fixable unit.

I understand from the Rural Doctors Incentive Group that there are probably some fourteen or sixteen practices around the State that are considered to be either vacant or under threat. Cygnet, for instance, is one of those that does have a doctor but is very much worked to the limit and what happens when he goes.

I think the Rural Doctors Incentive Program is an excellent opportunity but I think it is far too rigid at the moment to ever be any good. For instance there is $50 000 recurrent assistance available to a doctor who might come to Dover but that doctor needs to be fully registered, be vocationally registered and suit all the appropriate criteria. An overseas-trained doctor does not have a hope.

**CHAIRMAN -** So they would get no assistance?

**Mr DOYLE -** No. Not only do they not get no assistance, because they are not vocationally registered, they get a lesser Medicare rebate so it is a doubly whammy is you like.

**Mr HARRISS -** No sliding scale?

**Mr DOYLE -** No. I am aware, having said that, the Rural Doctors Incentive Program is under review and there are some new guidelines to come out shortly which I hope will add to the flexibility and make it so as it can actually achieve its aims a lot better.

**CHAIRMAN -** Do you believe that that would be one of the areas that this problem can be fixed, if the Rural Doctors Incentive Program was loosened so these overseas-trained doctors could also get their hands on this $50 000 assistance if they needed it.

**Mr DOYLE -** Can I say to you that it would take an awful lot of pressure off local government because at the moment councils are the ones that are footing the bill. They certainly have in the case of Huon Valley; I know Glamorgan, Spring Bay and Central Highlands in northern midlands have all had to put hands into their pockets. The sad part is that there must be a budget somewhere with $50 000 for each of those areas because they are identified as being areas of need and my argument has been very strongly to them that if you are not spending it because we do not have a doctor who meets your requirements, give it to us anyway so that we can keep somebody here.

**Mr LOONE -** That $50 000, is that a one-off grant or is that over a period?

**Mr DOYLE -**There are conditions that are attached to it. The doctor needs to stay for a prescribed period and so forth. My understanding is it is $50 000 per annum and there is also a one-off $20 000 relocation grant. So flexibility there would be good.

The other issue that I have touched on in my submission and one that is supported very strongly by my other local government colleagues, but perhaps not so much by the AMA, is the allocation of geographical provider numbers. Rather than having a provider number to each person, which effectively enables them to practice wherever they like, put the provider numbers on the areas which is the case with pharmacists. The pharmaceutical industry went through a similar process; now to set up a

chemist shop at a given spot, you need to get approval for that spot. I understand there is some political desire to go down that track but it is a pretty torturous one so whether or not we will get there, I am not sure.

Just to touch on issues such as x-ray machines and the like, which was referred to earlier, I think needs to be taken in context. It is a bit of a chicken and egg thing. You need sufficient equipment to attract a doctor but what is the use of having that equipment if you cannot get a doctor, so which comes first, the doctor or the equipment. I think there is a degree of medical equipment, from my experience, which is certainly appropriate and useable by registered nurses in the absence of a doctor. I think when you look at x-ray machines and the like, you need then to look at what radiologists are about or whether the doctor can use it themselves and there has never been x-ray equipment at Dover; I think it would depend on the incumbent as to whether it was ever there or not.

**CHAIRMAN -**Does the Council assist at all with the equipment?

**MrDOYLE -** Not directly. Council has been instrumental in securing some grants for equipment. There is an auxiliary which works for the multi-purpose centre which has helped with equipment. Council in the past has offered a range of assistance and currently does. Presently we are offering subsidised rental for the surgery; we are offering a home, virtually rent free, and we are offering a subsidised receptionist. In the past we have offered a free motor vehicle and, as I have said in my submission, we have even gone to the extent where we have managed the medical practice and paid the doctors sessionally and that is why some rapid changeover because until we could get someone who was interested in a long tenure, we had a patchwork of locums which may have been there a fortnight or you get someone in for a month while you are sort of hunting about. It does not go down well with the local community, the lack of continuity, albeit they demand that someone be in existence.

I guess that, in round terms, really adds to the submission that I wanted to put there except to say that on Friday I had a meeting with a guy by the name of Dr Tim Haggett who comes from Western Australia and has established what is called the River Medical Group over there. He has actually established a non profit company which is involved in the recruitment and retention of rural doctors and what he does is work in partnership with local government and manages the practices and engages doctors. His view after looking at Tasmania - and he rang me on Saturday night after visiting Dover - was that Tasmania could easily be fixed with the establishment of that sort of collective -

**Mr SQUIBB** - What was the name of that again?

**Mr DOYLE -** It is the River Medical Group and Dr Tim Haggett.

**Mr HARRISS** - There was an article in the *Examiner* last Thursday.

**Mr DOYLE -** He has a very keen interest in Tasmania. If I can, Mr Chairman, my understanding of it basically is that his group comes in, manages the practice, they recruit the doctors in, they have a set cost that is associated with the management of the practice; all the money that the practice earns goes into an account, the operating costs come out and what is left in there is the doctors.

So he calls it, to quote him, I think, was 'the suitcase practice' in as much as they can arrive in town with their suitcase and they are ready to go. He looks to local government to provide a house and a car and the financial arrangement with the doctor is as I have described it. He then looks though to someone to offer funding to cover his overhead costs, that is the operation of his business and his own costs. Local government play that role in Western Australia; he is looking to the Rural Doctors Incentive Program perhaps to be more effective in Tassie but he believes that Tasmania's problems could be fairly well addressed by a similar sort of move. I understand that he is going to maintain an interest in Tasmania and see what develops so that could be a positive outcome.

It means you still have the overseas-trained problem but he handles that and has a level of expertise in that area.

**CHAIRMAN -** So obviously it would seem if an overseas person wanted to come to Australia what they would do is write to him, he finds the area of need and then he does the leg work to endeavour to

get that doctor to Australia or to Tasmania to work in that area of need? He is like an agent.

**Mr DOYLE -** Virtually. I think too that he actually recruits people on a short term so he is not looking at any long-term registration of overseas-trained doctors so he is not upsetting Michael Wooldridge and his colleagues by bringing in additional doctors for additional provider numbers; he is making a short-term fix which could be helpful.

**Mr SQUIBB** - How popular is that with patients? We heard this morning, I think from the person who gave evidence from your area, that there is a need to have continuity and there is client opposition to short-term appointments.

**Mr DOYLE -** I raised that very question with Tim Haggett. He says that in his experience it has been fine and I guess to put it in context, he is talking about recruiting people in for two years whereas Vic's comments this morning related to locums that may have been in the area as short as two or three weeks. So I think a couple of years, there is a better acceptance.

The other thing that Tim Haggett did say is that he pushes for an appropriate overlap where there might be two or three days for an exchange of information whereas we could not afford that; we tended to ship one out and then bring the other one in.

**Mr LOONE** - Just one thing I wanted to enlarge on, the provider number - you floated the idea about the provider number being allocated for each particular area, has anything been done on that? Have you had any discussion with anybody else on that as to what the feeling would be? To me that sounds an excellent concept.

**Mr DOYLE -** We thought so and our council lobbied each of the Federal representatives quite extensively and I am aware that the Northern Midlands and the Central Highland councils have as well.

The answer we got back, after some consideration, was the AMA considered it to be unconstitutional in as much as it was restricting trade practice and they were not happy with the suggestion at all.

**Mr SQUIBB** - That is strange coming from them.

**Mr LOONE** - It is so, isn't it?

**CHAIRMAN -** Have you found the AMA to be obstructive more than of assistance to you?

**Mr DOYLE -** I have not necessarily had a great deal of dealings directly with the AMA, my dealings have been more with the Tasmanian Medical Council and the State authorities, although it does seem to me that overseas-trained doctors tend to get the cold shoulder. There is a reliance on communities like ours to do the leg work rather than anyone in professional network and I think if communities such as ours did not do the leg work, then other people perhaps would be quite happy to leave them out. The difficulty is that the doctors in city-based practices do not seem to have the interest in rural practices.

**CHAIRMAN -** I know a couple of mates of mine have been in rural medicine and when they wanted to go away for a week or two weeks, what has happened is they have got a friend of theirs from the city to go down and take their practice over for that period of time. Have you found that that occurs, or if it did occur there would not be the problem that there is now, partially?

**Mr DOYLE -** It does occur to a degree and there is becoming a very well-established group of professional locums. It seems to me that a doctor might get to 55 or 60 and decide that instead of being tied to the one practice now, he and his wife will effectively go on a working holiday and they can pick up a locum shift right around the country and look around. To me, my experience has been that sort of locum coming in rather than necessarily a friend from elsewhere.

**Mr LOONE** - Is the pool fairly buoyant with the locum, are they easily obtained?

**Mr DOYLE -** It depends on the time. I have had experience where you can obtain easily a Tasmanian locum but I have also had experience where I have had to negotiate quite hard and substantially with

mainland ones that have virtually held me to ransom and said, 'Well look you meet my demands or I can easily go to Broken Hill tomorrow' sort of thing, so it depends on the timing. Over the summer is the worst.

**Mr SQUIBB** - It would appear from your comments that mutual recognition in fact has worked against the best interests of regional and rural Tasmania rather than in support of it, as was claimed at the time that that legislation was being debated.

**Mr DOYLE -** Can I answer in this way, Geoff, that each time we have a vacancy at Dover - and vacancies have been existing, as I said in my submission, for some time now - it is getting progressively more difficult, progressively more complicated and more legislated to get anyone in.

**Mr SQUIBB** - That is Australian-qualified?

**Mr DOYLE** - Either.

**Mr SQUIBB** - Full stop.

**Mr DOYLE -** Full stop. Each time, as I said in my submission, we went through a process and then had the chap come from England for twelve months and I thought, well good, 12 months will give it a chance to all settle down and we will all be able to get back to normal life only to find that when he went back to England it was worse than it ever was and I think today it is worse than it was when he left. So it is not helping, no.

**CHAIRMAN -** Would it be fair to say that the real difficulty that you have getting overseas doctors is this red tape that you have to get through before they come, that is after they make the initial request. But in relation to your Australian doctors, it is not the red tape because they are already a specialist in their field so therefore it is just getting them down here and offering them enough incentives and back-up to be able to work in the rural areas. Is that a fair summary?

**Mr DOYLE -** It is a very fair summary.

**Mr SQUIBB** - Are they prepared to come on the basis of a two year tenure?

**Mr DOYLE -** Which ones?

**Mr SQUIBB** - The overseas ones - or is that a drawback?

**Mr DOYLE -** It is horses for courses. Some of them, like the chap who came from England for twelve months - he and his wife came out virtually on a working holiday and it was a difficult process but we got them here. This ten years of working in private practice is crazy. If somebody wants to come out and be an overseas-trained doctor and be permanent, they expect them to disappear into a system somewhere for ten years before they can actually go into solo practice and in reality that is crazy, it will never happen. So really the choices, I think, for overseas-trained people coming in now, if they are freshly coming in, are to come for two years to have a look at the place and then make that their tenure. For anyone that is here, like our current chap, who is trying to get registered, is caught in the middle.

I can understand if we have too many provider numbers in Australia, that they do not want anyone coming in from overseas, except for maybe the two year people, but the dilemma is, no doubt like your north-west person and ours in the south, they are caught in it because they exist; they are not here for two years, they are here with their family.

**CHAIRMAN -** The fellow that you are talking about, the Egyptian fellow who has a very good name down in the Dover area, as you will be aware, has tried to pass the exam on three different occasions and this is his fourth try -

**Mr DOYLE -** That is my understanding, yes.

**CHAIRMAN -** Has he spoken with you at all on why he believed he failed? Did he believe that he passed but they were harder on him than others?

**Mr DOYLE -** Yes, it is a difficult situation to broach with him but I have and each time he has been unsuccessful he is more amenable to talk about it. He tells me that they are increasingly raising the pass mark. I thought maybe there could have been a language barrier but he assures me there was not. He puts it down to, as I said earlier, being busy and trying to maintain the practice and after-hours coverage, which hopefully we have addressed this time, but certainly he feels that it is being progressively more difficult to get through, not necessarily I do not think for him alone, but just generally making it tougher.

**Mr HARRISS** - Just one part there Glenn, you mentioned in your submission that Dr Gurgis has to satisfactorily sit each component.

**Mr DOYLE -** Yes.

**Mr HARRISS** - I guess I am going to need to come up to speed with how that all occurs but that suggests there is a process rather than just come in and sit the one exam and if you pass it you are up and running.

**Mr DOYLE -** That is right, Paul. As you know I am not clinical but my understanding of it it is a two part process. The first part is a written exam which comprises of multiple choice questions, you need to get through that.

The second part then is a clinical component where you are actually observed undertaking procedures and the like and there is a time frame from achieving the first part to achieving the second part. You need to get both components before you are able to be fully registered.

You then need to go on and do further training in what I think is called the family medicine program to become vocationally registered, which then makes you eligible for a rural doctor's incentive funding.

**Mr HARRISS** - Yes, thanks, I am probably going to need to come up to speed but that is a real subject.

The other thing the Chairman has already reinforced, you made a comment probably using your words along the lines of the goal posts seem to change such that Australian-qualified and resident doctors have their profession, if you like, somewhat protected. That might be okay but you are still in this dilemma out in the rural areas that even those people do not want to go to the remote/rural areas. So you still have a problem and you are aware of a number that you have already mentioned where they just cannot be attracted.

**Mr DOYLE -** Very much so and as I said earlier maybe it is simply my experience but my experience has certainly been that those that meet all the eligibility criteria as far as registration is concerned tend to have their hand out with their arm extended much, much more than those who come from overseas. I am aware that the Rural Doctors Association has a list of requirements that their members need but there are issues like after hours back-up and equipment and provision of accommodation and all those things.

**CHAIRMAN -** What happens in Dover when the doctor is not there and you do not have a back-up?

**Mr DOYLE -** At the moment we are lucky because we have the multi-purpose centre. What happens, any after hours attendance comes to the multi-purpose centre; there is a registered nurse on twenty-four hours of the day. So they come in and the nurse does some triaging and will make a decision. The person can either take a Panadol and come back tomorrow when the doctor is there, she can assess it and decide that it is something that should be referred to the doctor - she always knows where he is - or the third thing is she recognises that it is an acute situation and she will send them on, by ambulance if necessary, to Hobart.

In knowing where that doctor is - if for instance he is in Sydney - she will take the appropriate action of either referring them on to the next nearest GP or shooting them through to Hobart, so that is the first port of call.

We took that deliberately because there was a lot of concern in the early days by doctors who were getting rung up all through the night. We have educated the community now and said to the community, 'Look you cannot drive these people out of town; if you want to keep them, work with us' and so we steer them into the centre where there is somebody at work who can do that.

**CHAIRMAN -** Drive the nurse out of town.

*Laughter.*

**Mr DOYLE -** Well, she is getting paid so it does take the pressure off the doctor and his family and also gives them a break.

**CHAIRMAN -** And do you find that the nurses themselves because of the, it would seem - not being disrespectful to the ones in the cities - there is added pressure upon them to make the right decision in the first place. Do you find that they are a dying breed as well? There are not as many nurses going out into the country because of the problems that they have really taking all the pressure themselves to make that decision as to whether it is serious or not.

**Mr DOYLE -** I could write you a whole new submission, Mr Chairman, on the difficulty in recruiting nurses to rural areas.

**CHAIRMAN -** Right, so it is not just doctors?

**Mr DOYLE -** It goes right across all allied health professionals but certainly the average age of our registered nurses at Dover would be late fifties and that is not uncommon with a lot of rural areas in Tasmania.

I am not sure that it is necessarily associated with the added pressure. There is more clinical challenge in the cities with all the gear and it is a different lifestyle, professional sort of thing. Certainly one of our priorities, as an employer of the nurses, has been the need to provide adequate doctor back-up to them because they are exposed to all sorts of liability issues. If there is not a doctor and they need to act in a life-threatening situation, there is the possibility of nurse practitioners where nurses can up-skill to administer medication and the like, as is the case on Bruny Island and there are opportunities there.

**CHAIRMAN -** Thank you very much, Glenn. I do not know whether there are any other questions but thanks for coming along and thanks for your interest. It is a problem and I suppose what we have to do is to make sure that there is a balance because on the one hand we have to make sure, I think, that the doctors are of the high quality that we know they are within Australia and they remain to be so and the other one is that the country areas have to be looked after and looked after with the same expertise as the city areas. That is the difficult point that we have to look at.

**Mr DOYLE -** It is a dilemma that we acknowledge and we as a council have sat down at times and said, 'Are we better off with one that is not up to scratch or are you better to have none at all and make alternative arrangements'. We really are reliant on the registration authorities to make those decisions for us and can only make the comments at arms length to it really.

I can, if you like, send some information with regard to Tim Haggett through to Inta if you are interested in it.

**CHAIRMAN -** Yes please. Thank you for your time.

**THE WITNESS WITHDREW**.