Northwest Victoria GP Educators Group

Submission to the Parliamentary Inquiry into Overseas Trained Doctor Registration processes and support .

The objective of Medical immigration into General Practice is to supplement domestic workforce where there are deficiencies and to provide effective care through proper selection and training according to Australian Standards. Needs of the community, workforce requirements, and appropriate training must be catered for. The authors are educationalists working in the rural medical sector. The submission reflects content of the study recently published by Bob Birrell.

A. Needs of the community.

Graduate medical degrees are generically designed as a basis for both Specialist and Generalist postgraduate training and aim to make the doctor safe to practice in the intern year.

- Best Health outcomes require a uniformly good standard of General Practice.
- Health care demands are ballooning. The Health Reform process demands rapidly evolving, economically organised, community health teams of doctors and ancillary health workers. Care patterns need to be dehospitalised as far as possible.
- The Australian standard for General Practice since 1986, required by Minister Blewett, has been the postgraduate Vocational Training Program culminating in FRACGP and also FACRRM. Successful completion of this training results in specialist GP registration with the AHPRA. Conditions of training are tightly controlled and policed according to College guidelines.
- Australian medical undergraduate, immediate postgraduate, and ongoing postgraduate training is highly oriented to public need and safety, with major evolution over the last 20 years to provide flexibility and adaptability.
- Rural practice demands extra skills in acute medicine, procedural disciplines, and advanced chronic care.

B. Workforce requirements.

An optimally functioning workforce requires a balance of appropriately trained and training doctors and incentive or direction to create an even spread proportional to population.

- **A review has recently been published by Bob Birrell**
  - Total doctor numbers working in General Practice in 2010 were 26,613; FTE were 19,729, a ratio of 1:1,139 (1995 RACGP recommended ratio 1:1,500) suggesting oversupply.
  - Total IMGs in General Practice 9,191. Estimated FTE 8,000 (41% FTE workforce).
  - Total IMGs without specialist recognition unknown: possibly 50% of the total.

- Total FTE GP workforce with specialist recognition ?15,729, a 2010 population ratio of 1: 1429, not oversupply if evenly distributed.
- Bulk billing rates at near record levels suggest adequate supply.
- Desired population ratios of trained and training GPs need fresh definition.

- **Domestic GP workforce**
  - Decreased to 2002
  - Has slowly risen since 2004 with 367 in excess of attrition in 2010.
  - Annual increase will rise to around 850 over the next few years as GP registrar output rises to 1,200 and then ? fall in 2016 due to retirement of baby boomers unless output is increased.
  - Total medical school output is rising to 2,955 in 2014 with added <500 fee-paying overseas students.

- **IMG/OTD workforce- routes into General Practice.**
  - Rural shortages from the mid 1990s stimulated basically placement of unsupervised but specially selected IMGs with suitable/equivalent experience.
  - Other IMGs/OTDs with AMC part 1 have progressed through hospitals to obtain AMC part 2 and hospital experience as required under GP training standards *before* entering General Practice for supervised experience and progression to Fellowship, which in our experience few fail if properly supervised (although selection has already occurred prior to hospital employment).
  - Many IMGs have proceeded through mainstream vocational training programs, to become principals of practices, own their own practices, and are accredited supervisors within the Australian General Practice Training program.
  - COAG has determined that sponsored employment of IMG/OTDs with the AMC part 1 only be allowed into General Practice, with limited registration (LROTDs). This has been supported by the AHPRA/MBA with significantly weaker guidelines for supervision.
    - There is no assessment of clinical abilities except in the few cases (Birrell) where Pre-employment structured clinical interview (PESCI) assessment is conducted.
    - LROTDs currently comprise 2,732 in GP and 3,430 in Hospital.
    - 2,420 section 457 visas were granted in 2010-2011.
    - Corporate clinics are expanding rapidly as allowed by the weaker AHPRA standards of supervision of LROTDs.
    - Hospital LROTDs stand to be displaced by domestic 'tsunani' graduates as numbers increase.
    - LROTDs have low rates of Fellowship examination passes for a range of reasons, including weaker supervision and training processes.
  - 'Backdoor entry' through family sponsorship, educational visas, and via NZ is substantial but unquantified.

        - From 2001 to 2006 (Census) entrants were 6,704 of whom 2,159 remained unemployed in 2006.
        - Large numbers have arrived since then. Hospital junior ED jobs get hundreds of applicants.
        - There may be 3- 5,000 currently unemployed.
        - Corporates prefer to recruit from overseas in the interests of better corporate discipline.
        - Australia is seen as a prime destination for medical immigration.

- **Workforce Balance**
    - Large numbers of unemployed and non-fellowship qualified IMG/OTDs within the workforce are an undoubted problem.
    - Birrell describes the potential scale of over-supply of IMG/OTDs combined with the 'tsunani' of graduates as a 'powder-keg situation'.
    - For balance in GP units and community teams there must be an even distribution of specialist GPs and supervised GPs in training.
    - It is recognised that undersupply increases costs but oversupply, especially of partially trained doctors has it's own drawbacks.
    - It is now imperative to grossly scale back the immigration influx, to preferentially use unemployed IMG/OTDs, and to raise the bar for workforce entry, probably with the AMC part 2.

C. Training Requirements.

GP Training for domestic resident doctors is well developed and curriculum based, flowing on from appropriate curriculum-based training in medical schools and intern years, and there is competition for places.

- **Australian General Practice Training** is undertaken by a network of accredited Regional Training Providers across Australia, with requirements for governance, operating and training standards.
    - Numbers entering the domestic GP training program are Federally controlled.
    - Consortia, training practices and teachers are accredited.
    - Comprehensive guidelines for accreditation, teaching conditions and educational requirements for teachers are published by the RACGP and the ACRRM.

- **AGPT training** aims to build capacity and confidence through the training years.
    - The primary supervisor is allowed to mentor only 2 doctors.
    - Supervisors or other Principals are physically available at all times for advice and review of patients and themselves require adequate experience and capability to simultaneously manage their own workload.
    - Registrars are allowed to practice after hours on-call with telephone supervision only when agreed capacity is attained, usually after 6-12 months.

- Virtual training is not effective as a primary tool for General Practice: supervised patient contact over a long time is what builds expertise.
- Satisfactory completion of both the 'in practice supervision', with accredited teaching conditions *and* Fellowship assessment needed for Specialist General Practice recognition, by the AHPRA.
- The process is analogous to specialist training in hospitals, with cautious expansion of licence to deal with disease conditions.

- **Components of training.**
  - Vocational Training aims to engender strength of capability across the '5 domains' of communication, knowledge, population health, professional ethics and organisation/legal.
  - A combination of hospital and community practice is required.
    - In the interests of patient safety, the RACGP requires second post-graduate year experience in casualty and paediatrics, prior to undertaking the first year of training in General Practice.
    - The ACRRM allows and encourages more hospital practice to accommodate the needs of rural combined community and hospital practice,
    - Recognising the impracticability of providing specialist care to the full spread of Australian population, and the needs of rural hospitals, curriculum based *advanced* Generalist training in various specialties is available through AGPT programs.

- **Remote locations** not otherwise able to recruit benefit from a special education program
  - This is the Federal **Remote Vocational Training scheme.**
  - Governance is by a Board constituted with RACGP and ACRRM membership.
  - Mentoring is remote and 1 on 1 for the first year.

- **Provisions for Limited Registration doctors.**
  - Annual increases of IMG/OTDs in the GP workforce have escalated and from 2007 to 2010: were 342, 518, 569 and 1,140.
  - **We regard all doctors working in General Practice without Specialist recognition as being in training**, and should be placed under supervision standards *not less than that mandated for domestic GP registrars.*
  - Only ad hoc supervision arrangements have been in place.
    - The numbers demanded regularisation.
    - The AHPRA issued guidelines dated 8.6.11.
    - The guidelines are presumably for community not hospital based LROTDs.
  - **The AHPRA appears to have created its own weaker set of standards for supervision** independent of the two Colleges: RACGP and ACRRM.

        - There is no evidence so far of consultation with these Colleges.
        - It is not clear what the end-point of training is intended to be, given that specialist recognition requires completion of an approved training pathway structured according to College standards and guidelines.
        - Key aspects of GP training such as experience in casualty and paediatrics appear to have been dropped.
        - Close supervision is stated as necessary but the ratio of one supervisor to 4 trainees, or more at the Board's discretion, is not compatible with proper supervision, especially if the supervisor is a corporate doctor with rapid turnover of patients and is especially concerning when that supervision occurs offsite.
    - The lessons of Bundaberg and other incidents (background documents) apply as much to General as Hospital practice. Supervision of all GPs in training is required to ensure the safety of the community, and to provide quality training.
    - Who is responsible for educating IMG/OTDs?
        - The RACGP and ACRRM are presumably under no compunction to accept the AHPRA training pathway.
        - Is the AHPRA now a training organisation akin to AGPT?
        - AMC accreditation of the FRACGP presumably takes cognizance of the standards for supervision and education. How will the weak AHPRA requirements affect this accreditation? Will IMG time in non-accredited practice be discounted?
        - With entry numbers into the LROTD workforce currently somewhat in excess of domestic registrar training, this is the larger defacto 'GP training program' in Australia now.
    - The AHPRA has given evidence to the Inquiry that it is unable to police its guidelines.
        - Policing is a major part of AGPT program operation.
        - Self-regulation by the profession cannot be guaranteed, especially where professional independence is geared to commercial corporate interests.
    - Whereas the AHRA/MBA clearly states its powers to register, continue registration or deregister under the guidelines, it is not at all clear
        - how quality control is to be exercised,
        - how success of the defacto 'program' is to be measured against domestic GP training,
        - what the academic basis for the program is, if any,
        - How corporates without accredited teachers, teacher supervision and support will effectively train IMG to specialist standards.
        - Is the oversight of training compatible with the APHRA/MBA role of assessment and registration of training conducted by authorized domestic and overseas agencies?

- In the context of COAG direction, does the AHPRA have a role independent from Government in ensuring standards of practice?
- **LROTDs recruited under AHPRA guidelines can only be regarded as in training since that is their purpose in coming to Australia. Effective mentoring is required from the very outset to acquire necessary skills.**
- **The authors do not support either the AHPRA guidelines or this weakened alternative pathway into Specialist General Practice for training and graduation of IMG/OTDs. A single standard for supervision of doctors is essential to ensure quality training**

- **Entry into GP training.**
  - As suggested above, all doctors in GP without specialist status should be regarded as being in training and supervised accordingly.
  - With the workforce shortage all but over, and oversupply developing, full registration to AMC standards should now be required.
  - A reading of the AHPRA guidelines for LROTDs suggests that the intentions of the program might not necessarily be towards permanent entry.
    - Is it the intention that doctors not progressing into formal GP training pathways must repatriate?
    - History suggests that this does not always occur especially when there is press coverage and public reaction.
    - LROTDs must not be exempt from Australian standard supervision requirements because they are regarded as being here short term.
    - Otherwise they will continue to exercise leverage towards relaxation of standards.
  - A number of IMG/OTDs have progressed into GP without the AMC part 2 and have been accepted into College approved GP training pathways.
    - There are advanced mechanisms.
    - It is suggested that this should only occur in fully College accredited practices with fully and independently accredited teachers teaching according to RACGP and ACRRM guidelines.
  - Excessive numbers of IMG/OTDs either unemployed, or long term without GP specialist recognition, calls for a radical rethink and monitoring of numbers.
  - In the interests of openness, consideration should be given to public disclosure of training status for all doctors working in General Practice.
  - If the AGPT does commence a training program for a limited number of IMG/OTDs (the actual numbers are far beyond the capability of the AGPT), then this should be linked to proper

supervision conditions and accreditation of teachers to specialist GP college standards.

- **Provisions for unemployed IMG/OTDs.**
    - Life is very tough for them.
    - There are training programs to help obtain AMC part one
    - Obtaining employment is then problematic
        - Corporates prefer overseas entrants without permanent residence.
        - Hospital appointments will be much more difficult to obtain from 2013.
        - Obtaining hospital experience matching AGPT program requirements will be increasingly problematic.
    - Some practices employ them as nursing assistants to help make a transition.
    - Acquisition of the AMC part 2 can be difficult for doctors not employed in the casualty setting.
    - The problem of mandatory hospital experience and safety as acute diagnosticians for them would however remain, as it does for LROTDs.
    - State assistance is required in all States to identify and instigate accreditation of casualty departments for IMG/OTDs to acquire experience before they commence General Practice experience. Thought has to be given as to whether sufficient paediatric experience will be occur in such departments.

D. The needs of Rural Practice.

- Populations without close access to funded Emergency Departments require GP emergency and acute care capability.
- Placement of doctors without such capability entrenches disadvantage. It can also reduce the capacity of existing rural practices to provide VMO services and educational programs.
- Organisations concerned with such placement must have statutory obligation to progressively place doctors with such capability. Currently such expertise is patchy.
- Progressively fewer but still vital hospitals providing advanced services require GP anaesthetists and obstetricians. Programs have not been particularly effective at harnessing such skills already posessed by IMG/OTDs.
- A national commitment to, and mechanisms for training of, rural generalists is imperative, with provision for recruitment of both Australian resident and non-resident doctors.
- Rural mainstream practices (not corporates) carry a heavy load of registrar and student teaching, most rural Victorian towns of any size being thus involved.

E. Conclusions

- IMG/OTDs are being recruited in excess of workforce requirements.
- This has impelled the creation of a separate training stream for them
- There are serious questions over the future efficacy of this training for implementation of best practice population health creation.
- To minimize mishap all doctors should have fully supervised post-graduate training in GP.
- Casualty with a paediatric component should remain a prerequisite.
- Except in limited and exceptional circumstances:
    - The criterium for entry into GP training streams should be full registration, with exemptions only in extreme circumstances.
    - There should be only one standard set at the current AGPT level for the supervision of all doctors in General Practice who do not hold specialist recognition .
- *With the large increase in home grown medical graduates, immediate steps are required to prevent gross workforce oversupply.*
- An overhaul of the 10 year moratorium and conditions of entry to metropolitan and fringe metropolitan practice, as called for by RDAA and AMA, is overdue.
- Better education and workforce orientation of resident unemployed IMGs makes more sense than the current policy favoring immigration.
- **A single standard for supervision is required for all doctors training in General Practice. The policy of relaxed guidelines for LROTDs creates risk and is also discriminatory against both domestic graduates and IMG/OTDs undergoing standard conditions of supervision and training.**

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The views expressed are the authors' own though much advice has been received. Other representative positions are not therefore listed.

Background documents

AHPRA Requirements for Supervision of Limited Registration OTDs
http://www.medicalboard.gov.au/Registration-Standards.aspx (scroll down)
"The Board will not normally approve any practitioner to have direct supervisory responsibility for more than four doctors. Any prospective supervisors who are proposing to supervise four or more doctors must provide a proposal to the Board about how they will provide supervision to each registrant."

RACGP 2005 Standards for General Practice Education and Training – Trainers and Training Posts. Google or
www.racgp.org.au/vocationaltraining/standards

ACCRM Standards for Teaching Posts and Teachers in Rural and Remote Medicine'. Website or Google.

ACRRM supervisor policy 2010. Website, or google.

Recognition of specialists under section 3D of the Health Insurance Act
http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s3d.html
Summarises the procedure for recommendation by Colleges to AHPRA.

Dr Bob Birrell, Director Centre for Population and Urban Research. Australia's New Health Crisis – Too many doctors. 23.9.11. This article is the background to this submission http://arts.monash.edu.au/cpur/staff/bbirrell.php#publications

Dr Bob Birrell. Australian policy on overseas-trained doctors. MJA 2004; 181 (11/12): 635-639. This article influenced the decision to establish a uniform test for IMG/OTDs, namely the AMC MCQ..
http://www.mja.com.au/public/issues/181_11_061204/bir10706_fm.html

Birrell and Schwartz. The Aftermath of Dr Death: has anything changed *elecpress.monash.edu.au.* Examines the Bundaberg and similar instances.

Schofield and Beard. Baby boomer doctors and nurses: demographic change and transitions to retirement MJA 2005; 183: 80–83

Rural Doctors Association of Victoria. Position Statement: "The supervision of doctors working in General Practice prior to Vocational Recognition."

The Age. 21.7.04 Foreign doctors to be helped back into medicine. This reported the $1m given to the RACGP to establish programs to assist unemployed IMG/OTDs gain jobs, kicking off a series of educational programs still running.
http://www.theage.com.au/articles/2004/07/20/1090089157809.html

ABC 16.9.10. Overseas doctors facing 'professional death sentences' Bronwyn Herbert. Covers Public reaction to imposition of the AMC MCQ as criterion for Limited registration. **http://www.abc.net.au/news/2010-09-16/overseas-doctors-facing-professional-death/2262472**

News.com.au. 17.9.11. Death of 16-year-old Kundai Chiundiza shows doctors' lack of training. Boy dies after being examined by junior doctors. Doctors had "clear gaps" in their medical knowledge. Death result of system breakdown, coroner says. **http://www.news.com.au/top-stories/death-shows-doctors039-lack-of-training/story-e6frfkp9-1226139666326**. This is a reminder of the necessity for close supervision of IMG/OTDs.