Rural Doctors Association of Victoria
Submission to the Victorian Legislative Council Inquiry into the AHPRA

The RDAV has had extensive dealings with the AHPRA (Medical Board of Australia) for several years of a not altogether satisfactory nature. This is a short account of the experience to date.

The RDAV saw fit to question actions of the Board with respect to the placement of doctors from overseas with Limited Registration into General Practice in Areas of Need through medical corporates. The matter arose in 2010, when it became evident, from multiple reports received, that a substantial increase had occurred, and circumstances indicated lack of supervision. In Victoria the numbers of Limited Registration Overseas Trained Doctors rose in Area of Need (Rural, Regional, Fringe Metropolitan and Metropolitan after-hours clinics) from 227 in January 2011 to 279. Nationally the figure was 2731 in January 2011. Once they obtain general registration these doctors are not required to have any supervision.

In the interests of brevity and because of time constraints, this document is unreferenced. A fully referenced version and copies of all documents would be provided on request should the Inquiry wish to uptake this matter.

History.

Since severe shortages began in the 1990s, Overseas doctors have been carefully incorporated into the Victorian rural medical workforce, mostly into standard non-corporate practice. They now comprise 44% of the total 1389 doctors in rural and regional Victoria, which for several years has had a doctor to population ratio identical to that of metropolitan areas. Until recently Medical Boards have been careful about partial or limited registrants being employed in General Practice rather than hospitals and this was considered reasonable by the profession. Except in small isolated locations, very close on-site supervision was required and the maximum ratio, of one Fellow to two doctors in training, paralleled supervision standards for Australian GP registrars in training.

AHPRA supervision Standard.

On 24.12.09 The Medical Board of Australia published Consultation paper No 2, containing proposals for registration standards for limited registration, which did circulate, and in April 2010 posted another Consultation Paper which included Limited registration. Neither paper made note of supervision standards and no responses are published for either. The RDAA is not notified when consultation papers are posted. On 8.6.11 the AHPRA published, (without consultation as far as we know), "Guidelines – Supervised practice for limited registration" to "provide assurance to … (The Board) and the community that the registrant's practice is safe and is not putting the community at risk". This allowed a ratio of 1 supervisor to 4 LROTDs (or more at the Boards discretion) and distance supervision (by electronic means at any distance) with no on-site Fellows required except for level 1 supervisees.

It is these guidelines for supervision which have legitimised and facilitated a major expansion of the workforce, derived from mechanisms for acquisition of Limited Registration based on multiple choice examinations conducted overseas. RDAV communicated a list of concerns about supervision standards to AHPRA in January 2011. The Board however replied 10.3.11 indicating that it was satisfied with its registration requirements and that the new supervision Standards would shortly be published. The Standards themselves in June 2011 legitimised the process already in place, making the lack of consultation regrettable, since comment would have been made on the experience to date, as signaled by the RDAV letter.

RDAV investigation.
(Full documentation of the following assertions is available). This section covers the capacity of the Board to look at wider issues and to link information where necessary.

There are number of corporates in rural Victoria all using Limited Registration OTDs. The RDAV was suspicious about capacity to provide even 1 on 4 supervision and undertook investigations. These were difficult and took some months because names are commonly misspelt and not to be found on the AHPRA registration pages. However, in one group of 72 identified doctors, including 25 limited registrants and only 16 registered Fellows, in the States of both Victoria and NSW, there were 15 doctors listed against one supervisor, the Corporate owner, who was co-supervising an additional 5 doctors. On 23.9.11 this doctor had claimed to the Age newspaper that he "had a fully accredited training program." This was passed on to AHPRA (MBA) who replied 30.9.11 indicating that supervision was in accordance with the "Board's supervision guidelines".

On 20.11.11 RDAV forwarded the database of names and registration details to AHPRA (MBA). They replied that because of devolution of function they had passed it to "the Director of Registrations at the Victorian State office of the AHPRA". We replied that as the matter involved two States we felt it appropriate to correspond with MBA. We sent a copy to NSW, acknowledged. However nothing further was heard, and in case the documents had been mislaid, we sent a copy of the Database to the chair of the Victorian Medical Board Dr Laurie Warfe at his practice address. No acknowledgment or further correspondence was received. However the AHPRA (MBA) website practice of listing the supervisors of limited registration overseas trained doctors on their registration papers ceased forthwith.

The failure of the Boards to engage with and give explanation to the RDAV as to these facts was in itself worrying but the situation went further. There appeared to be a high degree of trust given towards corporates. RDAV had however received documents strongly questioning the bona fides of the corporate doctor concerned. After some months investigating their origin and authenticity, (since independently confirmed, as communicated to AHPRA (MBV), RDAV forwarded copies to both State Medical Boards. Acknowledgement was not received from

NSW but Victoria treated the information as a notification (of fitness to practice). RDAV wrote to both State Boards emphasising the wider implications of the notification.

Nothing more was heard. An investigation finally eventuated, but only after further queries were raised with AHPRA (MBV) in May 2012, when RDAV was requested, but declined, to withdraw the notification. Letters were received indicating 'continued investigation' in September 2012 and 17.1.13, and mentioning that the matter of appropriate supervision was being looked at. Finally an email has been received on 4.2.13, to say that the investigation has been completed and forwarded to "The Board" for a decision. The inquiry might learn of the outcome if it is seen fit to look into all this. Internal AHPRA policy is to finalise such investigations within 6 months.

The corporate owner in question has repeatedly indicated to the media that his supervision processes have been cleared by AHPRA (MBA). He also stated on television "This is a new direction which is going and it doesn't put – I won't call it too standard general practice, it is not – this is actually the new way general practice is going" (ABC Transcript).

The AHPRA appears to have been tolerant of such statements and has indicated to the Media (Stephen Bradshaw ABC 730 report) that thorough investigation had taken place and no adverse findings made (despite written assurance to RDAV that investigation into supervision was ongoing). Does the statement therefore actually reflect an AHPRA (MBA) belief that standards below those of Vocational General Practice are desirable and without risk? In October 2012 RDAV raised questions about statements on the website of the same corporate implying that services provided by Limited Registration doctors are equal or superior to Specialist GP Fellows. These questions were dismissed by AHPRA on the grounds that registration by AHPRA, (including Limited Registration), allows such claims to be made about any doctor providing General Practice services.

What then is the purpose of GP Fellowships and other measures creating an environment in which improvement of professional standards is generally desired and often increasing? Is the promotion of LROTDs as fully capable (and by implication qualified) GPs, in accord with Board's aim, to "provide assurance to … (The Board) and the community that the registrant's practice is safe and is not putting the community at risk"? (Australian GP registrars in training are required to declare their training status to their patients.)

Other consultation.

RDAV consulted membership early and at the 2011 AGM voted to support a 1 to 2 supervision ratio, in line with supervision of Australian trained graduates un General Practice training. It has communicated its concerns to AMA, RACGP and GP Registrars Association. AMA had consequent private discussions with the AHPRA. RACGP voted at Convocation 2012 to develop standards of supervision of OTDs. There is probably a division of opinion within the RACGP because the AHPRA (MBA) program has enormously increased RACGP membership. RACGP

now claims more than 7000 'rural' members, (well above actual workforce numbers). RDAV has also expressed views publicly to press and radio about the inadequacy of Medical Board arrangements for supervision of LROTDs. RDAV also submitted as part of the Northwest Victoria educators group to the Federal "Parliamentary Inquiry into Overseas Trained Doctor registration processes and support", in which the supervision question was addressed in detail.

Victorian State's interest in the good function of AHPRA Medical Boards.

The State of Victoria is responsible for 91 rural health service campuses providing advanced, usually hospital based, clinical services which utilise rural GPs. It has major published health promotion plans for rural and regional areas that depend on highly competent GPs working in close association with primary health services, (control of which it has refused to relinquish to the Commonwealth). It needs the AHPRA (MBA) to be responsive to the needs of Health planning and to work with medical professional organisations in the establishment and maintenance of standards.

The AHPRA program.

It appears that the AHPRA (MBA), (was it requested to do so by COAG or Council of Health Ministers?), has firmly committed itself to a substantial program of overseas doctor importation to General Practice set at a standard significantly below that of Australian GP training. These doctors can continue in fully unsupervised general practice once fully registered through the clinical second part of the Australian Medical Council examination.

The usual function of Medical Boards is policing of behavior and practice of practitioners who have achieved established competence in programs implemented by the profession. In this instance the Boards have elected to implement a program of General Practice training with its own standards, which do not include supervised adult and paediatric acute medicine and no compulsory physical exposure to daily assistance from qualified GP Fellows (as required in Australian GP training).

The AHPRA (MBA) admitted to the Parliamentary Inquiry into OTDs that it had no resources to police this program. The Federal Government has been discussing how the medical profession can assist with training these doctors, and has just announced a program. Since they are mostly corporate based there will be great reluctance from non-corporate trainers. The AHPRA (MBA) program also coincides with the arrival of a "Tsunami" of Australian trained medical graduates who require Specialist and GP training, which itself will put a huge training impost on the profession. The number of overseas-derived doctors involved is far beyond anything that the profession could accommodate by way of formal training. Australian GP Training (AGPT/GPET), in the program just announced, could accommodate 500 at the most, with doubt about the availability of supervisors and teachers approved to College Standards, especially in involved corporates.

As a result, overseas doctors are dependent on courses run for prospective GP Fellowship applicants. They do not get the day-to-day, patient-by-patient assistance that produces such a high quality of general practitioner in Australia.

Comment.

Distance supervision was originally introduced, in Victoria with RDAV support, for isolated communities unable to recruit a doctor. It was not designed for use in training within the general medical community in a large program designed to put limited registrants into telephone supervision after very short periods of large ratio physical supervision in parent corporate practices.

One of the first documents that the AHPRA (MBA) published on 24.12.09 was "Good Medical Practice". This comprehensive document provides standards which we believe cannot be implemented in a program which does not provide substantial supervision and mentoring of new entrants not educated in the Australian undergraduate and post-graduate medical environment, especially where such supervision is loose, provided by telephone and not even to the much diluted supervision standards selected by the Board for such doctors.

Members of the RDAV have been hugely involved with training OTDs for two decades. These doctors need help and protection. OTDs are 4 times more likely to face formal complaints than Australian trained doctors and 40% more likely to be found guilty at disciplinary hearings (MJA 197 2012 8 study of Victorian and WA doctors). This is not surprising when they are put into practice raw from overseas without assistance, teaching, supervision and mentoring.

The AHPRA (MBA) perhaps mistakenly generated this program in its early days. It now needs to take steps to wind it back and progressively move prospective specialist GPs into mainstream training, concentrating on quality not quantity. The program is damaging to standards of General Practice. It has had various unforeseen consequences. It caused a drying up of recruits to mainstream rural practice through State Rural workforce Agencies. It is interfering with the capacity of mainstream practices to provide advanced rural community and hospital medicine. Corporates will inevitably take advantage of loopholes. The AHPRA has to close them and develop vigilant preventive mechanisms.

There has been a large volume of anecdotal material reflecting the inadequate training and supervision, especially from Emergency Departments. Unfortunately doctors have been extremely reluctant to make formal complaints and appear to be distrustful of the process and the Board. Dr Peter Radford, a senior RDAV committee member who has also submitted to this Inquiry, wrote to Dr Flynn with a written complaint based on cases referred to the Emergency Department he had been working in, but in discussion found the Board implied that similar complaints had not been made, (interesting in the light of the study of complaints mentioned above in progress in Victoria at the time).

Considering the Bundaberg experience and that of Queensland in general, this is quite surprising. What is not at all surprising to experienced practitioners has

been a multitude of anecdotal reports of many and varied examples of mismanagement, quite in keeping with unsupervised and inexperienced practice.

The aim of RDAV has been to put pressure on AHPRA (MBA) to limit its activities. Our information appeared to be not welcome, although we had previously indicated all our concerns which we were now verifying, so that they made no response and immediately made it impossible for us to continue to collect further relevant data. Since then, even though numbers in Victoria have not blown out to the levels in Queensland and WA, the main corporate studied (as do others) has continued to expand to be one of the 4 largest in Australia.

Would AHPRA have responded to our information in the same way if it had mechanisms of overview, and a clearer understanding of its function as a regulatory and not an educational body? Does AHPRA (MBA) support expert General Practice or the establishment of a filtration structure for cases presenting to GP, expecting a quantity of more serious clinical material to not be intercepted and flow through to casualty departments? If the latter, is there an evidence base for this as a satisfactory system? Does AHPRA (MBA) have mechanisms for the development of organisational expertise in these matters and overview of the overall effect of operation on the profession?

Recommendations.

AHPRA (MBA) is not an appropriate body to oversee the supervision and postgraduate training of untrained doctors in General Practice. It is designed to respond to complaints about undesirable and adverse events – which does not translate to training processes.

It is suggested that the State needs to maintain some avenue of control and moderation with respect to the AHPRA (MBA). The State has a Health Agenda and has to be prepared to put pressure on the AHPRA to respond constructively to that agenda. The Minister is responsible for appointments to the State Board. Greater transparency of operation is required so that the separate operating of the State and the Australian Boards is visible and the level of response is discernible, which at present it is not.

AHPRA (MBA) may not have the capacity to assess and correlate activities across its different departments. It needs to establish mechanisms of overview. The anomalies in supervision detected by RDAV could have been picked up early by computer analysis. Corporates, dealing with large numbers of practitioners, especially when operating across State boundaries, need careful surveillance.

The purpose of centralisation of registration was understood to be to enable free flow of doctors across State borders, with disciplinary responsibility maintained at the State level. The underlying purpose of Medical Registration has been to ensure that evidence-based medicine is competently practised. The Medical Profession has reason to believe that it does by and large conform very well to this standard, especially through the vocational system of education. It is essential for public safety that within the context of the conglomeration of

various other Health registration bodies, this focus on evidence based standards is in no way compromised. An academic element to operation is required. AHPRA (MBA) needs to keep very much in touch with both government and medical bodies but retain vigilance that vested interests do not benefit.

Government will find it quite difficult to control an organisation the size of AHPRA. Perhaps the scope and size of AHPRA as a monolithic bureaucracy is not appropriate to its aims. It has been very difficult to understand its structure and function. People can be forgiven for being confused about the State Boards, for which a list of members, an address, but no other details are available. In correspondence we have often not been sure as to precisely who we have been dealing with. Respondents talk about "the Board". Our database was forwarded to "the Director of Registrations at the Victorian State office of the AHPRA"

Is it necessary to have one overarching body? What is gained by having all these different providers of health care mixed up with one another? They have hugely differing requirements. It can only detract from the function of their individual Boards. If it is to place greater Governmental control then that is bad also. Professional standards must be regulated from within the professions.

Victoria itself needs independent channels of feedback to the State Minister for Health. This could include the office of the Health Complaints Commissioner.

Postscript. The unbudgeted, unplanned and unfettered expansion of the GP workforce using overseas recruits is an extremely expensive exercise, almost certainly enough to have an impact on the overall health budget, including State Hospitals, as part of the overall $6.7b Medicare rebate budget and not counting additional impost for pathology, imaging and pharmaceuticals. The Monash Centre for Population and Urban Research (Prof. Bob Birrell), has constantly drawn attention to GP oversupply, (measured against Australian and International yardsticks), and is about to do so again, with recent AIHW and Productivity Council figures. There are no studies to support efficacy of open-ended supply of under-trained General Practitioners in promoting population health. With significant ongoing loss of rural hospital services, because of lack of properly trained doctors, the RDAV feels justified in criticising the AHPRA (MBA) exercise as contributing to disparity of health expenditure between genuinely rural and other areas of Australia.

Dr Mike Moynihan
President, Rural Doctors Association of Victoria

The RDAV, as part of RDAA, through its members lobbies and gives technical advice for the fair and equitable provision of Medical Health Services to the 1.4m non-metropolitan residents of Victoria by the medical workforce of approximately 1400 generalists and generalists-in training. Salient priorities include provision of advanced community practice for 137 locations, emergency and after hours services in 91, procedural services in 42 including collaborative obstetrics, the nascent Rural Generalist training program, State-wide industrial arrangements for Generalist Visiting Medical Officers, and the development of rural General Practice infrastructure to accommodate growing demands for extra doctors and the physically supervised on-site rural training of medical students, GP registrars and IMGs. RDAA also lobbies for improved provision of rural specialists.