MELBOURNE MEDICAL DEPUTISING SERVICE
when quality matters

Melbourne Medical Deputising Service (MMDS)

Submission to the Senate Finance and Public Administration Committees

Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)

14 April 2011

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SUMMARY OF RECOMMENDATIONS

1. *That as a key element in the delivery of primary medical care, MMDS (and other medical deputising services) be formally recognised as general practice and, accordingly, included as stakeholders to receive direct notification of all health and ageing announcements, media releases and publications relevant to general practice.*

2. *That website information provided by assessment and entry systems including AHPRA is backed up by approachable, accessible and knowledgeable trained staff.*

3. *That the assessment and entry system organisations including AHPRA investigate ways to improve administrative efficiency and remove unnecessary delays.*

4. *That the different options available to arrange a PESCI are well-publicised on the AHPRA website and that an information box is added to the PESCI question on medical registration application form(s).*

5. *That video conferencing be an option for International Medical Graduates (IMGs) who are interstate or off-shore and that the management, scheduling, interview type and content process are consistent across all PESCI providers.*

6. *That within 10 days of lodgement of a medical registration application a PESCI where required can be scheduled to take place in a timeframe of no more than one (1) month hence.*

7. *That representatives from the registrations section of AHPRA Vic visit MMDS to ensure they are fully informed about the work carried out by visiting medical officers (VMOs) and are confident about the clinical governance and support systems and accredited QI&CPD provided.*

8. *That AHPRA establish efficient special consideration or discretion mechanisms in order to avoid or remedy unintended consequences related to administrative processes.*

1 Introduction

Acronyms commonly used in this submission: (1) VMO = Visiting Medical Officer; and (2) IMG = International Medical Graduate.

Melbourne Medical Deputising Service (MMDS) is a medical deputising service (MDS) accredited by AGPAL[1] which arranges for doctors to visit and treat patients at home (private home or residential care) after hours and on behalf of the patient's usual GP. When GPs close their clinics at the end of the day, on weekends and on public holidays, they divert their phone to a medical deputising service so their patients have access to appropriate and timely medical care 24 hours a day, 365 days a year – GPs provide care for their patients in-hours and visiting medical officers (VMOs) provide care on the GP's behalf after hours.

VMOs provide excellent medicine and manage the medical problems of patients and take responsible action on any medical problem with which a patient presents.

In doing so they:

- record a history of presenting complaint, relevant history, current medications, allergies, their examination findings, a diagnosis and their management plan which may require the patient to see their regular doctor for follow up or ongoing care.
- prepare a comprehensive report for each patient seen which is transferred electronically an hour after it is completed to the clinical software of the patient's usual GP. Accordingly, VMOs play a significant part in continuity of care for the patients they attend.
- treat patients from all socio-economic and cultural backgrounds of all age groups, in their private homes or residential care facilities. Residential care includes aged care, community residential units for the disabled, youth justice centres and refugees. Patients are triaged on their symptoms by the Service, however, outcomes can range from URTI's to AMI's, requiring extensive history taking and examination by the VMO to allow formulation of an appropriate treatment and management plan.
- Contend and cope well with all the challenges posed by the provision of after-hours primary care in the home setting. The practical care provided includes but is not limited to organising emergency treatment and transfer, prescribing and administering medications, oral and IMI, suturing lacerations, nasal packing, peg tube maintenance, catheter replacement, urine testing, BSLs and observations including B/P.

As an extension of general practice there are medical deputising services across Australia. Medical deputising is an essential service within the umbrella of primary health care in Australia[2], however, medical deputising is regularly left off stakeholder lists and overlooked for input or comment regarding government policy or departmental matters related to general practice and of significance to MMDS in particular.

[1] A recognised accreditation agency

[2] On a national basis, each year medical deputising services provide 10 – 12 % of all primary medical care consultations – eg in 2009 the figure was 850,000 consultations

As a result, MMDS believes that it[3] (and other medical deputising services) should be included in the general practice category and recognised as stakeholders to receive direct information about health and ageing announcements, media releases and publications relevant to general practice.

MMDS is one of two medical deputising services in Victoria and it has operated successfully since it was established in 1979. Each year in Victoria, MMDS facilitates the provision of 120,000 home visits, of which, some 54,000 are visits to patients in residential aged care[4]

These are significant consultation numbers and at any one time MMDS has a pool of 70 – 80 visiting medical officers (VMOs) who work predominately on a part-time basis and provide these home visits. These doctors (almost half of whom are Fellows of the RACGP) combine the work they do after hours with their in-clinic or hospital emergency department work.

Our workforce is sourced from the Australian health system – that is, doctors who trained in Australia and IMGs who have had the tenacity necessary to overcome the many hurdles encountered on the way to registration to practice in Australia (and FRACGP or recognition in another field). The MMDS workforce comprises:

- vocationally registered, FRACGPs who combine work in their own practices with part-time VMO work with MMDS;
- vocationally registered, FRACGPs who are career VMOs working only with MMDS and at a level of hours that suits their lifestyle; and
- VMOs working part-time with MMDS via the AMDS Program (this accounts for almost half of the MMDS clinical workforce)

At MMDS we have mechanisms in place that ensure we maintain a close working relationship with all our VMOs and together with what's happening in their lives in general, we stay abreast of their career progress and any difficulties encountered in this regard. In addition, MMDS provides all necessary administrative support towards medical registration, registration on approved placement programs, provider numbers and support regarding verifiable hours worked as required by RACGP assessment processes.

Accordingly, MMDS is well-placed to provide input about registration processes that affect its VMOs including IMGs who are either on-shore or off-shore.

Recommendation

[3] MMDS has demonstrated adherence to a continuous quality improvement model and as a result of its successful 35 year history in medical deputising as a depth of knowledge which it is happy to share in the interests of better outcomes for all concerned, not the least of which being those patients who have to rely absolutely on others for the provision of their care.

[4] One of the most vulnerable groups in the community, totally dependent on others to ensure they have access to appropriate medical care, adversely affected by the fact that each year fewer GPs are willing or able to visit patients in residential aged care.

1. *That as a key element in the delivery of primary medical care, MMDS (and other medical deputising services) be formally recognised as general practice and, accordingly, included as stakeholders to receive direct notification of all health and ageing announcements, media releases and publications relevant to general practice.*

2 Continuing Need for IMGs

Australia has long since recognised the importance of IMGs in order to alleviate workforce shortages in the provision health care for the Australian community. IMGs have made a substantial contribution to the provision of primary medical care after hours and in the home setting. They have been, and continue to be, willing and able to work where other doctors have not, for example, overnight, on weekends and public holidays including Christmas and Easter. As VMOs working with MMDS, IMGs are the doctors who provide a high proportion of all consultations for patients in residential aged care – as noted earlier, every year our VMOs provide some 54,000 home visits to patients in residential aged care. IMGs deserve respect and appropriate reward for their contribution.

There is little on the horizon to indicate that workforce shortages will ease in the future – certainly not in the provision of after-hours care. The latest MABEL Survey Report[5] found that GPs are no longer able to provide the after-hours service themselves:

- Around 50% of doctors would like to reduce their working hours.
- Around a quarter of all doctors are very or moderately dissatisfied with their hours of work.
- The first wave of the study's data collection completed in 2008 found that nearly 12% of the GP workforce was expected to retire within five years (*MO, 1 May 2009*).
- Intentions to quit are largely driven by those over 55 years old who expect to retire, and thus reflects the loss to the workforce of the 'baby boomer' generation

These indicators together with a growing and ageing population and the advent of the national call centre[6] will compound already exacerbated workforce shortages.

It is unlikely (particularly in regard to primary medical care after hours) that Australia's reliance on IMGs will diminish in the foreseeable future. (It is possible but highly unlikely that we will be able to persuade expatriates to return to Australia to provide after hours care and home visits.)

Australia needs entry systems and medical registration systems that are rigorous but not obstructive; that encourage and support participation in QI&CPD; and Fellowship goals that are practical and allow consideration of the circumstances of individual doctors.

[5] The MABEL Survey funded by the National Health and Medical Research Council (NHMRC) for five years until 2011 and endorsed by key medical Colleges and organisations.
[6] As part of the Commonwealth Health Reform agenda a National Health Call Centre to provide patients with access to telephone-based GP medical advice will come into effect 1 July 2011.

As workforce shortages in the after-hours arena have worsened MMDS is now endeavouring to recruit suitably qualified and experienced doctors from overseas to work in Australia on a temporary resident visa. The pathway to medical registration for IMGs will differ according to their qualifications and experience, however, having been granted registration they will then go on to be governed by other legislative mechanisms which are in place to ensure the provision of high quality primary medical care by doctors working in Australia, that is, Section 19AA which requires vocational registration unless exempt in line with Section 3GA and subject to QI&CPD compliance.

3 MMDS as an example of encouraging and supporting Quality Improvement and Continuing Professional Development

MMDS has structured processes in place to manage and monitor the professional development of its clinical workforce and, in particular, doctors who are part of programs to ease workforce shortages and improve the quality of and access to care provided by medical practitioners in Australia.

It is important to note that MMDS (and medical deputising in general) does not receive any incentives or compensation from government in recognition of its investment in QI&CPD for its clinical workforce.

As an accredited RACGP QI&CPD provider, MMDS is able to provide structured learning which entitles its doctors to RACGP points that verify compliance with continuing professional development.

3.1 Induction Program

Completion of the comprehensive induction program is a mandatory requirement for all doctors new to MMDS. MMDS has a structured learning program (accredited by the RACGP as a Category 1 Active Learning Module (ALM)) which involves 12 hours of training.

This ALM is a comprehensive 3-module induction program, usually conducted on a one-to-one basis but can also be delivered as a small group induction.

Its purpose is to prepare VMOs for all aspects of treating patients at home on behalf of the patient's principal GP. The program comprises

A Predisposing module: introduction meeting, selected reading

B. Face-to-Face module is in three (3) parts:
   1. MMDS policies and procedures including statutory compliance formalities; protocols for personal safety; Medicare requirements and item numbers, Medicare On-line, Clinical reports electronically transferred to principal GPs.
   2. Clinical observation shift with the MMDS medical director (or his delegate).
   3. Pharmacy induction with a pharmacist who has particular knowledge of the work of deputising doctors and the medication and prescribing requirements which commonly apply to after-hours and home visits.

C. Reforcing module - reflection on feedback from medical director following his review (at the end of first month) of a new VMO's clinical notes; and evaluation questionnaire completed after appropriate time for reflection based on actual practice as a VMO.

4 Assessment and Entry Systems

Evaluation and verification of qualifications and suitability for particular positions must be rigorous but not obstructive.

MMDS personnel have witnessed the difficulties encountered by IMGs in finding a way through the maze of complex information. Each step in the process is long and frustrating, the overall financial cost for IMGS is many thousands of dollars and they are at a loss to understand why everything is so hard when dealing with the relevant assessment and entry systems, not the least of which is AHPRA - it's as though these particular bodies (AMC, AHPRA and RACGP) don't want register IMGs or see them progress.

There are valid reasons why the entry system processes are complex, however, it's important to remember that one size does not fit all and a simple 'let me help you' approach takes no more time and in the long term is beneficial for all concerned.

Recommendations

2. *That website information provided by assessment and entry systems including AHPRA is backed up by approachable, accessible and knowledgeable trained staff.*

3. *That the assessment and entry system organisations including AHPRA investigate ways to improve administrative efficiency and remove unnecessary delays.*

4.1 Australian Health Practitioner Regulation Agency (AHPRA)

While MMDS is sympathetic to the administrative workload and difficulties that may be related to the introduction of the national registration scheme, our experience with AHPRA has been most unsatisfactory.

MMDS concerns about the PESCI waiting list and what mechanisms can be put place at AHPRA Victoria to improve its administrative and communications processes related to medical registration have been lodged with the Health Industry Ombudsman in particular concerning case study 1 below.

MMDS understands that other states manage and schedule PESCIs using a priority list mechanism – it's unclear if this type of system applies consistently across the national scheme, however, what is clear is that we are very dissatisfied with the service provided by the Victoria office.

4.1.1 Case Study 1 - IMG off shore

5th August 2010	Application lodged with AHPRA Victoria
29th September 2010	Wrote to Medical Board Australia (MBA) with concerns about delay in the process.
12th October 2010	Advised by MBA that the enquiry had been forwarded to State office (in this case Victoria) where individual registrant queries are handled.

16th November 2010	Formal notification from AHPRA Vic that the doctor had been placed on PESCI (pre employment structured clinical interview) waiting list of 4 – 6 months, however, no scheduled or indicative date was available. We were told that we would be given a few weeks' notice once the date was set. A few weeks' notice may work for a doctor who is on-shore but it is not at all helpful for a doctor who is off-shore and needs to arrange a visa in order to travel to Australia to complete the PESCI – such visa application requires written evidence of the purpose and date for which the doctor is required.
6th December 2010	Follow-up email enquiry to registration manager Vic – no response
13th January 2011	Further follow-up email to Vic registration manager. Email response from person responsible for scheduling PESCIs in Victoria: *'…still some way down the PESCI waiting list; I suggest you make contact with South Australia RACGP.'*

This suggestion was acted on immediately and the doctor was booked to complete the PESCI 31 March 2011 in Adelaide – it would have saved a lot of angst for the doctor (and others) if we had known about this option earlier.

The doctor's Certificate of Good Standing has now expired – in many parts of the world obtaining another is both difficult and dangerous. AHPRA apparently has the option to consider if circumstances warrant a waiver of the currency requirement for the good standing certificate, however, it will not do this until after the IMG has completed the PESCI.

(Status as at 14 April 2011: the doctor concerned completed the PESCI satisfactorily and was recommended by the Panel, however, in spite of assurances given by AHPRA Victoria on 6 April 2011 that a case manager would be nominated immediately, the doctor still does not have an AHPRA Vic case manager who can obtain the official result and arrange for the Registration Committee to finalise its decision regarding the doctor's registration.)

Since the commissioning of AHPRA in July last year we have found the processing of national registration extremely slow and while the staff on the help lines are always polite and do try to assist they field calls in a generic manner. On some occasions information provided has been found to be inconsistent and inaccurate. On more than one occasion, when necessary information was not available from the AHPRA website, MMDS personnel have experienced 'I can't give you that information because of privacy reasons' – central call centre staff did not seem to know that a doctor's registration status is public information.

As directed by the AHPRA central call centre, we have made many enquiries to the AHPRA Victorian office. We are very concerned about the lack of response to messages and the lack of information available from the Victoria office and the detrimental effect this has on our IMG candidates and our VMOs in general.

When dealing with AHPRA nothing has been forthcoming in the way of options or possible solutions – as noted above, we have only just discovered that there are options

other than AHPRA for an off-shore IMG to complete a PESCI – a simple phone call or email much earlier would have avoided all the angst.

The way things are progressing, it is likely the doctor's English Test will expire and AHPRA will require the doctor to go through the process again (more time, more money). It is hoped that AHPRA can apply a special consideration approach and accept that the verification of English language skills in the PESCI process is adequate evidence.

PESCIs

We understand (as recently advised by AHPRA) that off-shore IMGs can arrange a PESCI through AHPRA, Health Workforce Assessment Victoria or the RACGP (SA) and that PESCIs are currently only available in person on-shore in Australia. Although AHPRA has not mentioned ACRRM, we understand that ACRRM can arrange PESCIs. At this stage we are not sure if our (MMDS) off-shore IMG candidates are eligible to access the ACRRM process, however, the ACRRM website certainly indicates that video conferencing is available for both off-shore and on-shore doctors.

We understand that individual state offices of AHPRA differ in the way they manage and schedule PESCIs and that there is inconsistency in the way PESCI providers ensure that interview content is relevant. For example, the RACGP (SA) is an accredited PESCI provider and the panel of assessors rightly require full information (position description, support and supervision/mentor mechanisms) about the position for which an IMG is being considered – this is not the case for the Health Workforce Assessment Victoria which refuses any information about the position or available support systems for which the doctor is being considered. Differences in the way medical registration is handled at the state level seems inconsistent with the intent of national registration.

Recommendations

4. *That the different options available to arrange a PESCI are well-publicised on the AHPRA website and that an information box is added to the PESCI question on medical registration application form(s).*

5. *That video conferencing be an option for IMGs who are interstate or off-shore and that the management, scheduling, interview type and content process are consistent across all PESCI providers.*

6. *That within 10 days of lodgement of a medical registration application a PESCI where required can be scheduled to take place in a timeframe of no more than one (1) month hence.*

7. *That representatives from the registrations section of AHPRA Vic visit MMDS to ensure they are fully informed about the work carried out by visiting medical officers (VMOs) and are confident about the clinical governance and support systems and accredited QI&CPD provided.*

4.1.2 Case Study 2 – IMG Application to renew registration

5th November 2010 application to renew limited medical registration lodged. Expiry date on current registration was 11th January 2011 so renewal submitted in timely manner and with all required supporting documentation including RACGP assessment and enrolment statement which verifies that doctor (1) sat exam 20 October

	2010 but failed by .79 of 1 mark and (2) is well on the way to achievement of Fellowship of the RACGP.
2nd December 2010	Registration Committee scheduled to consider application.
9th December 2010	Registration Manager advises doctor that renewal has not been approved and will be forwarded to Registrations Director for further consideration. The doctor is most distressed, FRACGP is within sight and previous applications have never been a problem.
11th December 2010	RACGP Deadline to enrol to re-sit exam. Unable to enrol without registration, no RACGP discretion, only option is to sit in the second half of the year which of course affects all related dependency timelines.
22nd December 2010	Registration renewal approved

MMDS is confident that the doctor concerned would be more than happy to take the Inquiry Committee through chapter and verse of her experiences with the administrative hurdles of both the RACGP and AHPRA.

Recommendation

8. That AHPRA and the RACGP establish efficient special consideration or discretion mechanisms in order to avoid or remedy unintended consequences related to administrative processes.

4.1.3 Case Study 3

This is an extract of an email (dated 8 April 2011) sent by MMDS to the AMC (Australian Medical Council) because AHPRA were unable to assist.

Scenario

- *IMGs granted limited registration (without AMC requirement) in 2005 and practiced medicine in Victoria (after hours area of need) initially as a temporary residents*
- *Subsequently obtained permanent resident immigration status followed by Australian citizenship*
- *RACGP assessed their overseas experience equivalent to Australian general practice as >5 years*
- *As a result, they have been permitted to enrol to sit for Fellowship of the RACGP exams*
- *Limited registration has been renewed not less than three (3) times*
- *Current limited registration is valid to January 2012*
- *They are now on the cusp of achieving Fellowship (final exam this year) and status as vocationally registered general practitioners (as required by 19AA of the Health Insurance Act).*

Can you please advise the position regarding their access to general or specialist medical registration?

Notwithstanding their achievements thus far and contribution to the Australian community, AHPRA advises that unless both components of the AMC are passed, such IMGS will not in future be eligible for general or specialist medical registration and that further limited registration may be an option but unlikely. AHPRA was unable to direct me to the statutory requirements or guidelines which underpin the advice given. Our experience with AHPRA in the past indicates that the

information they provide is not always reliable. Ian Frank was a witness at a public hearing held in Melbourne by the House of Representatives inquiry into the registration processes and support related to international medical graduates, accordingly, I made contact with his office in the hope of obtaining dependable advice about the facts, relevant statutory requirements and appeals processes.

Is it so that IMGs who have surpassed AMC entry exams are now (since 1/7/2011) required to go back to the beginning? That is, IMGs whose skills, experience and academic capability complies with the legislative requirements introduced by government to recognise general practice as a vocation requiring specialist training (applied and monitored by the RACGP or ACRRM); who have been registered and practiced medicine in Australia since long before 1st July 2011; and who have achieved Fellowship of the RACGP.

14 April 2011 – the AMC office advised that Ian Frank (CEO) is 'going to make a few calls' to senior management at AHPRA and RACGP to establish the position – MMDS expects to hear the results of his enquiries by early next week.

MMDS is available to provide further information for the Senate Inquiry.