THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON THE REGISTRATION OF OVERSEAS-TRAINED MEDICAL PRACTITIONERS MET ON WEDNESDAY, 17 JUNE 1998 IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART.

Mr IAN FRANK, EXECUTIVE OFFICER, AND **Dr KERRY J. BREEN**, PRESIDENT, AUSTRALIAN MEDICAL COUNCIL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIRMAN (Mr Wilkinson) - Thank you for coming, gentlemen. Prior to starting, would you please state your full name, address, and occupation and in what capacity you are before us today?

Dr BREEN - My full name is Kerry John Breen. My professional address is 55 Victoria Parade, Fitzroy in Melbourne. I am currently serving as President of the Medical Practitioners Board of Victoria and the nominee of that board on the Australian Medical Council. For the last six months I have served as President of the Australian Medical Council.

Mr FRANK - My name is Ian ... Frank and my address is 13 Napier Close, Deakin in the ACT. I am currently the executive officer of the Australian Medical Council and I have had that position since 1990.

CHAIRMAN - I have read the submission, thank you, and I wondered whether you wanted to take us through that and draw us to any particular point in it or put your submission in any way you feel most comfortable.

Dr BREEN - I would just like to make one introductory brief remark, if I could, and then invite Mr Frank to highlight a couple of parts of the submission. From a board and Australian Medical Council perspective, we are very aware of the difficult issues facing all States in terms of what we call in some States 'area-of-need registration' and some 'conditional registration'. Although our submission addresses what we perceive as the important legal and standards impediments to changes in this area, we are not unpractical people and we are very happy to have a discussion beyond our submission and if we can make useful suggestions to your select committee we would be delighted to do so.

Mr FRANK - In preparing the submission we noted the terms of reference and felt that the Australian Medical Council really could only comment specifically in relation to three of those: the implications of the proposed bill in relation to mutual recognition; the procedures and agreed national standards for assessment of overseas medical qualifications; and the extent to which the Parliament should or could become involved in the registration of individual overseas-trained practitioners. They are terms of reference, 1, 3 and 5 respectively.

In the submission we have outlined a little bit about the role and function of the Australian Medical Council to put it in some sort of context. We have also referred to the issue of medical registration in Australia, specifically in relation to the fact that each of the States and Territories have enacted over a period of a hundred or so years legislation that seeks to regulate the practice of medicine, in particular by establishing registers of those who are legally qualified to practise medicine, defining the qualifications required for registration, setting limits on clinical responsibilities through the categories of registration, defining fitness to practise and providing mechanisms for members of the community to lodge complaints and in turn for the regulatory authorities to impose sanctions or follow up on disciplinary action.

We have also referred to the issue of the assessment of overseas specialist qualifications in Australia, as well as those for general registration. The specialist assessment pathway is somewhat more recent, having been developed in about 1990 as a result of some work done with New South Wales Medical Board and the relevant specialist medical colleges. It is that process that I think bears specifically on the issue that is in relation to the proposed bill that you have.

We have also addressed the issue of the mutual recognition legislation which has, since 1993, had a fairly significant impact on all the States and Territories in that action taken by any one State or Territory to register a medical practitioner in effect impacts now on all other States and Territories because one a practitioner holds unconditional registration, for example, in one State or Territory that person is entitled to commence practice in another subject only to notifying the local authority. One of the key issues of mutual recognition that does impact on all medical boards is the fact that the legislation will override local acts, therefore a person who is registered in one jurisdiction will be entitled to practise, even though they may not meet the requirements for registration in another jurisdiction, as set out in the local practice act.

The other important aspect of mutual recognition is the fact that the whole of the Mutual Recognition Act relies on a principle of equivalence of occupations. If a dispute arises concerning a particular application, then the act states that 'an individual may be registered in another jurisdiction if the activities carried out in both jurisdictions are substantially the same'. That is section 29 of the Commonwealth Mutual Recognition Act and it is mirrored in the State acts. Why that becomes really important is that if you try to limit a category of registration to, say, a particular region that will not, we believe, have the effect of quarantining that registration because, if tested, the test supplied is really the nature of the work that is being undertaken. So if a person, for example, had a category of limited registration to work in a particular town but could work in a certain field of medicine, if that person applied for registration of mutual recognition in another State or Territory, the test is not where they are located but the test is the type of work that they are going to undertake. If the type of work they are seeking to undertake in another jurisdiction is the same as in the first jurisdiction then mutual recognition, we believe, would apply because the test is equivalence of occupation not anything to do with the location.

It is a bit difficult to take that much further because in medicine that clause has not been tested in the courts. In nursing it has been tested and there are cases involving people who are registered in New South Wales for a particular field of nursing applying for registration in the ACT and being rejected under the local acts because they did not fulfil certain criteria the local act required. They challenged on the basis of the nature of the activity being performed. Those challenges were upheld by the Administrative Appeals Tribunal and they in fact were registered in the ACT because it was tested on this equivalence of occupations.

We have commented a little about the proposed Iastrebov bill and I think that is covered there. We have raised what we believe to be some concerns about the actions of Parliament's Legislative Council to grant registration to individual practitioners. This is an issue that was looked at very closely by the full council - the Australian Medical Council - which has representatives from all the States and Territories on it. The concerns were, I think, essentially that the direct intervention by legislature in the registration of individual practitioners in effect challenges the integrity of the registration process and the independence of that process from political or other interference. That has been a fairly key feature of professional registration in this country over a number of professions for well on a hundred years.

There is also concern that the registration process is designed to assure the community that people who practise a particular profession or are registered in a particular profession have the requisite skills and knowledge to undertake that. If the registration is not based on an assessment of that competence then, in a sense, we are in effect misleading or may be misleading the community in terms of the qualifications of the individual.

There are some concerns about whether the legislative body, which is obviously an elected sovereign legislature, has in fact the expertise in assessment to determine whether somebody in fact is appropriately qualified within the context of the medical acts requiring registration to be undertaken for the purposes of protecting the community. There is a specific issue there that needs to be looked at.

Another issue of concern is that if action is taken in one jurisdiction for whatever reason, perhaps to meet a particular need in that jurisdiction, and people are being registered who do not fall within the nationally-agreed standards that have been put together over a long period of time, then in effective we are achieving a lowest common denominator principle. That undermines the efforts that are being made by health ministers and others to try to ensure that all communities in Australia have access to appropriate health care standards.

I think we would qualify that by saying that members of the council in other roles are well aware of the practical problems of delivering health services and that there has to be a balance between the standards issue and the health service delivery issue - which is something perhaps Kerry could comment on later.

CHAIRMAN - If I can just stop you there for a minute. I know I have said on a number of occasions - and that is my personal view as opposed to perhaps other members of the committee - but I have always had a problem with members of parliament acting as a de facto registration board because I think that can be dangerous as we might make a decision which is fair but it could be dangerous because it is setting a precedent and it could be a back-door method for doctors to come in and so on. That is my real concern with it: that I do not believe people who do not have the expertise should be acting as a de facto registration board.

Mr FRANK - The only other issue that perhaps we could touch on at this point is to go back to the point I referred to earlier in relation to the Mutual Recognition Bill, section 29 of the act. That is, that as we read the draft proposal, the bill, the intent was to try to restrict this particular practitioner to - or to impose conditions on a particular practitioner that he must remain in the employ of a particular hospital and is restricted to provide a certain type of service, in anaesthesia and intensive care, within Tasmania only. The point I was making before was that from what we do know of the way mutual recognition operates, that may not be possible. You may not be able to restrict something, even if that is the intent, because in practical terms it may not be possible to restrict it in that way. This means that the leakage that would occur through mutual recognition is likely to happen if the case were appealed on the grounds that we have seen in some of the other professions.

CHAIRMAN - That is the nursing profession you were speaking about?

Mr FRANK - Yes. That is the only one we know of at the moment that has been tested in this way.

CHAIRMAN - Have you had any legal advice on that?

Mr FRANK - The legal advice is that one State was looking at this and was told that it could not go ahead with this because that problem would occur. In other words, a State was endeavouring to try to lock out somebody for various reasons and was told that, 'No, it would not work. You would have to register that person' as they had been registered in another jurisdiction.

CHAIRMAN - So they would have to have full registration as opposed to this registration which would be conditional upon them to practise in an area or hospital?

Mr FRANK - Yes, because they had full registration in another jurisdiction, even though they did not meet the requirements of the local State in terms of supervised training prior to registration. They could not maintain that distinction because it was based on the equivalence of occupations and it was not defensible. Now that was not tested in a court of law; that was based on legal opinion. The nursing one was actually tested in a sense that there was a decision of the Administrative Appeals Tribunal which overturned the action of the regulatory authorities in that case.

CHAIRMAN - Have you got that case or the name of the case?

Mr FRANK - No, but I can get a reference to it and get it down to you.

CHAIRMAN - That would be good, if you would not mind. Do you know the State that was involved?

Mr FRANK - Yes, it was New South Wales. The person was originally registered in New South Wales and was seeking registration in the ACT.

CHAIRMAN - Was this for nursing or for doctors?

Mr FRANK - This was for nursing.

CHAIRMAN - You said that a State was thinking of bringing in the same type of -

Mr FRANK - No, what happened what that when mutual recognition first came into operation - once New South Wales had a requirement that, for example, all AMC candidates had to complete twelve months supervised practice before they could be unconditionally registered. Not all States had the same uniform requirement at that stage and people who passed the AMC exam were able to get unconditional registration in another jurisdiction; in this case in the ACT. The person concerned then tried to reapply for unconditional registration in New South Wales, based on the ACT registration. New South Wales sought to re-impose its normal conditions, ... the twelve months civilised practice, and was told on legal advice that they could not do that because the act effectively prevented that from happening.

CHAIRMAN - So if we gave somebody a restricted conditional licence to practise, let us say at the Mersey General Hospital, fullstop. What you are saying is by giving them that registration they will then be able to go to New South Wales perhaps and be -

Mr FRANK - As I understand it you need to be a bit careful about the nature of the practice but if the practice was in a specific field, for example, an identified field -

CHAIRMAN - Intensivist anaesthetist.

Mr FRANK - intensive care, if they could seek a position in New South Wales in the intensive care then they could mount a case to say they wanted registration on a mutual recognition to work in intensive care in New South Wales.

Mr SQUIBB - Why can they not do that now?

Mr FRANK - If they are registered in those fields now they can do it.

Mr SQUIBB - If they are conditionally registered as - not just Dr Iastrebov, we have other specialists we have identified at the Launceston General Hospital where they have a restricted registration, you are saying that they can do that now?

Mr FRANK - Technically, yes. There is a difficulty that comes in that if, for example, say - I do not know if this is the case - but if you have somebody in Tasmania Hobart, say, who is registered to work as a cardiothoracic surgeon, they cannot go to any town in New South Wales and say, 'I want to work as a cardiothoracic surgeon' if there is no facility there for them to work as a cardiothoracic surgeon. In other words, if the type of practice requires certain things to be in place the local registration authority could say, 'No, you can't do it'. But if they were going, for example, from a facility in Hobart to a facility in New South Wales that had all the equipment and everything to do the job then it is probable that under mutual recognition they can do it.

Mr LOONE - What you are saying then is - my terms might not be quite correct but I think you will get the story - we get an overseas-trained doctor who comes here on a two-year contract and he does not meet the Australian Medical Association's requirements but he has two years virtually to prove up in that time, if he does not prove up in that two years he technically cannot have his registration renewed and he goes back to where he came from -

Mr SQUIBB - Unless he enters into -

Mr LOONE - Unless he enters into studies and starts - he may not be completed, but as long as he has started but if he has not started his studies he would have to go back to where he came from. Am I

getting it right, that you are saying that in twelve months or eighteen months he has been here he could then apply at the end of his two-year term to go to New South Wales if there was another facility similar to what he is working here?

Mr FRANK - Under mutual recognition it is possible for them to do that. What has not been tested as yet is there is a clause in mutual recognition that says that if you have conditions imposed upon your registration, provided the same conditions can be imposed in the other jurisdiction, then they can do it. What we do not know yet, because again they have not been tested, is if you have time-limited registration, say registration over two years, whether it is possible for the second jurisdiction to continue the same time limit upon it because, again, that has not come up yet and has not been tested yet.

CHAIRMAN - Getting down to the major things that we are wrestling with, the real concern is that, as you know, because of the ministers' meeting they had around Australia what the ministers have now come back and said is, 'In January 1999 everybody who has conditional registration will not have registration any more unless they are, of course, sitting for these exams' and therefore within Tasmania these 80 unconditionally-registered doctors could be placed in a situation where they have to suddenly have to turnaround after practising for *x* amount of years, some over ten years, within the State and either find another job or go back to their native country. To us that seems unfair, especially when prior to 1991 they were given a nod and a wink if they came to Tasmania. It was an area of need. They had been advertising for doctors over a number of years, they had not been able to find any doctors, therefore if you come to Tasmania it will be conditional registration. But nobody has said that they were going to come, if they do put their hand up to work in that area then you will have to go - they were told that - but they said, 'Look, that just won't happen, and therefore you will be able to stay here ad infinitum'. They sold up their business, perhaps, they sold up their house, they brought their family out here with that belief and now suddenly the rug is pulled from under them. Unfair. We are trying to get around that problem.

Mr SQUIBB - And bearing in mind the implications of mutual recognition. We understand that. We were of the belief that those who have been registered on a short-term basis, those who do not meet the Australian requirement, because of the area of need or geographical specialty, have been granted provisional registration. We cannot see the difference between that being renewed on an annual basis, in the case of those who are already here, and giving some sort of permanency to the same sort of registration. If it is limited, for instance, to a location or a specialist and a location, we could not really see how that would provide a problem with mutual recognition as opposed to full registration and the provision of provider numbers and all those sorts of further complications.

Dr BREEN - - It is certainly very complicated and the terminology in each State sometimes varies so you can have what you think is the same conversation but you are talking about slightly different things.

My understanding of the two year limit is that it is not set in any act, that it is a guideline. It is there to deter the back door entry and to encourage people to achieve the standards required for full registration. It is in their interests, it is in the community's interests and so there needs to be some lever, some way of pushing and some way of pulling. I think the pushing is there; I am not certain the pulling is there yet and I think that the people involved in providing educational support either for the AMC exam, which is a general exam, or for the specialist pathway ... the colleges probably need to do some more pulling to assist these people.

Every State is struggling with this same problem. In Victoria we have exactly the same problem. We have people coming to what we call 'area-of-need registration', which is equivalent to your conditional registration. They do not meet the criteria to be fully registered yet they fill, particularly rural areas, general practice for two years. They know that they are meant to be getting themselves fully registered. At the end of that two years they have struggled. We, at our board, are prepared to extend that if they have shown progress. In other words, if they have sat the exam and intend to keep trying it - they still cannot do it forever because eventually we say at the end of four years we pull the plug because clearly working and studying is not getting there or they will never get to that level and sadly some of these

people just, although they can appear to function quite well, at the end of the day they are not capable of providing the standard. So some of them do drop off.

CHAIRMAN - I understand that with people who know the goal posts when they first come and that has been happening since probably post 1991-92, has it not? When people came to Tasmania, Victoria, wherever it was, they knew the goal posts. So to me I do not think they really have an argument if they are suddenly trying to change them after knowing what they were getting themselves into.

But prior to 1991-92 the goal posts were there and now they have changed to here without any fault of theirs - that is, the doctors who came out - in fact they have been given undertakings that they will be able to remain here ad infinitum. That is, I think, the gross unfairness of the whole thing if they have suddenly to be told to pack up and leave.

Mr LOONE - A glaring example of that is in Launceston: the radiologist has been twelve years or something, he is a man in his early fifties, I guess. He is recognised throughout Australia as a top radiologist and he says he could not handle going back to study.

Mr SQUIBB - That was a point I was going to make there are two ... here. One is that in a lot of cases these people are not able to leave their working post and go to a teaching hospital because it is not just possible to do it and it then creates a problem at the employing hospital having lost that person; they are back to square one again, they have to go through the same process.

Secondly, as the case that Mr Loone referred to, where a person who has been through all these exams in his own country, he has been here for fifteen years, does not want to get back in - in fact refuses, in some cases, to get back into the routine of full-time study and those sort of people are just going to be lost.

Mr FRANK - All right. The issues you have touched on here - and I think this is what we alluded to earlier, that the difficulty is to find a balance between the need to maintain adequate standards of health delivery on one hand and to be able to actually deliver any kind of health service on the other. If you impose the standards strictly this person then does not meet the requirements, you have to cut out, they go, you lose the person in that particular area - which is obviously not acceptable and not effective in terms of ability of service.

Mr SQUIBB - But surely if they are good enough to do it for twelve months - if they are a risk to the community they should not be there in the first twelve months.

Mr FRANK - But how do you define that they are doing it without risk to the community? One of the concerns that we have - and let us leave aside the specialists for a moment because the Australian Medical Council does not - that is handled through the specialists colleges, we are not involved, but the area we do get ourselves involved in, which is the ones seeking general registration, one of the things we do know is that from some 20-odd years of examining these people and the data we have collected over that period of time we know that there are areas where there are, for all sorts of reasons and we can explain all of those, why there are gaps in knowledge from different parts of the world and different areas in terms of what they do and where they come in. For example, those trained in eastern Europe until even fairly recently tended to perform quite badly in any assessment that involves looking at their knowledge of pharmacology or the action of drugs because in their training they did not get access to these things. They were not there. Unless you were working in a very specialised group of practitioners working usually for senior party people in the particular country you were in you did not get access to drugs at all and so their training in that area was almost non existent.

Psychiatry is another area of major problem. In lots of parts of eastern Europe it was not used as a means of treatment of a condition, it was a form of incarceration for political reasons. But, again, the training was not there.

So if you look at the base of knowledge that these people are bringing into the community, there are gaps that are quite significant and in some cases they are very worrying gaps. You may have the luck of somebody who is one of those sort of positions who has not met the assessment requirements, does not strike a problem in that particular area: that the kind of stuff that they are working on, the nature of the

work that comes through their front door, does not present a particular difficulty because it does not cross over those areas. But then again you could find that they do.

The concern we have is in trying to assess them, whether it is us or whether it is the specialist colleges that are doing it, you are trying to assess them over a whole range of the sorts of things that they could be presented with in various areas in the nature of the work they are going to be undertaking. We have concerns that in some of those areas they do have substantial gaps that, if left unchecked, could present a major problem down the track.

Mr SQUIBB - You are referring to a peer assessment?

Mr FRANK - I am referring to a formal assessment.

Mr SQUIBB - Examination?

Mr FRANK - By examination.

CHAIRMAN - What do you do with the people who were here with an undertaking prior to 1991-92? Do you say, 'Stiff. See you later, thanks for your troubles. I am going back on my original promise'? Or do you try to go through another pathway to enable them to get up to standard - they are obviously of standard because they have been for fifteen years a lot of them ten years, they have had no complaints, they would seem to any impartial person to be doing a proper job. What do you do with those people?

Dr BREEN - I suppose what other States have done might answer that but I cannot tell you for sure of all of the States. In Victoria we certainly have been quite flexible over the years in granting - we use to call it 'temporary registration' - we now have six section or five section segments of specific registration. We have been pretty flexible in applying that for people who generally want to get full registration, encouraging them to get down the specialist pathway or through the AMC exam.. That can mean putting pressure on employers to point out that if they do not they will lose those people. So in other words, supporting them but having relevant sections in the act where instead of it being conditional or area of need it is under some other aegis which allows them to continue to work while they train for the appropriate examination.

CHAIRMAN - Are you doing that with the people who have been here for ten years or so who have always been given a nod and a wink that they will be able to remain?

Dr BREEN - I guess we are fairly comfortable because we did not have many. We had in Victoria for a long time, similar to New South Wales, accepting people from South Africa, Singapore and Hong Kong et cetera and so they were there on full registration and we had virtually no people long term filling area of needs positions. We have not really faced that problem, to be honest.

CHAIRMAN - Can I ask you what you do now or is it too short notice?

Dr BREEN - Oh, no. We do have area-of-need people and we try, as I said before, to stick to the two year rule but where someone is, the sort of condition here of a person not having quite the time to study, we would encourage them. We have a provision of the act that allows us to register them on temporary basis supposedly for preparing for the AMC examination. So if they pass the clinical exam we will allow them to continue in some sort of supervised position to maintain and to improve their clinical skills to pass the exam. That will not be particularly onerous supervision. We are prepared to modify that; it does not have to be hospital supervision.

Mr SQUIBB - Do you have any situations where they are unable or unprepared to enter into the examination process and if so, how do you handle that?

Dr BREEN - Our registration decisions in Victoria are appealable to the Victorian Administrative Appeals Tribunal. No such matter has yet gone but there is one doctor who currently is taking on the Australian Medical Council at the Human Rights Commission over his failure at the AMC exam and, depending on the outcome of that, he intends to take on the Victorian Board through the Administrative Appeals Tribunal. He has been rejected after a total of seven years of temporary registration in three

States in Australia and has tried to sit the examination four times and his performance over the four times is deteriorating rather than improving. He believes he can still -

Mr SQUIBB - He was obviously a person who was in a position to be able to study and sit the exam?

Dr BREEN - Yes.

Mr SQUIBB - We have people here because of the actual location where they work, which are not teaching hospitals, again I guess I am speaking of specialists, who do not have access to do that without leaving their job. You do not have that situation?

I suppose the other thing too is that mutual recognition has had a positive effect for the major populated States like New South Wales and Victoria, whereas it has had a negative effect for Tasmania.

Dr BREEN - Because you have had a flow out of people from here who were previously registered?

Mr SQUIBB - Yes.

Dr BREEN - Can I just suggest something, may be as a way out of this. The problem you are grappling with - Victoria may not have it but other States have tried to come to terms with this - I think the concern we would have is that tinkering with the medical act is necessarily going to solve your problem because what it does is, it then commits the community. Okay these people may not have had any problems but we would certainly know that a lot of them have not been evaluated according to the standards that are now there for training people.

Your kids who are coming through the University of Tasmania will go through training programs to certain standards; if they go on to specialist training they will go through certain programs. They have to satisfy those programs in order to practise as specialists in this community.

Clearly, you have identified one problem and that is the access and availability to training. But this is an issue that really affects the whole community, not just simply the regions. In some States they have come up with some innovative ways where the local health authorities working together with the regional hospitals have been able to set up rotational programs and various programs that can enable people to lift their skills without losing the service availability in those areas. For example - and I do not know enough of the circumstances here - if the Tasmanian health authorities can see an advantage in keeping a person there but lifting their skills level up to an agreed standard by setting up some sort of rotational system with that person so they can exchange with other people to have time out of their program to prepare or to study. Those sort of programs have been developed in other States and Territories. I believe, for example, in South Australia there are programs like that that have been put together.

If the issue was an issue that affects the community where that person is currently practising but it also affects the whole of the Tasmanian community if you start registering people who are, in a sense, a kind of a second tier group of people in terms of the official categories -

Mr SQUIBB - We have not registered them; they have already been registered.

Mr FRANK - No, no. What I am saying is in terms of giving them a particular category registration if they have not yet fulfilled the requirements of them.

So maybe there needs to be discussions with, for example, depending on the field, with the relevant college that provides training in Australia in that field with the relevant health authorities here in terms of what could be done for those individuals. I take it you are talking about a transitional group or a grandfather group of people who have been affected by decisions of the past?

CHAIRMAN - Yes.

Mr FRANK - What I am saying is, rather than chop them by applying the rules strictly, maybe it needs a more innovative solution to the problem with the relevant stakeholders involved in trying to sort out

how do we deal with these particular people, so that you can maintain the standards that have been agreed all over the country but do it in a way that recognises the particular problem of that individual who cannot get time off. If the person then turns around and says, 'Look, I'm not interested' that is another matter, and that is a matter, I think, that warrants some concern because these programs are designed to ensure a certain standard, a certain currency of knowledge and what have you. If they have rejected that then you have got a concern.

Mr SQUIBB - Could I just say, they have said it in the context, I guess, of they are not interested in going back and going through the course of study again to get full registration. All they want to be able to do is continue to work where they are - where they have been for fifteen years without any problem.

Mr FRANK - Okay. But, I mean, again the question is -

Mr SQUIBB - And we agree - I cannot say 'we' - I agree with that in that they then have the option; they either are provided with the opportunity to continue to do that. If they want to go into a position where they have full registration and can go anywhere within Australia, they really only have one option, and that is go down the exam pathway.

Mr FRANK - Okay.

CHAIRMAN - Because one of the ridiculous things, and part of the evidence we have had. As you know, at one stage people who were registered as specialists always remained specialists. In New South Wales that changed; I think it was 1987. There was a doctor who was a paediatrician in New South Wales, and a specialist. He went to New Guinea. He was practising there; he was also working with AusAid, a lot of aid agencies, setting up medical regimes for those agencies. He has been asked to prepare rural medicine programs. Obviously a person who was classed by all his peers as an expert in his field.

When he was in New Guinea, the New South Wales Medical Board rang him up - or contacted him in some way - and said, 'Are you still going to practise within New South Wales?' He said, 'Well, I'm not at the moment; I can't tell you when I'm going to again; I'm in New Guinea at the moment'. So they took his speciality away from him. That was the only State that did it. If you were a specialist in another State you remained a specialist, and he would have been a specialist here.

He came back to Tasmania, could only get this conditional registration, sat his exam and did not pass - even though he is lecturing, they are asking him to still do a lot of setting up of medical regimes. He is obviously an expert in his field. A lot of doctors have come and said, 'He should be a specialist; he should be registered'. So you have those -

Mr SQUIBB - And quite a few of those overseas-trained doctors are in a similar situation from the point of view of teaching and training those that go on to get full registration.

CHAIRMAN - But obviously that is not peculiar to Tasmania.

Mr FRANK - No. But again you need to look at the circumstances of the case - and I do not know the circumstances of that particular case. A lot of them do train. They train in particular areas, and in those areas they may be entirely competent. But the thing is they are not only going to be working in that area alone; they may be working in a whole range of other areas. It is the kind of registration they are seeking - that is, registration as a specialist paediatrician or general registration.

CHAIRMAN - This fellow was an Australian doctor who went through the Australian universities and went through the Australian speciality. He was passed as a specialist within Australia.

Mr FRANK - If he has a fellowship of an Australian specialist college then he would be currently registrable, as I understand the way it works.

CHAIRMAN - No, only in New South Wales you are not, because back in 1987 there was some rule in New South Wales that -

Mr FRANK - If he holds the Fellowship of the Royal Australasian College - well, in this case it will be the College of Paediatrics or the College of Physicians - he would be registrable in any State or Territory in Australia as a specialist.

CHAIRMAN - No, because -

Mr FRANK - They do not have a category of specialist registration in New South Wales, but they have a category of conditional registration as a specialist.

CHAIRMAN - Well, the evidence which seemed to be uncontested a number of months ago -

Mr FRANK - The thing that we have referred to in our submission here - the pathway for assessment of overseas -trained specialist - was actually piloted in New South Wales in 1990, and from 1990 to 1993 New South Wales was the only State that ran it.

Mr SQUIBB - He was not overseas trained.

CHAIRMAN - No, he was not overseas trained. This was in 1987. He was a specialist. He had passed his specialist exams within Australia. He was a paediatrician up on the north-west coast; Edwards his name was. He passed his paediatrics in Australia, was practising in New South Wales - passed it in New South Wales - and because of some law within New South Wales, the Medical Council within New South Wales in 1987 was his evidence. But that is not the case now. He cannot be a specialist. He moved overseas -

Mr FRANK - If you actually look at the wording of the acts, provided the person has either been assessed as equivalent to an Australian-trained specialist or holds a fellowship of Australian-trained specialists. A great many people who were caught before who prior to 1993 had, say, for example, a qualification from an African university or Middle Eastern university or some other university, came out to Australia on a scholarship and undertook specialist training here in this country and did a fellowship of the College of Surgeons or fellowship of one of the other colleges - which is an Australian-awarded post-graduate qualification - but could not get registered because you have to be on the general register first - which means they had to go back and sit the AMC exam - then they could get recognition for Medicare purposes of their specialist training which was Australian based. From 1990 in New South Wales and 1993 nationally that system changed. If you hold a fellowship of an Australian specialist college, even if you do not hold a recognised primary qualification, it does not matter where your primary qualification is from, you can apply for and be registered to work in that field of specialisation based on that qualification alone. That is right throughout the whole of Australia.

CHAIRMAN - But in 1987, because he did not train in New South Wales, he lost his specialty.

Mr SQUIBB - Was it not something to do with the period in which he had not practised there?

Mr FRANK - There might have been a rule in 1987 at that time but certainly since 1990 in New South Wales there has not been the case. Since 1993 nationally - I think WA was the last State to come on-stream - that has not been the case.

CHAIRMAN - He was not practising within New South Wales at the time.

Mr FRANK - But if he turned up today in any medical board in Australia with an Australian fellowship of an Australian college - College of Paediatrics -

CHAIRMAN - A current one.

Mr FRANK - issued by the college - it does not have to be current -

CHAIRMAN - Issued by a college back in, say, 1965 or 1970?

Dr BREEN - They are not time-limited in Australia.

Mr FRANK - then he can apply in any State or Territory and be registered as a paediatrician to work in a -

Dr BREEN - There has to be something else there.

CHAIRMAN - Dr Edwards - he is a paediatrician on the north-west coast.

Mr FRANK - Any of the State medical acts in Australia now have a clause that allows conditional registration to work in a field of specialisation. This is why this problem comes in with trying to limit people. If you register them to work in a hospital but within a field - field of paediatrics, field of radiology, whatever - they can then go to institution in another State and say, 'It is the same task that I am performing therefore I should be registered under mutual recognition'. So even if there was not that clause, they could probably get it under mutual recognition. But all States and Territories were brought into line about 1993 with this mechanism and the mechanism that we have outlined in our submission went national in 1993.

Mr SQUIBB - If the Mutual Recognition Act was amended - and this probably looking at some time in the future - in that it referred only to unconditionally registered practitioners and specialists, would that overcome the problem; would that then enable -

Mr FRANK - We live in an age of so-called micro-economic reform and the principle under which that act was set up is that all the steps should be facilitative. In other words, whatever you have in the way of a set of conditions the second jurisdiction should try to facilitate that by imposing similar sorts of conditions. The only time that cannot work is if it is physically impossible to do that. There is a grey area in terms of disciplinary action but that is another field altogether. But provided similar conditions can be imposed in the second jurisdiction to the first, to work in a facility that is designed to cope with whatever that kind of work is, a psychiatric facility or whatever, then there does not appear to be any impediment in the act to stop a person from moving from one to the other.

Mr SQUIBB - So if it is somebody going from, say, a regional or rural situation in Tasmania to a metropolitan area?

Mr FRANK - If the work was the same, yes.

Mr SQUIBB - Well, take Iastrebov - we do not like using him as an example - but take Iastrebov as an anaesthetist working in regional Tasmania, under what you are saying he could then go to a major hospital in Sydney and work as an anaesthetist?

Mr FRANK - If he can establish that the nature of the occupation in Sydney is equivalent to the occupation he was performing in regional Tasmania, yes.

CHAIRMAN - That is the first time we have heard that.

Mr FRANK - That is the test.

Mr SQUIBB - So if that is the case, before the end of this year - he has a conditional registration, admittedly at the moment it limits him to Mersey. If he could get a job somewhere else, he could go.

Dr BREEN - I think the obstacle is that those sort of jobs are not easy to find. That is basically the practical obstacle. But under mutual recognition that is certainly possible.

Mr SQUIBB - My understanding in the past has been that it only really applied to unconditional - those with full registration.

Mr FRANK - Your view, I think, is the view that most people held and probably still do. But what I am saying is that in medicine it has not been tested; in nursing it has been tested. In nursing the equivalence of occupation principle under which that act is drafted - and it is right in front of the act saying 'this is the principle on which this act operates' - that was held to be true in that particular case.

CHAIRMAN - Originally we were told that there was not going to be a flexible approach taken. I think now a lot of people we have spoken with in positions of power have said, 'I think there has to be a flexible approach taken. We can't just suddenly say that that is the cut-off line. We have to be more flexible'. Do you agree that the councils should be more flexible?

Mr FRANK - Which council - our council or someone else's council?

CHAIRMAN - Any council, whether it be the anaesthetists -

Mr SQUIBB - The colleges.

CHAIRMAN - Colleges, I am sorry. The anaesthetists college, the orthopaedics college?

Mr FRANK - As I understand it, all of the colleges are struggling at the moment with this issue of the area-of-need type and the problems that that creates in terms of ongoing standards and so forth. I think everybody working the field recognises that at the end of the day this issue is a very serious one in terms of the need to provide medical services. So some approach needs to be looked at. What I think there is a danger of is that if you just say, 'Well look, we can't solve this problem, so what we are going to do is modify the Medical Act to allow for this to happen' without putting anything in place. One of the suggestions I have seen referred to decisions being made by the chief executive officer on the fitness of somebody or their qualifications to work in a particular discipline. Totally open-ended; no auditing, no monitoring and no mechanism in place to ensure that that person can raise their standards up to what might be the agreed standards in that particular field.

That seems to be a very open-ended and fairly dangerous way to proceed in terms of maintaining standards of practice for the community. But that is not to say you could not design a system where there was some ongoing mechanism for auditing in those critical areas - and you have obviously, in this State, got some critical areas where it is difficult to recruit people - that you go back to the health authorities and say, 'Look, we are grappling with this problem because no one has really addressing the key issue of how do you make these positions more attractive? How do you get people to get in there?' That is what all the States are trying to look at at the moment. How do you put infrastructures in to ensure that the guys can do training or that there is some provision for continuing education as required now by most of the colleges so you keep the standards at an adequate level? Maybe that needs all the stakeholders: the colleges, the Medical Council, the health department, all of them to become involved to try to address the problem rather than saying, 'We're going to amend clause 19 of the Medical Practitioners Act to deal with this particular problem' without creating any scope for the thing to be resolved or improved over in the future.

CHAIRMAN - What about flexibility? Do you say that people who are not properly qualified, that have not got full registration by a certain time, should have to leave or do you believe that there should be a flexible approach taken and a person's peculiar circumstances should be looked at?

Dr BREEN - You are talking about the two-year limitation particularly?

CHAIRMAN - Yes.

Dr BREEN - I believe that all boards will be flexible in that because it is reality. I do not believe there will be a single board in Australia that will absolutely insist on that two-year rule.

CHAIRMAN - Right. You are happy with that?

Dr BREEN - I do not have a problem with it from our Victorian board's point of view.

Mr SQUIBB - That will breach mutual recognition, will it not?

Dr BREEN - No, no, it is just in each State.

CHAIRMAN - Also the other thing that disturbed me was that if there was an area of need and, for example's sake, a doctor from China came out to that area of need, that doctor immediately goes into

that area of need and begins practice. The authorities within Tasmania - and I do not know whether it is the same with any other State - do not oversee the work done immediately by that overseas-trained doctor. He gets the job really on the basis of a couple of references and they look at his qualification. That seems to me to be strange. I would have thought that the better approach would have been for that doctor to go into a training hospital for a period of, let us say, three months or whatever you think is an appropriate time and then be put out into that area of need because that is the only way that his expertise could be looked at properly.

Dr BREEN - That raises the whole issue of temporary registered doctors -

Mr FRANK - The Australian Medical Council in 1996 was asked by the health ministers to prepare a report area of need particularly and we consulted with all the States and Territory medical boards and councils. We came up with a set of recommendations that attempted to try to tie the particular requirements of the position to the qualifications of the individual concerned. So there are some area-of-need positions - you referred to metropolitan hospitals, for example - where the degree of supervision is very high and so you can actually put somebody in there who maybe does not have the total set of qualifications you might necessarily want but you know that their supervision is very close and you know that their clinical responsibility is not very high because they are part of a team where some more senior people take the decisions. You compare that then with a remote or rural area practitioner, who really is a solo practitioner to all intents and purposes, where you really want to know that this guy or woman is really competent, reasonably well trained. So even though they may not meet the requirements for full registration, you want to know that they have some experience that prepares them well for work in that area. But if they do not, you maybe need to look at, as you say, the possibility of, say, spending three months in a particular facility. The example we used in our document was people going to work in Aboriginal health areas, where it is a very specialised field, and maybe a three-month attachment to one in a city before being sent out would prepare them to work in that area.

The key issue we then put in was monitoring, and that is the point I was trying to make earlier. If you create a system where there is no monitoring of that, then it is a very dangerous thing to do but, as I understand it, with the Medical Act in Tasmania, for example, certain conditions could be imposed by the Medical Council that would enable, say, regular reporting if you have a mechanism to ensure that can be done. The other thing you might want to do is you may want to have some audit capacity so that you do not have to wait until you get a complaint or some negative outcome, but the council would have the capacity to regularly audit a person's performance to see that they are on track. The audit would be done in some appropriate way with peer review, or whatever combination you may want to have, but so you do have a way of monitoring it.

I believe New South Wales, for example, in its area of need has now very strictly put in place a whole set of alternatives that it requires them to meet, particularly if they are in remote areas, to ensure they are in fact up to standard or they are performing at a reasonable level. Also, if there is any aberrant problem or any adverse outcome it is detected early enough in the sequence of things and it does not become a complete disaster medically for somebody. I think the guidelines we prepared for area of need that we circulated and were approved by the Health ministers, put in that monitoring is a very important part of this process. Monitoring and feedback, because you need to feed it back in. If they are not performing, it may be for some minor technical reason that can be adjusted fairly quickly, but having monitoring and feedback after you have appointed them is an absolutely crucial part of putting people into those sorts of positions.

CHAIRMAN - But monitoring itself could be too late unless you have that initial screening of a person to see whether he is what his references say he is.

Mr FRANK - That is why the proposal we came up with was to try to tailor the individual to the position, and that required the employer, or whoever was making the appointment, to try to define what it is they really want to have in that post. From what we could see, some of the area of need appointments were, 'We've got a Grade 27B position somewhere here', without defining what that individual is expected to do. By definition, we meant what is their level of clinical responsibility? What special skills do they really need to have to do that job, if any? What background would be useful for them to have? So you can then match the job specification to the individual who comes along, and if

that is a little out of sync then you need to think about do we have topping up training, do we have some kind of networking that can monitor it in.

In New South Wales, for example, they are now starting to use regional GPs as a network, so even if you do not have, say, a supervisor or a mentor on site, you may have someone in the next town who can keep an eye on that person and they can refer to if they have a particular problem. It is a fully-registered person linked into the general practitioner training programs who can provide assistance to that individual, so you use the network of regional people to help out. That is one model. There may be other models you can use, but the idea of trying to tailor the needs of the community and the particular position and define it as a specification, and then try to match that to the individual and top up, using rotations or other ways of providing the training, seems to be a much more practical way of doing it than dumping people out in a particular area and leaving them to their own devices.

CHAIRMAN - I agree with that, but does it trouble you to know that people come on the say-so of a reference and their papers or certificates, and are then placed in Queenstown, for example's sake, without any of their peers within the State knowing what their expertise is other than what is written down in a paper? That troubles me.

Dr BREEN - I think that is a very important issue. In Victoria we would depend on the thoroughness of the employing agency. For the major hospitals and the medium-sized hospitals it is not an issue but, clearly, going into remote practice it is. We rarely interview such people; we basically look to see - these are people going into general practice on a two-year area-of-need position - that they have had equivalent experience in some other health care system where they have had general practice of an adequate period of time, and their referees. We do not do any other testing, but I suspect the time will come when nationally anyone wishing to come into this country will have some sort of formal testing up front, even before they get a visa, and so on. That is not in place at the moment but when that day comes I think some of the issues we are worrying about at the moment will be taken out.

Mr SQUIBB - I guess there is an onus or a duty of care on the employing authority, particularly with litigation the way it is these days, to make sure they have done a certain amount of checking. In some cases I guess it could be quite desperate.

Dr BREEN - They can be and people can fill them. Was it not Milan Bric who almost got into Queensland on Joh Bjelke-Petersen's recommendation?

Mr FRANK - That point you raised, I think, is very crucial. Because at the moment perhaps there is not enough networking of the key players in this issue, people do become desperate. If you are the medical director of a hospital in a region and you are desperate to try to get somebody and your surgical lists are backed up and you have to have somebody there on the ground, of course there is a tendency to think, 'This guy's got some qualifications. It's nowhere near what we need but it's a body and it's there and we can keep an eye on him and it'll be all right. Let's put him in'. That is a major worry for everybody in terms of the ongoing standard of health care for those communities.

That is why I was suggesting that maybe what needs to be done is for people to try to take a bit of that heat off those individuals and get all of the players involved. That might involve the colleges and the health authorities and the Medical Council to think up how we can best do this so that we do not create that kind of pressure in a particular area. May you cannot, maybe in some of these areas it is just about impossible.

Mr SQUIBB - Would you also not agree that in those situations, having had a person there for anything between two and fifteen years, as we were saying, that specialist or practitioner is known by the employment authorities, known by his colleagues and obviously is acceptable, is it not better to keep that person on than to say, 'No, you're finished, your two years are up; you haven't entered into an agreement to start the formal study', and then go through the process of bringing in a completely unknown person again? Are you not better to stay with the one you know?

Dr BREEN - I have to agree with you that some of those people are clearly very competent and it is sad they were not put through the systems originally. The longer they are out in isolated practice the harder it is going to be to pass those sorts of examinations, and I could not agree more. I guess I am

looking to the future in terms of what might happen with new people coming in, and the thing I think is really crucial is that anyone who comes with area need or conditional registration who plans to stay, it is crucial they be supported and to get up to speed, and to become fully qualified and therefore a fully registered GP; join the College of General Practitioners or, if they are a specialist, to be approved as a specialist and join that college. That is the only way in which they can be integrated into the whole medical system: to work with colleagues, to go to college meetings, to go to continuing medical education programs, and so on, otherwise they are isolated out there for the rest of their careers.

So whatever we do we have to try, as a country with ongoing migration, to get those people supportedly into the system, and I support what Ian said. I do not think that all of the players are working collaboratively enough to achieve that. The Australian Medical Council, I think, is doing its job with the colleges over the last three or four years to make them much more aware of the issues, but that has not yet rubbed off at a State level to do the sorts of things that are needed.

Mr FRANK - One of the concerns I think a lot of people have is that if you have this person, particularly if they are in an area - you have described somebody who cannot even get time off to go and train, assuming they are prepared to do that - you have to wonder how they then maintain their knowledge base and the currency of their knowledge in that particular discipline. The sequence that Kerry was just describing of getting them involved in those programs so they become part of that network and can continue to maintain their standard of knowledge and upgrade their standard of knowledge as new developments come along in their particular fields of medicine, is crucial to ensuring that the standards are maintained. If they are isolated and cut themselves off by refusing to participate in any of these programs then you have a real problem.

Mr SQUIBB - I do not think there is a problem getting off for short term, but to do a three-year full-time course, as one witness has indicated he would be required to do, that obviously means resigning from his position or taking leave for three years as opposed to a continuing education or a seminar.

Mr FRANK - But that is what I am saying. Maybe we need to find all of the players and there is a need to find better solutions to those sorts of problems. For example, In South Australia - and I am not saying this necessarily would apply here - Flinders University is running a program for its undergraduate teaching program where a large number of students are placed in the Riverland. It is away from the main campus of the university. They receive the bulk of their instruction, their training, is done actually remotely from Flinders using a telemedicine link-up to that area. The South Australian psychiatric service now cannot service the things, they use the telemedicine system to assess patients in remote areas rather than having to transport the patients all the way down to Adelaide and then send them all the way back again.

Okay, they are new developments but they are developments that show you can start looking at some of these ways of getting services in, either instructional stuff, educational stuff, or in fact providing services in different ways. It is a question of getting the key players involved. I do know, for example, whether there is any mechanism or any spare capacity in the Tasmanian health care system to rotate people out in some ways, to provide for some kind of compromise training program for these guys so they do not have to resign their jobs and go away and do something somewhere else. But you can provide some kind of remote supervision, some remote kind of program or rotational program for them which would enable them - maybe over a longer period of time - to build up their skills to a level that you require. So it is not necessarily two years or one year, or something, which is full time and intensive, but it is done in a tailored way to suit them and being flexible, as we said a minute ago, but in a way that does not lock that person to one standard level where they are not going to do anything because they cannot get time off to do it. It allows them to build up their standards, but does it in a practical way that suits the environment and suits the resources you have available to you. That is going to involve the college, the health authorities and that individual, and probably the individual's employer. If you approach it from that perspective, at least you have a chance of getting the standards up and getting them linked into a system where they can maintain those standards adequately in terms of the kind of service they deliver to their community.

CHAIRMAN - What do you think of a situation where - and again, these people prior to 1991-93 are the ones I am mainly thinking of - the colleges say, 'The only way you can become a specialist is if you

sit the exam' and yet in relation to some of them that is not the case because there are some who do not sit the exam but they are known as a specialist in the field, and the peers say -

Dr BREEN - Peer assessment.

CHAIRMAN - Yes. The peers are saying, 'I've seen your work, it's terrific. You should become a specialist'. Therefore they get their fellowship and they do not sit the exam. There are these people within the areas who do seem to get registration because of their expertise in the area, and I think there will be a couple in Tasmania very soon doing it that way. I would have thought that one of the best ways of testing whether a person can cut it or not is by peer assessment: people who have seen him work, they see that person work on a number of occasions and they are able to say, 'Yes, he is up to scratch, he should become a specialist without sitting the exam'.

I know law is my background and there are a number of people who you see, and I would say without even knowing whether they had sat an exam or not, 'They are up to scratch, they are excellent in their area'. I am positive it goes over all professions and I just wonder what you think about that.

Dr BREEN - I would respond in two ways. There is the opportunity for that already in a formalised sense in that there has been a booklet prepared over the last eighteen years or so by a national committee called the National Specialists Qualifications Advisory Committee which has assessed certain specialist training programs around the world and made a listing to say that those specialist training programs are equivalent to the specialist training programs here. As you might imagine, most of those come from English-speaking countries, western countries, and those people are both eligible for Medicare benefits as specialists and usually are readily embraced by the local colleges, sometimes with some sort of formal testing, sometimes without, depending in the levels of experience, and so on, so that exists already.

I think in terms of people who are not eligible under those criteria, and where you are looking at work assessments, I think the problem with that is it would have to be pretty thorough and probably would mean them working in a hospital alongside someone day in and day out.

CHAIRMAN - For how long? It depends on the worker.

Dr BREEN - Three, six or twelve months, and so on. In a way, some of the Australian Medical Council college specialists pathway that Ian referred to before in fact do that. So if a witness has said they needed three whole years of training then either the college has it badly wrong - which is not impossible - but it is more likely that person's basic education and skills and claims to be a specialist are very, very thin. That would be unusual. If they are here and practising as specialists and then told they need a whole three years, that is very unusual.

Mr FRANK - I am not sure whether the evidence has been presented to this committee or not but one of the things that is very apparent is that medical training around the world differs. There are different emphasis, different health care priorities, different access to technology, different cultural factors that affect the way you deliver health services that are reflected in the training program. While that is true of under-graduates - that is, the primary degree training - it is even more so in the case of specialist training, which is enormously diverse.

For example - I am assuming that again the committee may have had some evidence - in the Australian context if you were training as a paediatrician you would do a full under-graduate program, an internship, may be a couple of years of junior medical officer position and then go into a specialist training program that can be up to about five years or more. So you have already had a basic training plus some basis experience before you go into the specialised field that you are going to work in. That is usually done in two parts. There is a general part to start with and the first exam and then the advanced training, which is highly specialised training, and the final qualification of some form and then you come out as a specialist.

If you go to some of the countries in eastern Europe in Poland, for example, you actually commence your paediatrics training in the last two years of your under-graduate, what we would classify as your under-graduate training, and you concentrate then in that field. You then finish your under-graduate

training and do three years post-graduate. So you have done five years but it is five years in an extremely narrow band without the rest of the training that we would expect somebody here to have, across a broad range of conditions, that act as the base or the foundation of that kind of training and that is multiplied throughout the world. If you around and have a look you will find that what they classify as specialist training may be very, very different. In some cases it would be what you would call a masters program or a three year diploma program here and yet they are in their countries of training classified as and recognised as a specialist but in a very narrow field. Some fields, for example, they are excellent in trauma surgery or in a particular field but not in general surgery, not beyond that.

The categories of registration, even the conditional registration as a specialist here is a very broad category that expects them to be to operate across a fairly wide range unless they have some special subset. So I think that there are enormous differences in the nature of the qualifications and experiences that they have had.

The kind of program that was set up with the colleges to have them interviewed and then sent through various pathways was designed to try to recognise the differences in those different types of training. The idea of the interview and the review of the documentation was that you cannot categorise these people exactly accordingly to our method of training. You have to get a feel for it first and then say right we feel this person needs to do this, this and this or if they know nothing about the program they will set the an exam and see how they will perform, where the gaps are and then they can tailor the advanced training from there. It is designed to pick up those differences that are in the training programs.

There are very real problems, as I said earlier, that if you restrict somebody just to work in that one area and you do not put them into the mainstream of their field then the knowledge base is going to narrow down over a period of time and that is a worry.

Mr HARRISS - In terms of a rural doctor an overseas-trained specialist - I think he might have been involved in eye specialities - practising here in Tasmania sat recently, as I understand, the AMC examination for general practice so that he can then gain -

Dr BREEN - Unlimited registration and you go and use it.

Mr HARRISS - unconditional registration to continue practice. The pass mark in each of the modules in the examination, as I understand the story being told to me, was 45 per cent. He absolutely creamed all of the modules in the 80 and 85 per cent but got only 43 per cent - missed out by a couple of questions in the gynaecology section - and therefore misses out on unconditional registration.

Mr FRANK - He misses out on getting to the clinical exam. There is a two part exam. You have to pass the written part first then you go on to the clinicals. The last two examinations we have administered - the October 1997 and March 1998 - the gynaecology sections of both of those presented major problems for us in the sense that we were surprised at the relatively poor performance of candidates as a group in those questions.

We went through and analysed that very carefully. We had people from a number of different States have a look at the material to make sure that the questions were appropriate and that they were relevant to the kind of practice that you would be seeing turning up in your major hospitals or in your general practice settings and they have confirmed that is the case.

In relation to both of those exams, in notifying the candidates of their results we drew specific attention to that because we are getting very concerned about this issue, that the areas that they are falling over in are really very basic areas. In the October exam last year, for example, we asked a question on post-partum haemorrhage, which is a very common problem, and 80 per cent of our candidates got it wrong: 56 per cent of them elected for a treatment or a way of approaching this that would have been fatal to the patient and that was disturbing to us.

CHAIRMAN - More so to the patient.

Mr FRANK - What we have done in part is we have spent the last couple of years going through all of our exams since 1990 and we have actually prepared this, which is a selection of 600 questions taken out of our exams but instead of just giving them the correct responses we have also written commentaries on each of the questions that explain why the correct response is correct, why the others are not and what constitutes best practice in that area in Australia. We have done that because we started to get concerned that, firstly, the gaps were turning up; secondly, they did not seem to be correcting from one exam to the next - you could ask the same question in two consecutive examinations and they were still getting it wrong and, thirdly, that the areas that they were getting wrong were, what we considered to be, either common or important or potentially lethal in the circumstances that they would ... If they missed them either in general practice or in a hospital setting the outcome could be disastrous. That was released in December last year so it was not out in time for the October exam and probably they did not have a time to absorb it all for the March exam.

We are monitoring very closely that particular problem to see if there is anything else we need to do, either in feedback to bridging courses or feedback to candidates or reinforcing it in some other way, to find out what is going on as to why they are falling over in that particular instance.

Mr HARRISS - What is the next step in those circumstances? Is it the whole exam over again?

Mr FRANK - They have to sit the whole exam again. It is an integrated exam, much the same as the university examinations are. You might ask, for example, a question to do with women's health that actually is a surgical question; it has to do with, say, for example, treatment of gynaecological cancers, so that is why you actually assess them over the whole of the field rather than just simply picking out one area.

I would also point out that 45 per cent is not a pass mark by any Australian medical school standard. It is a minimum threshold we have set in to ensure that they are at least basically competent across all of the ranges of the material we are testing so you do not get these sort of things where they are very strong on medicine surgery, because that is their area, but they know nothing about paediatrics or women's health issues. You could not equate 45 per cent to a pass mark that you would apply, for example, in an Australian medical school. Forty five per cent of the knowledge basis is pretty low.

Mr HARRISS - But nonetheless it is the threshold.

Mr FRANK - It is the threshold we have set.

Mr HARRISS - Mr Chairman, has any mention been made of apologies for my absence for a little while about the Australian Medical Association recommendation here? Have you discussed that with the gentlemen.

Mr SQUIBB - I have not indicated where that recommendation came from and I was going to ask in fact, through Mr Chairman, whether it was appropriate -

Mr CHAIRMAN - Yes, sure.

Mr SQUIBB - to seek comments from Dr Breen and Mr Frank in respect to some evidence given by another professional body? The reason I have not is because I did not have that particular submission with me.

Mr HARRISS - I do not have it with me but we could paraphrase it.

Mr SQUIBB - Basically it was a proposal where in fact those overseas doctors who do not currently have full registration and have up until this period of time relied on annual re-registration and who have in the last six months or so received notification that as of December this year or January next year - it varies on when their anniversary date came up - unless they undertook a formal course of study as required by their particular college their registration would not be renewed.

In those cases there was a suggestion that they be granted some sort of permanent or certainly longer-term provisional registration and there be some conditions associated with that. One was, in fact, that

the chief executive officer of the hospital or the employing agency was prepared to continue to give them a contract. It provided them with the opportunity of having some security in their position but it was also on the basis, that may be in some conflict with some of what you said today regarding mutual recognition because I think we were probably under the impression at that stage that because it was quite restricted registration that it would not in fact contradict mutual recognition. I do not whether I have missed any requirements of it. That was basically it and that came from in fact the Australian Medical Association.

Mr HARRISS - I think the one caveat on that was where they have been practising in a public hospital that in fact they continue to practise in a public hospital. It was not carte blanche across a number employment agencies. I would be interested in your reaction to that suggestion by the Australian Medical Association.

Dr BREEN - Did the submission have any recommendation that the person, if the registration was extended in that field, should be either reviewed or monitored in terms of ensuring that the standard of the work they are providing is adequate?

Mr SQUIBB - Well, I think that onus was going back on to the CEO or the employing authority and it was also in relation to those who were currently - certainly it would not apply to anybody coming into the State from this point on, it was just in relation to those who were already here and, as Mr Harriss points out, to enable them to continue in their particular area. For instance, if somebody was working at Burnie it would not automatically apply to them getting a position in Hobart ... The other alternative they had, of course, was if they wanted full registration they still had to go down the particular path. This was an alternative to that, to help the health authorities in this State overcome that problem that they have had and also to provide some tenure to those who have given good service, obviously, to this State for a period of, in some cases, up to fifteen years.

Mr LOONE - Before you answer that. I have a copy of a letter here from Bernie Oneida, who is the current superintendent, if that is his right position, at the Launceston General Hospital. If I just quote two or three paragraphs from the letter I had from him: 'In this hospital we have five specialists who are performing equal good work and who are the only specialists we have in their specialty doing such work in northern Tasmania. If they are to lose their registration the Launceston General Hospital will not be able to employ them. Without these people sections of the hospital will need to close in fact the whole hospital may have to close. For example, Dr Bosanac is the acting director of radiology. He is one of the few radiologists in Australia able to perform interventional angiography procedures. This means an aortic aneurism can be fixed by a minor procedure in the angiography department of radiology rather than by a major life-threatening procedure in a main operating theatre. Two radiologists working with him are also from overseas and not able to be registered in Australia under the new regulations. This, therefore, means that on 1 January 1999 we will have no radiologists in the Launceston General Hospital. In other words, our X-ray department will cease to function. With the X-ray department the hospital will cease to function. This is obviously not appropriate and definitely not in the best interests of the northern community'. Then he goes on that there are three other specialists or four other specialists in virtually the same situation. So they are the sorts of problems that we are facing.

Dr BREEN - Do we know whether they have attempted or wish to go through the college pathway? It would seem to me that if they are working in that standard of hospital and providing that quality work I find it hard to imagine they would not be acceptable to the relevant college.

Mr LOONE - The one we did mention Dr Bosanac he is a chap in his early fifties I guess, in that age group, who has been here for fifteen years and he has just had an annual renewal - and he is looked upon as being one of the top radiologists in Australia.

CHAIRMAN - I understand that he will probably be registered by this peer assessment, as will Dr ...

Mr LOONE - So they may get through the pathway.

Mr SQUIBB - There is the inconsistency you see, not just between colleges but within colleges.

Dr BREEN - There can be, yes, because everything is an individual decision.

Mr FRANK - But I think the key thing here, there are a couple of issues there. This case, I think, perhaps illustrates it quite well. The key thing is that there has been some assessment and if that assessment is done by the college or the body that has the expertise in that field they do not necessarily have to use all of their assessment tools. They do not necessarily need to use their exams or they have other mechanisms that they can look at to determine the quality of the individual concerned but they have made an assessment on this case that can then be taken on board as far as the registration is concerned.

The model as I understand that the proposal has is that the chief executive officer, and I think you might have mentioned earlier, that sometimes these guys are under pressure to get somebody which does not necessarily mean that the evaluation is going to be made on either the same basis that it is applied to all other people, it may depend on a particular crisis that occurs in that particular hospital. If there is some method of evaluation that goes on to establish that these people are reasonably qualified to do the job - peer assessment or whatever - if the Medical Council, and not just simply the executive officer - and the Medical Council is charged under the act with the protection of the community - has a monitoring capacity in that area, and if it is not totally open-ended, then presumably it is a model that can be looked at.

If you leave it open-ended, what is the difference between this and the circumstance you had a couple of years ago, where the guy has been there for fifteen or twenty years and says, 'well, I've been conditionally registered, why can't I be unconditionally registered? I have been doing it all for that period of time'. So you are just shifting the problem, in a sense, from this time to a later time.

Mr SQUIBB - But we do not want to make them fully registered, that is the point, because it is in our interests not to.

Mr FRANK - But what I am saying is, this proposal as I read it is open-ended. There is no time limit on that at all. I think that perhaps if it had something that said that it be reviewed periodically - it might be a five year review - just to see what has happened -

Mr SQUIBB - I think it has been suggested, even though it might not be there in writing.

Mr FRANK - Yes, I think they are the sorts of things, because otherwise all you are doing is shifting the date of crisis from here to some time down the track when the person turns round and says, 'Hang on, I've been doing this for so long and it has been conditional. Why can't it be now unconditional?' What is the difference?

As far as the mutual recognition issue is concerned, assuming that the Tasmanian legislature does come up with a model like this to meet the specific problems that you have described, these cases of people who are given undertakings and what have you, who have elected to stay within the Tasmanian system and do not want to move any place else, there is a mechanism under mutual recognition. It is referred to in the legislation but it is actually part of the agreement that goes with the Mutual Recognition Act. There was a heads of government agreement that laid the basis of the act and then there is the act itself. It talks about a council of ministers decision that could quarantine any action that would be below the standard set nationally. And that has not been tested either, so it is just something -

Mr SQUIBB - Is there a document that sets that out?

Mr FRANK - Yes, I can give you the references.

What may be possible is that if you have decided that there is a unique problem or a unique situation - for example, the undertakings these people were given of effectively unlimited conditional registration by somebody or other - and that is a problem that is unique to Tasmania because of the systems that were in place at that time, then it might be possible through your minister to go to the Health ministers and say, 'We would like to apply a decision of the council of ministers to exclude or quarantine this decision to be Tasmanian alone'. So in other words, the category of registration they would hold would not be open to the application of mutual recognition.

Mr SQUIBB - That is what we are seeking.

Mr FRANK - Okay. As I said, we have been aware of that from day one, because this problem has been something that everyone has been aware of since day one, because these temporary resident doctors and area-of-need things have been around since before mutual recognition came in. It has not been tested and it has never been put to the test. When this was drafted in 1991-92-93, it was a fairly practical attempt to solve the problem. Since then there have been various other efforts of microeconomic reform, and I am not sure whether that would hold up, but it is certainly something that could be looked at. I can give you copies of the actual act and copies of the agreement that go with it that show how that works.

Mr SQUIBB - I think it is probably appropriate to indicate that the Iastrebov bill, which you referred to at the start there, has been put on hold at the moment, and in fact will probably be dropped if this select committee can come up with something which is going to apply across the board rather than to one individual, but the problem of that individual I think is highlighted, certainly since we have taken evidence, that it is far wider than that.

Mr FRANK - I think the crucial things there would be that it would be desirable from a standards point of view, and therefore from a community protection point of view, that there is some evaluation that is more than just simply the pressures of chief executive officer, shall we say; some evaluation of the person's ability to do the task; that is not driven by workforce demands or labour demands alone; that the Medical Council would be involved in a sense of a monitoring role to ensure that it is able to protect the community in its capacity to ensure that the person is still functioning or continues to function at a reasonable level, particularly if they are isolated out of the loop of continuing education and that sort of thing; that there is some sort of review mechanism to ensure that there is not some problem cropping up or something that can be inadvertently not detected in any other way; and that , if it is achievable, it can be isolated out of the mutual recognition loop.

CHAIRMAN - And you say the way round that might be this quarantine provision?

Mr FRANK - Well, it was originally set up, I think to - they recognised that the lowest common denominator could occur. Let us move out of this State. The Northern Territory has had major problems in getting people into their hospitals, and there was a real worry when this thing was put together, in terms of medicine, that the sheer necessity of having people to be able to maintain any kind of service would mean that people would be put on who, once they got into those positions, could then leak out into other States and Territories - which would again not solve the problem for the Northern Territory ad create other problems elsewhere. And so at the time that the actual act was being drafted we had a technical advisory group that was going round, and it spoke to the people who were drafting legislation and said if there is this problem that we identify that for whatever reason somebody - I hesitate to use the word - some State, goes 'rogue' and starts doing its own thing, how do we protect the rest of the country? And the council of ministers decision is one mechanism that is there. It has not been used, it has not been tested as far as I know, but it is there and could be flagged. And if the problem is sufficiently serious, and if it is sufficiently local, then it is certainly worth a try.

Mr SQUIBB - I do not think there has been any opposition at all from those affected practitioners that have given evidence to being assessed. The main opposition has been to having to go through the formal process of exams, and in fact I think some witnesses have even indicated that they have requested a peer assessment and it has been refused. So I do not think there is any problem with that.

Mr FRANK - And some of the specialists said, 'Look, I don't think I'd pass an exam if I sat it again'.

Mr SQUIBB - Only because they have been 20 or 30 years out of the process of formal study.

Dr BREEN - You have to be very motivated to pass those exams, and if they are comfortable and they have a job here, why would they bother?

CHAIRMAN - Because one of our problems has been as well that last year or the year before there was a fellow on the west coast who came before the Legislative Council and said, 'I won't leave the

west coast; I love the west coast; I've got my business on the west coast'. He was an overseas-trained doctor. The AMA felt sorry for him and a number of others - there were two others, I think -

Mr LOONE - Four in all.

CHAIRMAN - around the State - well, you know the story. He got the registration and we had to chase him to the airport.

Mr LOONE - He was on the next plane after he got registration.

Mr FRANK - Queensland, South Australia and New South Wales is where they all are at the moment.

Mr SQUIBB - That is one of the reasons we do not support these people getting full registration. They have the option of going down the path to get that if they want it.

Mr LOONE - Mr Squibb said we do not like using Iastrebov as an example because this select committee is not all about Iastrebov, but he is the classic example. The Mersey Hospital at Latrobe struggled for years and years to get a specialist, an acute-care specialist and an anaesthetist, and the hospital was not performing really well. He has come to that hospital and has been like a breath of fresh air. The hospital has now attracted other specialists, and is performing as well as any hospital in the State, purely and simply because this fellow has got the thing up and running, and with the support he is getting around the community - there will be a lynch mob out if he cannot be left. He does not want to leave there. He is happy to sign a contract to stay there under the present conditions he is under. He does not want to go. All he wants is some certainty of a job, that he knows he is there for the long haul. They spent $100 000 advertising before they got him there. Now once he goes, there is no chance of getting another one on hand. They have to go overseas again, so the people in that area are going to be left unprotected. That is the big concern.

Mr FRANK - That is why earlier in the piece I suggested that the sorts of problems here are very complex problems. They are not simple, and everybody is trying to grapple with these problems, but solutions may not necessarily be the longer-term solution. The best long-term solution for the community may not necessarily be in tinkering with the Medical Act. You may have to do that anyway, but the longer-term solution may be to get the relevant players together to say it really is not good enough that you have to rely on this sort of system, that you really need to look at what resources you have on the ground and how you utilise them, and can you utilise them in a better way.

To go back to the South Australian example, the psychiatric system in South Australia was in total crisis. They could not provide services into the community, but they have thought of different ways of doing it that are relatively inexpensive, and they are becoming world leaders in that field. That solution will not apply everywhere else but it shows that in getting the players together to think how they were going to deliver services out to the country areas of South Australia, when they could not afford to have full-time specialists out there and yet the people could not afford to be left without access to that speciality, so they have come up with an innovative way of doing it. Queensland is trying to do the same thing at the moment in different fields. It does not apply in every field, but it does apply in some, and the relevant authorities, the State health authorities, the colleges if necessary, if it is to do with training or retraining or linking them into the continuing education programs, need to be involved in that as well.

And to take the point that the Chairman made earlier, you have got to start looking at flexible approaches to deal with this thing, but you have to start looking at perhaps more innovative ways of tackling the problem than simply saying, 'Here's one solution'. That solution will work for a while, but it may not work in the longer term and it may not maintain the standards in the longer term, for all sorts of reasons. If these person is, for example, keyed into the ongoing medical education programs in anaesthesia, that is fine. If they are not, then you fix the level at which they are capable of operating and that level will start to decline as medical knowledge moves ahead, which it is doing in dramatic terms in that area.

They are the sorts of things you need to look at. That is why you need to have some audit provision in place, you need to have some monitoring provision to see that everything is still working quite well if

you come up with this line to ensure that they are, particularly if they are out of the loop of continuing education.

CHAIRMAN - Would that type of amendment, with the provisos you put in, offend your council?

Mr FRANK - It is not a question of offending our council. The solutions are going to be difficult, whichever way you do them. I think the big concern that the council has at the moment is that in any State or Territory a solution that meets a local problem could impose difficulties elsewhere, and if we can come up with a way of getting around that then I think that is going to make it much easier for everybody. I mean, you have a real problem that has to be dealt with. But I think, as I said, the solution may need to be to deal with this one now, but get the relevant parties to really start addressing other ways of dealing with this problem, and not continually relying on this sort of situation to solve it.

CHAIRMAN - I cannot see there being a real problem in the future so long as everybody knows the goal posts when they come; I really cannot. The way I look at it is a matter of fairness as well. Sure, the areas have got to be serviced by proper medical practitioners, but if people come from Russia, Malta or wherever, and they know the goal posts when they come, and they want to try to change them and snub their nose at the authorities, I think unless they want to play ball you send them back. I have no problem with that at all. But when they came thinking something was going to happen and being told something was going to happen, and then the goal posts changed, I think that is a bit of a different scenario.

Mr SQUIBB - Plus we have been advised by witnesses that, unlike the present moment, in seven years' time there should be a sufficient supply of Australian-trained to be able to meet this need.

Mr FRANK - Yes, well, demographics is an interesting study too, but that does not produce brilliant results either.

Mr HARRISS - This has just highlighted a criticism of the whole system which was levelled by the Human Rights and Equal Opportunity Commission back in 1995, that the system for assessing relevance for admission to practice for overseas-trained medical practitioners is deficient in Australia - and I think the current Federal Government took some heed of that. Wooldridge, in a policy statement either pre-election or just after election, acknowledged that there needed to be some changes. And this situation which we have confronted here - probably had thrust upon us more than confronted - has again highlighted and probably in fact confirmed what the Human Rights and Equal Opportunity Commission had to say in criticism back in 1995.

Mr FRANK - But is your problem assessment, or is your problem work force? I mean, what is driving your problem here?

Mr HARRISS - In the particular instance we are talking about with Dr Iastrebov, and in fact others in rural areas, is probably work force. But assessment, as has been alluded to here, because of inconsistencies not only within the colleges but between the colleges, indicates a problem of assessment as well, I would suggest, or some inconsistency of assessment.

Mr FRANK - All right. What are you then going to say to your graduates coming through your medical school who are going to have to go through those college pathways to meet the standard to practise in this country, that you are saying these guys do not need to go through? That is the difficulty.

Mr HARRISS - Yes.

Mr FRANK - And that is why I keep coming back to the fact that we have to come up with better solutions. Everybody would agree that the system is not ideal by any means. For example, in our case we can identify down to specific topics where overseas-trained doctors who sit our exams have got deficiencies in their knowledge, and we can because the number of times they sit show you how consistent those deficiencies are, but we cannot send them anywhere to be retrained.

CHAIRMAN - Can you graph those deficiencies in certain areas as well?

Mr FRANK - Yes.

Dr BREEN - They are measurable. I think it is really a whole community thing. If we are going to, as a community, deliberately attract doctors from other countries here on a permanent basis - if they are here truly temporarily that is a different issue - and we are putting them in either general or specialist positions, then we have to be able to support them enough to stay here on a fully-registrable basis. I think this is where we have fallen down. I have no problem with saying the colleges in the past have got it wrong by being exclusionist. That changed five years ago, so I do not think they are exclusionist at all these days. I think they are very open, but there will still be individual problems where people are not assessed correctly, but all of the colleges now have transparent appeal processes in place so their decisions are appealable. What we perhaps have not put enough effort into is those employing authorities have tended to take a short-term look and just get them, put them in a spot and forget about them, and not support them quickly enough and soon enough to get them up to speed where the deficiencies are to make them fully registrable. That is where we have to do better in the future.

CHAIRMAN - Their answer to that was, 'Look, we're busy. We've got our work to do, therefore we can't afford the time', I suppose, is it not.

Dr BREEN - Yes. Hospital funding has been tough, so that is a real issue.

CHAIRMAN - I know it is off the point, but it seems to be a real concern as well, because with the money being held back from the States, it would seem, by the Feds there must be a concern in the medical fraternity and everybody, I suppose, that the level of medicine is going to drop -

Dr BREEN - The standards will drop.

CHAIRMAN - the standards will drop in the long-term, and I think Australians pride themselves with probably having one of the best, if not the best, in the world, and quite rightly so. But it would seem that if funding is not going to be there the standards have got to drop.

Dr BREEN - I think that is a very real concern. It will be very gradual. It will impact on the quality of the people providing the training. One of the greatest examples around the country is the outsourcing of pathology into private laboratories where they will not, because of economic considerations, be able to train future pathologists. I think where it is hands-on stuff in the hospitals, the apprentice-type system, I hope you will not see changes there. I think the pressures there have been just kicking people out of hospital more quickly. I do not think the standards are falling there, but in some of the outsourced services I think there is a very real concern.

Mr FRANK - But in terms of education and training, that problem has been around for a number of years now, and is getting progressively worse. The solutions people are finding are to come up with better ways and more innovative ways of training people. For example, years ago everybody went through a major teaching hospital to receive their basic training. Now they are using community-type facilities and taking the teaching out into the community more than every before. There is a proposal being developed now that would have a medical course almost entirely based on that kind of training, which would be ideal for training people to work in remote and rural areas, because that is where the emphasis is going to be. People are having to face the fact that they cannot rely on the old systems that they had years ago to train, and they are going to have to come up with more innovative solutions to that sort of problem.

This is a fairly scratched copy, it is the one I work on, but if I can extract out the act and the agreement which have those sections relating to the quarantining of the thing I can get that down to you tomorrow. Is that okay?

CHAIRMAN - That would be terrific, thanks. And also that decision, the nurses' decision, if you would not mind.

Mr FRANK - I will chase that up. I think I can get my hands on that pretty quickly.

Dr BREEN - Thank you for giving us so much time.

CHAIRMAN - Thank you very much for your evidence. It is much appreciated. If you think of anything else that you think would be of assistance, please do not hesitate to let us know.

Mr FRANK - The only other thing I can think of is that, as I said, in 1996 we produced a set of guidelines about area-of-need registration, which tried to match individuals, or set up an approach to the issue. It is a sort of psychological change in attitude and approach to the way in which people might want to consider moving down the pathway that would link up appropriate skills - not necessarily formal qualifications, because they may not have those, but appropriate skills to the needs of particular positions. It would require the employer or the relevant body to be able to define what it is they want, so that the medical councils could then say, 'Yes, this person has this sort of background and we can put him in'. But the key point was that it also built in the expectation to deal with the ongoing monitoring once they got there, and in some cases special training if that was deemed to be appropriate for the kind of work they are doing.

That paper was prepared with the help of all the statutory medical boards. It has been circulated. It is only a set of guidelines, so it is not a mandated thing, and various States have tackled it. I understand some States, like Western Australia, have taken it on board and are trying to develop it. Other States where their particular problems are more acute have had greater difficulty with it. But certainly it was an attempt to come up with a more structured and more rational approach to area of need and the skills of individuals that were going in. I can send you that document as well. You may find that useful too.

THE WITNESSES WITHDREW.