Submission No. 06
(Overseas Trained Doctors)
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SUBMISSION FOR IMG PARLIAMENTARY INQUIRY

Introduction.

I believe the Specialist Medical Colleges, the various State Medical Boards and the Australian Medical Council created the current IMG registration system to ensure safety and quality. This system also, unfortunately, ensures another sub-agenda that confers both immediate positive financial advantage to Australian trained medical practitioners and long-term disadvantage for the entire Australian populace. Across the entire registration spectrum there are systems that at first glance appear sensible, logical, necessary and reasonable. These systems also appear to be fair, unbiased and equally accessible to all applicants. They are anything but. Additionally, certain individuals would have the Australian public believe that all IMGs are medical refugees and as such should be grateful for any Australian hospitality. Further, that all IMGs have substandard medical training. I believe that my, and many other IMG's experiences, show the present registration system to be deeply flawed, often inappropriate, almost always unfair and prejudicial. I believe that this was not what was initially intended and that this enquiry will reestablish a system that will serve the Australian public beneficially.

My Case.

I graduated MbChB from the University of Cape Town in 1975 and obtained specialist registration as a General Surgeon with the South African Medical Board in 1983. I obtained the FRCS (Glasgow) and FRCS (Edinburgh) in 1981 before the introduction of the Certificate of Higher Surgical Training came in to being and whilst the FRCS was still an exit examination. In 1984 I took up the position of general surgeon at the Eshowe Provincial Hospital in central Zululand, South Africa. I ran a 120 bed surgical unit caring for the needs of a rural population of the order of one million people.

I worked in Eshowe until August 1999 when I received an unsolicited employment offer from [redacted], founder of the Spencer Gulf Rural School. He suggested that I apply for the post of general surgeon at the Whyalla Hospital. I would have disregarded the offer had it not been for the perilous security situation in my town and area. I visited both Adelaide and Whyalla in August 1999 and was interviewed by all the relevant authorities.

I returned home and initially informed my wife and family that I believed we should accept the job offer. There then followed an exchange of numerous telephone calls, emails and facsimile messages between the Hospital and myself. At some stage after my visit to Australia I became aware of acrimonious correspondence between the Whyalla Hospital and the South Australian Branch of the RACS. This disturbed me greatly and led me to decide not to accept the offered employment. I was given numerous email and telephonic reassurances that my reservations were groundless by the Whyalla Hospital Management and the recruitment agency. These reassurances, in conjunction with the deteriorating security situation in Zululand, convinced me to accept the job.

I arrived in Whyalla on the 17th April 2000 to fill a vacancy in an area of unmet medical need and immediately commenced work as the only resident general surgeon. An Australian trained general surgeon spent four nights a week in Whyalla but had his primary residence in Adelaide. He and an Adelaide based Professor of General Surgery were appointed my supervisors by the RACS.

My registration status with the South Australian Medical board was that of a non-vocationally trained general practitioner pending assessment of my foreign training by the Australian Medical Council. Shortly after my arrival I was appointed a Clinical Lecturer in the Adelaide University Department of Rural Health and was granted permanent resident status. My provider number was subject to a ten year moratorium and linked to areas of unmet medical need only.

On the day of my arrival in Whyalla I was met at the front door of the hospital by an Adelaide Professor of Surgery and informed that I was unwelcome in South Australia and should not consider traveling to Adelaide to partake in Surgical Departmental meetings, ward rounds etc., as "general practitioners" were not welcome at "surgeons" meetings. I immediately realized that I would experience difficulty complying with the RACS's Maintenance of professional Standards (MOPS) program and the CME guidelines, both of which were prerequisites to successful assessment as an IMG.

The Whyalla Hospital management informed me that my registration status was immaterial to them as I would work exclusively as a general surgeon and also perform all the emergency orthopaedic surgery. This resulted in my being on emergency call twenty four out of every twenty eight days. My name did not however appear on the duty roster for twelve of those twenty four nights, thereby saving the Hospital the standby allowance for 50% of my after hours work. My two week ends off also only started after the Saturday morning handover ward round, effectively giving me a one and a half day week end. This situation existed because the Hospital had an arrangement whereby the week end surgical cover at both Whyalla and Port Augusta was provided on alternate week ends by visiting surgeons from Adelaide but based in Port Augusta. The Adelaide surgeons received eleven times the standby allowance for performing the same work as I did. The Whyalla Hospital management was aware of all these issues and on two occasions informed me very bluntly that if I did not comply with the rostering requirements they could revoke my contract and I and my family would have to return to Zululand. An option we could not contemplate. The move to Australia had severely disrupted my son's and daughter's lives resulting in acute domestic tension.

It is relevant to mention that I held a South African Airline Transport Pilot's License which, inter alia, necessitated my passing a Class 1 medical examination every six months. Up until my second year in Whyalla I experienced no medical problems but then unexpectantly became hypertensive. No medical cause was found and my GP informed me that he felt it was tension related. He was aware of my excessive working hours.

When I attended my initial interviews prior to accepting the position in Whyalla, I was led to believe that I would use my aircraft to visit outlying hospitals. In fact, the reason I was invited to Whyalla was precisely because Professor [redacted] knew that I flew between my base hospital and two other hospitals in Zululand on a weekly basis. This belief that I would use my aircraft in Whyalla was reinforced following my return to South Africa by telephone and in vague couched terms in emails and in letters. I brought my aircraft out at great personal expense – of the order of AU$ 80 000. It then transpired that the service envisioned by the Whyalla Hospital did not materialize and I was never compensated. I was informed that "it was my decision to bring out an aeroplane".

I found it extremely demeaning to work with a team of specialists and perform the functions and accept the responsibilities of a specialist surgeon, whilst being considered

inferior. This was reflected in my salary scale and the Hospital was able to capitalize substantially as a result. Medicare also benefited financially as I earned 85% of the GP MBS fee.

After one year and two weeks working in Whyalla I was informed by the Adelaide based visiting Radiology Practice that they could no longer honor my requests for radiological studies as my provider number had expired. I immediately contacted Medicare and they informed me that my provider number had expired after one year and that I should have reapplied. At no stage had the Hospital or the Rural Doctors Workforce Agency informed me of this requirement. In fact the CEO of the RDWA informed me that he was "mea culpa" and that I should immediately apply for renewal of my provider number. This I did and it was immediately granted but I lost all pay for the two weeks that I had worked without a valid provider number. I took this up with my employers, Medicare and with Barry Wakelin, MP for Grey, all to no avail. I therefore worked for nothing for the two weeks.

After almost two years working exclusively as a specialist general surgeon I was granted an interview with the RACS in Melbourne. I was subsequently informed by the Australian Medical Council that my academic qualifications were acceptable. The RACS informed me that to qualify for registration as being equivalent to an Australian trained general surgeon I had to undergo a period of oversight assessment for one year and obtain laparoscopic surgical skills. I had worked in rural Zululand and all my work which encompassed the full spectrum of general surgery plus orthopaedic, thoracic, traumatic neurosurgery and traumatic vascular surgery was performed non-laparoscopically.

I immediately realized I was in a "catch 22" situation. I had experienced difficulty when attempting to hand my surgical log book to my supervisors every three months for their perusal and signature. Both gentlemen refused sight of my log book and neither ever observed my work in the operating or endoscopy rooms, or to my knowledge, ever requested reports from the hospital. Given the acrimony surrounding my appointment and the objections to my presence in Whyalla, I would have thought the slightest hint of impropriety or surgical inability would have been grasped and used against me. Just the opposite occurred. The Whyalla Hospital extended my contract and Professor Maddern offered me a Senior Lecturer post with the University of Adelaide. I informed the College of my difficulty with presenting my log book and was advised to merely continue making my log book available to my supervisors on a three monthly basis. To comply with this stipulation, I handed a photocopy of the most recent three month period to the visiting general surgeon in the presence of witnesses and informed the College. My wife and I traveled through to Port Augusta and I likewise left copies of my log book with the Professor of Surgery. On one of these evening trips and whilst having a meal the Professor informed me, inebriatedly, that "I like you but we will never accept you as a specialist surgeon in South Australia", and he helpfully advised me to apply for work in West Australia. He even set up two interviews for me in Western Australia which I attended but declined the jobs. Our move to Whyalla had been sufficiently traumatic to my entire family that we did not consider a second move possible. I found it intensely insulting to be expected to function as a fully integrated specialist surgeon whilst simultaneously being informed that there was nothing I could do to obtain acceptance as a decision had already been made in Adelaide concerning my future. Both my supervisors refused to sign the RACS Progress Report required for an Overseas trained Doctor.

An absolute impediment to my recognition by the College as a specialist surgeon was the initial requirement to perform 100 laparoscopic cholecystectomies under supervision. It is important to realize that surgical registrars in training in Australian Hospitals are only required to perform 20. The visiting general surgeon refused to allow me to assist him when he performed these operations in Whyalla, thus denying me the opportunity to learn. I was similarly denied the opportunity of traveling to Adelaide to learn on the pretext that I would be displacing one of the surgical registrars in training. I therefore applied to attend various overseas courses in the United States, Scotland and South Africa, but was informed by the RACS that these institutes had not been accredited by RACS and therefore any training conducted there would not assist me in gaining acceptance.

I was suspicious that my lack of laparoscopic skills was seized upon as a means of denying me acceptance as a Fellow of the Royal Australasian College of Surgeons as it was general knowledge that I could never comply with that stipulation. This occurred despite the fact that I consistently and successfully performed a wider spectrum of general surgery than my RACS registered colleagues. Whyalla Hospital performed an audit that conclusively confirmed this. I had identical surgical qualifications to many of my RACS colleagues and was aware that some of them did not perform laparoscopic abdominal work. I had worked in Whyalla in isolation and unsupervised, as a general surgeon for in excess of three years without incident. Part of my responsibilities included teaching both undergraduate and postgraduate students, and surgical registrars.

A Professor of Surgery based in Geelong and who is an old acquaintance from Africa became aware of my predicament and came to my rescue. I spent time in his department, was taught and performed the requisite number of cases under supervision and obtained certification to perform laparoscopic abdominal operations.

I was elected to Fellowship in General Surgery of the Royal Australasian College of Surgeons on 28th February 2003. I became an Australian Citizen on 17th September 2003 and I was commissioned with the rank of Squadron Leader in the RAAF Reserve on 19th June 2006. I still live and work in Whyalla.

The RACS states categorically that the lynchpin of their registration process is to uphold surgical standards and ensure public safety. At no time did the RACS ever assess my professional ability.

I believe firmly that bureaurocratic process is more important than substantive candidate analysis. My assessment, and that of many colleagues, has been purely document based, performed by clerical staff who are allowed no latitude of thought. If safety is of paramount importance why have we never been clinically scrutinized?

I believe the answer to the above question is partially answered by the cost savings IMGs impart to the system. My employment contracts have always been financially inferior to my Australian trained colleagues. I have brought this fact to the attention of my employers and the authorities. Over the years I have been a committee member of the Clinical Governance Committee of Country Health South Australia, the South Australian Branch of RACS, the Divisional Group of Rural Surgery of RACS, and the specialist representative on the Rural Doctors of South Australia. I have informed all these bodies and also the Clinical Senate of South Australia of the discrepancies that exist. These devalue rural practitioners and make recruitment of Australian trained

doctors to rural areas more difficult. The authorities, in my opinion, find it financially expedient to employ IMGs.

Another grave concern of mine is the issue of "safe working hours". All my entreaties regarding this have fallen on deaf ears. During my entire period of work in Whyalla, the Hospital has never considered locum relief for IMG resident general surgeons. This knowledge places unreasonable moral pressures on us rural residential surgeons.

I have also brought the issue of bullying to the attention of the Whyalla Hospital Management, Country Health South Australia and the South Australian Clinical Senate. Bullying is endemic within the IMG system; Michael Gorton of Russell Kennedy Solicitors states in RACS Surgical News Vol: 9 No: 8 "All workplaces have a statutory obligation to provide a working environment that is safe and without risks. "Bullying" has been identified as conduct which breeches this obligation and can be summarized as "behavior that intimidates, offends, degrades, insults or humiliates a person, which includes physical or psychological behavior". Bullying is usually repeated and unreasonable behavior, directed toward a person or a group. Occupational Health & Safety legislation places employers under a clear duty to deal with these issues. He goes on to say "The Medical Colleges, as workplaces, have an obligation to ensure that bullying does not occur within their own workplace. The College, being responsible for the training and supervision of Trainees, has a clear right and obligation to raise issues of bullying where they are encountered. In the main, they will be matters for the workplace (hospitals), but could raise issues for the College if conducted by their representatives. For example, a supervisor of training who bullied Trainees under his or her supervision could accrue liability both to the employer (hospital) and the College which he or she represents. He goes on to state "that bullying tactics are not clear cut" and lists a number of acts that constitute bullying, amongst which is "deliberately delaying or withholding information or resources". Almost every IMG has experienced this. He adds that many bullies, in general, are often not aware of the nature of their conduct. He states that the intention of the bully is irrelevant to whether bullying has occurred. Bullies are often motivated by the best of intentions, with the worst of delivery. He emphasizes that bullying is all about abuse of power and warns us never to underestimate the effect of our behavior on those who have little power. I believe the current IMG registration system is conducive to bully and warned all these bodies verbally and in writing that we could possibly be exposed to a class action by IMGs if we did not correct our ways. My advice has been consistently and assiduously ignored.

I recently learnt that an area of need assessment through a specialist College is a distinct assessment process separate from specialist recognition. Specifically IMG applicants are not assessed against comparability for specialist recognition, but as being "fit for task to undertake the requirements of the position". I have never seen a better exposition of the dichotomous system, metro vs. rural and IMG vs. local graduate, than this.

These latter three points adequately illustrate how certain aspects of the registration system have morphed into a monster that will ultimately harm Australians.

I am now fully registered as a Specialist General Surgeon but still experience the difficulties my IMG colleagues face. For example I have to register with GESA (Gastro-enterological Society of Australia). I have been performing upper GI endoscopies and

colonoscopies for the past twenty five years. Medicare has records of all these procedures for the past eleven years. My registration is however proving impossible as I am unable to comply with the strict clerical format and evaluation of my practice. The system works admirably for Australian doctors in training but is well neigh impossible for rural specialists working in isolation. I fear that I will never acquire recognition with GESA as it is impossible whilst working in Whyalla. This is extremely frustrating and reinforces my status as a second class doctor, who despite my best efforts is unable to alter my situation.

To summarize, I believe that as an IMG I have been:-

1) Used as a political pawn;
2) Invited and then made unwelcome, having burnt my bridges;
3) Rendered financially vulnerable and therefore manipulated;
4) Rendered professional insecure with no mechanism to prove my worth;
5) Subjected to an unsympathetic employer prepared to take advantage of my predicament;
6) Dealt with by a nameless and faceless system impervious to my suffering;
7) Forced to negotiate with a devious College which continuously moved the goal posts and
8) Subjected to bullying.

All the above resulted in my becoming initially hypertensive and then profoundly depressed and ultimately suicidal. I eventually sought professional help and have now withdrawn from many aspects of my former surgical practice. I will not return to my previous employment level.

I will be available to make oral representation and substantiate any of the above should the Committee deem it necessary. I have no objection to having my identity made known.

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