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Chair of House of Representatives
Standing Committee on Health & Ageing
PO Box 6022
Parliament House
CANBERRA ACT 2600

Submission No. 59
(Overseas Trained Doctors)
Date: 14/02/2011

Please find enclosed submission to the House of Representatives Standing Committee on Health & Ageing. This document has been authored by Dr John Best for presentation by the M2M consortium to the Committee. The M2M consortium consists of Numurkah District Health Service, Cobram District Health, Yarrawonga District Health Service and Alpine Health and is working together to build the medical workforce in this rural area.

We look forward to a hearing in Albury, Shepparton or Wangaratta to building on the written presentation and give you the opportunity to see at first hand what has been accomplished and what is in progress.

Yours sincerely,

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SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH & AGEING

Terms of Reference

Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the Committee will:

1) *Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions;*

2) *Report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs; and*

3) *Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies.*

Introduction

On behalf of a number of small health services in Victoria, this submission to the House of Representatives Standing Committee on Health and Ageing has been constructed in order the inform the Committee of what is actually happening in relation to supporting overseas trained doctors (OTDs), who may also be referred to as international medical graduates (IMGs). This latter term is used within the Victorian health system.

Further, in making this submission, the Murray to the Mountains (M2M) health services believe that the preamble "Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs)" may not be the only part of the health system contributing to the maintenance of standards.

The M2M health services in question are:

(a) Three within the Moira Shire, namely Yarrawonga District Health Service (YDHS), Cobram District Health (CDH) and Numurkah District Health Service (NDHS); and

(b) Alpine Health (AH), which has three campuses at Bright, Mount Beauty and Myrtleford.

All these health services rely on general practitioners with procedural skills able to handle emergencies and to provide a 24/7 cover. This is particularly relevant to Mount Beauty and Bright which provide the medical services to Falls Creek and Hotham during the winter. In the case of Yarrawonga, and to a more limited extent Alpine Health, the general practitioners also provide both obstetrics and anaesthetics services.

All the campuses have visiting specialists who consult and in some cases electively operate on site. While CDH and NDHS refer patients primarily to Goulburn Valley Health (GVH) at

Shepparton, Yarrawonga mainly refers to Northeast Health Wangaratta (NHW) as do the Ovens Valley based campuses of Alpine Health (Myrtleford & Bright). Mount Beauty refers patients to Albury Wodonga Health (AWH).

To achieve the best possible workforce, especially with consideration to the recruitment of doctors to prevocational positions, the above health services established a loose confederation called Murray to the Mountains (M2M) Health in 2010, and are establishing close working relationships with the three major regional health services mentioned above.

International Medical Graduates (IMGs)

All the health services are increasingly dependent on the services of IMGs, and one of our health services' strengths is having a robust credentialling, scope of practice, privileging and appointments system. Across M2M there are currently 24 IMGs in practice (excluding visiting specialists).

This process, undertaken at the health service level, gives the health service the best use of the data required to work out the level of competency and knowledge the individual IMG has achieved. The first question to be answered is – does each doctor require supervision or can he/she work independently?

Having a process where the responsibility is taken at the health service level (and here the presence of competent Directors of Medical Services (DMSs) is essential) the question of whether the expected level and actual level of competency match. This is a vital factor in promoting and assuring the skills level of those IMGs who are working both in general practice and in the hospitals and associated aged care facilities. The small health services receive relatively few critically ill patients (triage categories 1 and 2). However, there are a sufficient number of moderately seriously ill patients (triage category 3) who need to have a competent doctor as the first line after the receiving nursing staff. It is important that the doctors have the confidence of the nurses on staff, who are often the best bellwether of the doctor's ability to cope.

Many of the IMGs have different cultural expectations. Thus communication is crucial and level of comprehension and communication relies on a good command of English, which does not deteriorate under stress. On the other hand, when dealing with non-English speaking patients, their interpreter skills may be a boon in a situation where there are potential problems.

The IMGs are on the after-hours and weekend roster for hospital-based clinics, caring for inpatients and handling those patients who present at the emergency department. CDH is the only health service which owns its own clinic and has recently completed the construction of this clinic within the hospital grounds where both doctors and dentists work within an integrated care framework.

One of the positive outcomes that has been achieved has been the number of IMGs who have come and stayed in the various health services. Success is considered to be a five year stint, since as with Australian graduates there is far more mobility in the work force, and the concept that doctors staying put in a region for their whole career is a universally desirable characteristic is one which has never tested empirically. The willingness to unquestioningly providing funding for retention allowances does not address the challenges to rural practice which I identified when undertaking the Rural Stocktake[1] a decade ago for the Commonwealth Government namely:

[1] Best, J. *Rural Health Stocktake.* Commonwealth of Australia, March 2000.

(a) social dislocation,

(b) professional isolation,

(c) community tolerance,

(d) succession planning.

While "professional isolation" and "succession planning" are self-evident, "social dislocation" can briefly be described as "where your spouse/partner will not come to" or "where you have to send the children away to school". "Community tolerance" is the preparedness of the community to give the doctor/s professional space because in a small rural community nobody is anonymous as he or she may be in the city. One of the problems is when you have two medical practices at war with one another. The quality of community tolerance becomes strained. Fortunately this last scenario does not occur in any of towns mentioned above, although most have two practices in competition yet share the hospital workload after hours.

It is the ability of those responsible for health service clinical governance to be sensitive to the above as well as the income targets of each of the doctors (including the IMGs) residing in their health service area.

Terms of Reference 1 and 3

The first and third terms of reference are in many ways interdependent and therefore in this submission will be considered together.

One of the matters, which needs to be recognised by those concerned with the registration requirements is the need for the local surveillance and supervision mechanism to be able to complement the registration procedures which have now become national through the Australian Health Practitioner Regulation Agency (AHPRA) rather than the previous State-based registration system.

Equally, it is important to recognise the role that the Australian Medical Council (AMC) will have for the next three years as an independent national standards and assessment body for medical education and training.

In its consultation paper on "competence-based medical education" released in August of 2010, the AMC talks about codified and tacit knowledge. The first is gained from a library environment; the other from self-experience. The paper asserts that "competency" with all its related terminology has yet to be clearly defined. In the paper the link is made from competency (codified) and tacit (quality of the experience) as vectors for competence, which in the actual performance (influenced/affected) by external factors lead to the patient outcome.[2]

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2 "Time spent in training is not representative of experience gained. There needs to be a focus on the quality of the experience and assuring the right experience. Time invested specifically to facilitate wide exposure to, and experience with, complexity is likely to show a good rate of return." (Competence-based Medical Education and Consultation Paper, August 2010, p 19.)
It is recognised that the above statement contains a number of normative judgements, but in isolating these and attempting to provide a quantitative framework will only serve to progress thinking in this crucial area.

One outcome from this AMC paper may well lead to a total questioning of the need for a separate structure for the prevocational year, and advocacy for a training program structured as a three year period up to and including the PGY3 year. This is especially so where there are now pressures on reducing the length of postgraduate training before the medical practitioner can enter unsupervised medical practice. With the injection of the overseas-trained into this medical education/registration mix, it is important to ensure a strong local system attuned to improving and maintaining standards.

Therefore, all matters relating to standards take into account the national requirements. Before a doctor can be appointed to the hospital, it is necessary for the doctor's qualifications to be checked (credentialling) and scope of practice determined,[3] and privileged (assuring that the work undertaken by the doctor is within the capabilities of the hospital).[4] This is undertaken by the Moira Health Services DMS and the Chair of the Alpine Health Credentialling & Privileging Committee, who has the authority to authorise interim credentialling and privileges until there is a meeting of the full committee.

There are two credentialling and privileging (C&P) committees for M2M:

(a) Moira Health Services

(b) Alpine Health

Each Committee has a distinct membership but what sets these committees apart is the number of outside "medical peers" who have no pecuniary interest. These medical peers are highly experienced leaders in the fields, and while most doctors receive three years credentialling and privileging rights, those in training are assessed year by year until completion of training. Also, when there are doubts as to competency, then a lesser time than three years is given.

Many of the IMG doctors working across M2M are endeavouring to achieve their Fellowship either of the Royal Australian College of General Practitioners or the Australian College of Rural & Remote Medicine either as General Practice Education & Training (GPET) registrars or under the variety of other schemes which provide limited registration with mandatory terms to be served in rural practice, where area of need is a major criterion for being able to practise.

However, implicit in all schemes, is an abiding concern reflected in the credentialling, scope of practice and privileging ethos that the doctor must be competent to practise under supervision or independently. That is the core question which each health service has to determine about all its doctors, including the IMGs. It is important that each doctor is considered on his or her merits and referee reports are thus very important. Even given concerns that such referee reports should be used appropriately, there has been only one case in the six years of the system being operation in our area, where the decision of the C&P committee was questioned.

Because the process is worked out on a local basis, common sense prevailed in this case. Rather than a formal appeal, the particular doctor was kept under close watch when rostered on weekends, with orders given that the Director of Nursing (DON) and DMS be informed of any problems with this particular doctor's performance. There were none, and so the hospital was

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[3] The basic scope of practice for a doctor practising in a small rural health service is to be able to admit and care for inpatients, handle emergencies, undertake minor surgical procedures and be able to competently treat the elderly and children.

[4] For instance, general surgeons operating at these hospitals do not electively undertake abdominal surgery, including appendicectomy.

able to avoid a lengthy appeals process against the decision of the Committee, which was subsequently revised by the Committee.

There are always differences in the competencies of doctors. Some improve; some do not and in the case of those who do not, in this environment they leave for jobs presumably where the skill level required is not so great and probably the surveillance/supervision not as stringent.

However, the appointments process to the hospital is undertaken by the Board in consultation with the Chief Executive Officer (CEO) and the DMS where necessary. In Victoria, the value of the local Boards of Management (BoMs) is that they are composed of members of the local community – and hence can be considered informed surrogates for the particular community.

The message is simple in response to the terms of reference.

Ensure that the systems of assessment are locally based and the responsibility for clinical governance is clearly defined as it is in the M2M health services.

It will not happen if the health care services do not interact with their IMG doctors. The assumption should always be that you have a doctor recruited for five years. Many of the doctors have served time in rural areas as part of the condition of being able to practise. However, in the case of our health services, if the environment has a structured, continuing medical education program and the doctors are encouraged to contribute to clinical governance, then a workforce arises where the objective of serving out the time and then decamping to the city at the end of seven years (or whatever restriction is placed on the doctor's being registered) becomes less important to the ultimate decision of the IMG doctor.

Attached is a relevant presentation made by Dr Michael Chabbou to a forum organised by the Victorian Department of Health in 2009 where, as a keynote speaker, Dr Chabbou described his progress from being a Syrian national undertaking his undergraduate course in Romania, to his subsequent practice in Syria before migrating to Australia. After initial difficulties, Dr Chabbou gained his Fellowship of the Royal Australian College of General Practitioners and has settled in Cobram as a senior doctor in the local clinic owned by Cobram District Health.

The success story that he epitomises is being bolstered by funding designed to enable the local doctors, who are increasingly IMGs, to both maintain and develop their clinical skills and knowledge and also be able to teach undergraduates and medical graduates in training.

Term of Reference 2

The significant sources of funding for the M2M health services comes from the Commonwealth and Victorian Governments. The Victorian Department of Health has recognised the innovative nature of M2M and has provided funding to implement an ambitious program of education of both students and young postgraduates.

In the 2000 Australian Federal budget, substantial funding was made available for rural clinical schools attached to pre-existing university medical schools, and it may be argued that the subsequent expansion of rural clinical schools and the funding of rural medical schools has enabled the substantial increase in medical students over the past decade to get appropriate training. In fact, the rural placements have been popular and in many circumstances this has been reflected in excellent results in the final exam.

The problem confronting the young graduate is to find a similarly enriched training environment in the first postgraduate years (including the first prevocational year when supervision is crucially important) in rural Australia.

Therefore, it is important to construct and assure a training environment for the young graduate equally as successful as that for medical undergraduates training in a rural environment.

As many of the doctors who will be involved in the training of these postgraduates will be IMGs, it is important to recognise their potential contribution and assure their competency as supervisors.

Many IMGs may already have experience in teaching through the Commonwealth-funded GPET program, where there is a requirement for graded supervision as the registrar proceeds through basic, advanced and subsequent terms. Added to this, there are cases where some doctors require ongoing or remedial supervision. In other words, there may be IMG supervisors and IMGs being supervised. Therefore, it is important that IMGs are not considered as a homogeneous group, which they are clearly not.

However, it is unlikely that all the benefits from the wide variety of projects for which funding has been received will be completed by the end of any one year. One of the problems faced when one is effecting system change is that such change cannot necessarily be defined as "sustainable" in one annual round of funding. Thus, once the system has been established, it may require supplementary funding to achieve sustainability.

The IMG Grand Rounds Project

A case in point which has been one of the success stories is the use of IMG designated funding provided by the Victorian Department of Health to set up a Grand Rounds program where IMGs have been variously the presenter or discussant across a wide variety of topics – essentially the use of the case study to exemplify a problem, enlist expert discussants to comment on what has occurred, provide encouragement to the presenting doctors and/or provide a variety of alternative courses of action if appropriate – a complete learning experience within a multidisciplinary environment. Ten Grand Rounds have been listed for 2011, and it would be expected that a similar number will be listed in 2012 with the prevocational doctors taking some responsibility for the organisation of the subject matter and, in association with the designated presenters and discussants, determining the relevant clinical cases as part of their learning experiences.

It can be reasonably expected that some of the endeavours may attract funding from the Government either by direct grant or more likely from the various program grants, and some may be undertaken legitimately with Medicare funding. One of the consequences of sustainability is not only diversifying the funding pool but also being able to generalise the successful application of the program to elsewhere in the most cost-effective manner.

Below are a number of further initiatives which, quoting the appropriate Term of Reference 2, "will provide suggestions for the enhancement and integration of these programs" relevant to IMGs.

Director of Clinical Training

Mr Paul Sheahan, a distinguished educationalist well versed in organisation, has accepted the post of establishing the framework for the education and training of postgraduates and undergraduates. Initially on a three month contract, he will be working with the DMSs and the doctors.

With the creation of the post, an M2M Medical Forum chaired by Dr Jeff Robinson, the part-time DMS at Alpine Health, will be created to facilitate formal input from the various practices on a quarterly basis to monitor both the level of teaching and the level of satisfaction that the local medical work force and the postgraduates and undergraduates have with the process being developed. Mr Sheahan will be involved in the creation of the Medical Forum and it is hoped that such a forum will provide a useful point of communication with the relevant universities and the Bogong Regional Training Network, the regional training provider.

Geriatrics Program

One of the most important areas where it is important to assure clinical skills is in the care of aged. One of the problems has been the dearth of consultant geriatricians in rural Australia. Western Health has one of the most substantial geriatric units in Melbourne with campuses at Footscray, Sunshine and Williamstown. The head of the Unit, Dr Richard Whiting, has been providing his services as a consultant geriatrician to the Hume Region for nearly twenty years, and the proposal to establish a clinical teaching service using the expertise of his unit not only to provide clinical services but to use the opportunity of direct visiting and through video-linkage to provide teaching as well, will have a direct impact on IMGs' skills in this area.

A Memorandum of Understanding (MoU) between Western Health and M2M is being prepared, following discussions about the proposed clinical teaching service. The aim is for the service to start in February with six weekly visits by a consultant geriatrician and/or advanced geriatric registrar employed by Western Health to the three Moira Shire health services over three days supplemented with videoconferences or teleconferences between visits.

The aim would be to extend the clinical teaching service to Alpine Health. At the same time it is expected that MSOAP funding[5] will be rationalised between the various campuses; and the development of the service will take into account the need to encourage identified local general practitioner to gain expertise in geriatric medicine as well as monitoring the recruitment of appropriate specialists into the larger regional health service. In due course this service should become regionalised and serve as a model for other clinical areas, such as rehabilitation medicine, psychiatric medicine and addiction medicine.

Skills Workshops

The aim is to provide young doctors working across M2M with a wide exposure to areas of medicine where it is important that they have some knowledge. One of the challenges that medicine as an academic discipline presents is the breadth of areas which could and/or should be taught. The objective of having skills workshops in such areas as ophthalmology, ear, nose and throat, ECG interpretation, fractures, and dental emergencies that doctors in rural areas may have to confront is to develop a syllabus not only of relevance for the committed general

[5] Medical Specialist Outreach Assistance Program is a Commonwealth-funded program administered through the Rural Workforce Agency. Although it has been revised a number of times, it provides specialists in areas of deficiency to be funded to visit smaller centres. It has been very valuable.

practitioner in training but also for those younger doctors who inevitably may specialise after the first two years in practice. Hence, the objective in the first years is to expose the young doctors to as much clinical experience as possible (and as many IMGs fill these junior positions this applies to them equally). One of the problems is placement of the young doctors so as to reduce the amount of clerking that they do. It is an ongoing criticisms of some major teaching hospitals that some of the rotations provide limited clinical experience and the junior doctor becomes *de facto* a ward clerk.

The discussions on these workshops and preparation of same have reached the negotiation stage with a view to a number being staged over the course of this year commencing in March 2011 with an ophthalmology workshop.[6] While the number of workshops is yet to be finalised, M2M expects that there will be six workshops established to be repeated next year.

In relation to radiology, a workshop is proposed for May 2011 to expand the number of doctors able to undertake radiography after hours and then be able interpret the routine images. This is the basis of the Victorian radiation licensing available to rural general practitioners. It will be important to see how generalisable this project is in assuring that the doctors who are trained, accept the same level of responsibility in relation to radiological practice as the Mount Beauty and Bright doctors do.

In concluding this brief submission, it should be noted that by establishing a congruent subregional grouping of health services with coherent clinical governance and teaching program, M2M is in the process of establishing a system that may provide at least one answer to the matters raised in the three Terms of Reference.

Conclusion

The Parliamentary Committee is seeking advice. The M2M program provides one way of addressing the Committee's terms of reference, and if the Committee wishes us to expand on any of the matters which we have addressed, we would be only too happy to do so.

The Colleges may have an important role; but so do the health services that recognise the importance of their teaching role especially in those areas where the Colleges have traditionally shown minimal interest – undergraduate and the first two postgraduate years.

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6 In 2010, Mr J.K.E Galbraith, a retired Melbourne ophthalmologist with a wealth of teaching experience mainly in the South Pacific, organised the first of these workshops in Numurkah. Seventeen doctors, including a number of IMGs, attended. The major practicable experience was in examination of the eye and the removal of foreign bodies.