Senate Inquiry into National Registration & Accreditation Scheme for Doctors and Other Health Workers

Submission by

Council of Procedural Specialists

Australian Association of Surgeons
Australian Society of Anaesthetists
Australasian Society of Cardiac and Thoracic Surgeons
Australian Society of Ophthalmologists
Australian Society of Orthopaedic Surgeons
Australian Society of Otolaryngology, Head & Neck Surgery
Australian and New Zealand Association of Urological Surgeons

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Chairman: Dr Gary Speck

Council of Procedural Specialists (Secretariat)
PO Box 12, Arncliffe NSW 2205
Phone: (02) 9567 7329 ; Fax: (02) 9567 4681

Council of Procedural Specialists

Inquiry into National Registration and Accreditation Scheme for Doctors and other Health Workers

1. The Council of Procedural Specialists (COPS) opposes the current COAG model of National Registration and Accreditation for the Australian medical profession and believes that a national medical register and harmonisation of registration criteria can be achieved within the existing regulation framework.

2. COPS believes the COAG model undermines the values and attributes of an independent profession.

3. The COAG model offers no credible evidence for improved productivity and patient safety. No patient safety impact statement has been produced on any part of the COAG proposal.

4. The COAG model opens up the pathway for a myriad of new agencies, duplicating existing structures, the cost of which will inevitably be borne by patients.

5. The COAG model makes the inaccurate and damaging assumption that the Australian medical profession is simply a workforce, in dire need of greater regulation and centralized control by unaccountable agencies.

6. The COAG model disregards the fact that the Australian medical profession has developed world-class standards of training and accreditation as an independent profession within a framework of sensible government regulation and recognition of professional boundaries.

7. In Australia, government has long recognised that accountability for patient safety and professional behaviour requires that the profession be given responsibility for determining standards of medical treatment including selection, training and scopes of practice of medical practitioners. As a result Australia has developed a world-class medical profession and enjoys the second longest life expectancy in the world.

8. By undermining the confidence of the Australian medical profession in itself, the model would contribute to an undermining of the public's confidence in the ability of the profession to provide world-class medical

treatment.

9. State and federal legislators should reject any model (however diligently pursued by state and federal health bureaucracies), that would undermine or unnecessarily threaten Australian medical standards.

10. Whilst COPS supports a national medical register, it does not support the COAG proposals which have submerged this simple administrative reform into a transformation model that would leave the Australian medical profession in a similar position to that developed under the British National Health System.

In the interests of patient safety, the Council of Procedural Specialists has no alternative but to,

OPPOSE

1. Any policy which would result in the loss of professional independence and separate identity of the Australian Medical Profession.

2. Policies that advocate the imposition of role change (**enforced task substitution/social engineering**) in the health workforce.

3. Policies that advocate de-medicalisation and de-professionalisation.

SUPPORT

1. The **recognition of the unique contribution of all professions** to the betterment of Australian society i.e. **professions are important**

2. **The recognition of the medical profession as a separate, unique and independent profession** from all other professions, groups and occupations derived from the **unique responsibility of a doctor in the care of his or her patient** i.e. a strong medical profession will enhance and strengthen the ability of doctors to maintain and improve medical treatment.

3. The ability of a medical practitioner to practice in all states and territories in Australia through a **single agreed registration process separate from any other profession or occupation.** Debate over the criteria for simultaneous registration of doctors must involve **extensive and meaningful consultation** with the Australian Medical Profession to prevent the erosion of the standard required to become a licensed medical

practitioner in order to maintain and **enhance the standard of medical care that all Australians have come to expect.**

4. The **establishment of a national register** comprising the names of all medical practitioners eligible for national registration separate from any other profession or occupation i.e. **national medical registration to be an administrative function only**.

5. **University Medical Schools and Medical Colleges continuing their unique education and training role as autonomous self governing bodies** dedicated to the delivery of the highest possible standard of medical care **with accreditation by the Australian Medical Council** comprising of experienced medically qualified and distinguished practitioners i.e. **the unique and separate role of university medical schools and medical colleges to be maintained and enhanced**.

6. **The continuation of State Medical Boards** in the role of disciplinary/ counseling bodies, provided that Boards ensure due process with right of appeal and the **reversal where necessary of the erosion of medical representation** (in quality and quantity) on these Boards. This is necessary to ensure that the disciplinary process has the trust and confidence of the Australian public as well as the medical profession.

Recommendations

1. The current COAG model of national registration and accreditation as proposed for the medical profession should be abandoned.

2. A national computer database known currently as the Compendium of Medical Registers should be upgraded and be known as the National Register.

3. The Chairman of State Medical Boards Committee (within the AMC) should be given increased recognition to deliberate on matters that are capable of harmonisation between states.

4. Progress on these matters should move incrementally to ensure the Australian public maintains confidence and certainty in regard to the medical care they are able to obtain.

Examining Claims of the Current COAG proposal

1. **The claim is that state agencies have failed in medical registration and need to be replaced by new Canberra-based bureaucracies.** Whilst state agencies have prevented the registration of many suspect medical practitioners, there have been some obvious failures.

   The causes of this failure can be generally determined as agencies **bypassing or marginalizing long established safeguards in order to fill positions under the misguided and dangerous view that any medical practitioner is better than none.**

   Agency failure to police its own and legislative standards is an argument for discipline and reform of that agency, not for a duplication of that agency in Canberra and the surrendering of powers to COAG. There is no guarantee that having an agency based in Canberra will eliminate such pressure. Geographical location does not prevent agency failure. There have been **some spectacular examples in other areas of agency failure emanating out of Canberra.**

   All state medical boards have had the ability to communicate with each other over a long period of time and have had access to the **National Compendium of Medical Registers**. The profession has never objected to an upgrading of the National Compendium of Medical Registers. Administrative reform in this area does not require the transfer of powers.

   As in any successful recruitment process where accountability is paramount, extensive time is required to investigate the claims of those who would be medical practitioners in order to obtain an accurate assessment.

   The Australia medical profession has always supported rigorous checking of potential medical practitioners.

2. **The claim is that national standards in medical practice do not exist and hence need to be established via COAG.** There already exist national and international standards in Australian medicine. **An Australian medical degree and fellowship is recognised in all states and territories and internationally**. Standards of medical care do not significantly vary from state to state, evidenced by the fact that there is no discernable interstate patient migration in search of higher standards of care.

3. **The claim is that doctors are prevented from working in other states**
   Doctors are able to freely move between states and do so. In times of crisis doctors from all states respond urgently, as was the case in Darwin with the Bali bombing. The threat of pandemics, such as the current swine flu breakout in Mexico has activated a national response across the medical profession in all states working with other professions and the state and federal health departments. **The system works.**

   Although most doctors prefer to establish a practice in one area or state, all that is required administratively to register in two or more states is to fill in two or more forms and pay two or more registration fees (once the criteria for registration have been correctly met). Administrative reform of this area does not require a transfer of responsibilities from state parliaments to COAG. It simply requires a computer upgrade.

4. **The claim is that a National Register needs to be established and needs a new bureaucracy to drive it**
   A National Register of doctors, called the National Compendium of Medical Registers, already exists. It requires a software upgrade to make it more flexible and usable. COPS has been advised that it has been used effectively, however greater uniformity of data is required. These are basic administrative, not legislative issues as has been demonstrated in the establishment of a national register for missing persons which has not required a COAG takeover of state police forces.

5. **The claim is that harmonised criteria for medical registration in all states can only be achieved by transfer of powers to COAG**
   Mutual recognition was the preferred model put forward by the NSW Medical Board in 2001 in its paper entitled "A Model for Medical Registration". Mutual recognition does not require a new COAG bureaucracy. Mutual recognition can be complex, but this simply reflects the need to uphold standards whilst not preventing legislators meeting the needs of their constituents. Central authoritative control will not resolve these complex issues.

6. **The claim is that COAG's proposals are based on solid research.**
   Professor Stephen Duckett is the architect of the current National Registration and Accreditation proposal. His justification for change has not been established in any solid empirical research. His language and claims are tentative:

   *"Contemporary **perceived shortages** of most categories of health professionals;*

*Health workforce is **probably not** suitable for 21st century healthcare;*
*The problem is **usually** couched in terms of workforce supply;*
*Specialisation now seen as **possibly** detracting from continuity of care and hence **may have** deleterious impact on quality;*
*Current assignment roles for health professions is **perceived to be inefficient"***

(Ref: Prof S J Duckett, Interventions to facilitate health workforce restructure, Australia & NZ Health Policy 2005, 29.6.05,p1)

Furthermore**, there is no cost-benefit analysis for this proposal**. Registration costs of all health professionals are eventually passed on to patients in the form of fees and charges unless they can be transferred elsewhere.

Finally, no patient safety impact statement has been produced on any part of the COAG proposal.

7. **The claim is that the COAG model would result in increased health workforce productivity**
   This claim fails spectacularly on the grounds that the Productivity Commission itself was not able to measure health workforce productivity:

   Overall, currently available information does not support the full assessment of health sector productivity and hence the efficiency of health service provision.

   Ref: Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005

8. **The claim is that change is required to avert a doctor shortage**
   These claims are usually based on workforce forecasts which in the past have proved woefully inaccurate. The Productivity Commission has stated that,

   in comparison to most other OECD countries, Australia does not appear to be significantly undersupplied with health workers. For example, on a doctor to population basis, Australia is not markedly behind in regard to practising medical practitioners – though the distribution of these practitioners between general practice and other specialties is different.

   Ref: Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005

It is acknowledged that Australia, as with most other advanced economies suffers a rural/urban imbalance in the provision of professional services in general. The situation can be improved through a direct re-investment in rural and remote medical facilities and with ongoing support of rural sector medical training which is now being given greater emphasis. COPS supports these initiatives.

Predictions of crises in Australia's health workforce are long standing themes in the health debate and should be treated with appropriate critical analysis.

In 1987 the Health Issues Centre claimed,

A Victorian government report estimated that at least 65% of these beds are closed because of nursing shortages. There are about 1400 nursing vacancies in public hospitals…One estimate puts the shortage at over 3,500.

Ref: Medicare: A Double-edged Sword, Health Issues Centre, Feb 1987 p24

9. **There are and will always be demand pressures on the Australian health workforce and the medical profession in particular despite the significant increase in doctor numbers**.

According to the AIHW Medical Labour Force Survey, the number of employed medical practitioners in 2006 was 15.6% higher than in 2002 (62,425 compared with 53,991 respectively). In 2006, 93.2% were working as clinicians, of whom 39.5% were primary care practitioners, followed by specialists (34.8%), specialists-in-training (13.1%), hospital non-specialists (11.3%) and other clinicians (1.3%).
Ref: Australian Institute of Health & Welfare, Labour force – medical, 31 October 2008

Specialists-in-training are medical practitioners who have been accepted by a specialist medical college into a training position supervised by a member of the college. The number of specialists-in-training increased by 39.5% between 2002 and 2006, from 5,474 to 7,635. This equates to a rise of 9 per 100,000 to 37 per 100,000 population. Trainee numbers in surgery rose by 65.5% while trainees in internal medicine increased by 49.8%.
Ref: Australian Institute of Health & Welfare, Labour force – medical, 31 October 2008

The undeniable facts are, according to Medicare statistics, Australian doctors produce over **280 million transactions with patients every year**, (approximately 12-14 transactions per head of population). This represents a remarkable productivity rate for the 63,000 strong profession. In

addition, record numbers of young medical graduates are being produced by Australian universities and medical colleges to the extent that existing training pathways are under significant pressure. Furthermore, there is abundant evidence in some areas of the Australian medical profession of government-induced unused medical capacity (rationing). Repeated surveys by the Australian Society of Orthopaedic Surgeons show that in the area of orthopaedic elective surgery, orthopaedic surgeons working as Visiting Medical Officers (VMOs) **could increase their output in public hospitals by between 33% and 40% on average if government restrictions (rationing), which inhibit their ability to work, were lifted.**

The claim is that role substitution will enhance productivity

Many of the substitution arguments are spurious and immeasurable, i.e. the proposed solution to the so-called doctor shortage being substituted by nurses overlooks claims of a significant shortage of nurses. Should imposed role substitution (as opposed to agreed delegation) be agreed in principle by legislators, it is likely to have a significant impact on non-medical health care workers, who can be more easily substituted. The role substitution argument is by definition open-ended. The proponents of imposed role substitution often reject or ignore the gains that have been made, in the forms of lower death and complication rates. **These gains have been achieved by regulators insisting on the highest level of expertise (including a comprehensive medical training) in areas where there is a possibility (however small) of a catastrophic risk to the patient**. The principles of preventative health care aim to lower death rates, not to increase them. Clinicians must be trained to the level where they understand the complex ramifications of their decisions even if the procedures they undertake appear to be routine.

The doctor/patient relationship is the cornerstone of quality medical practice. Creating roles that blur the division between a medical practitioner and a non-medical practitioner will promote uncertainty and lower the confidence of the Australian public in the medical profession. (sub. PP192, p.1)

Ref: Australia's Health Workforce, Productivity Commission Research Report, 22 December 2005, p58

Furthermore, delegation of tasks in a doctor-led team has been a hallmark of Australian medical practice. Imposed role substitution is a dangerous non-solution to a perceived workforce problem.

10. **The claim is that the Australian Medical Council is no longer adequate as a national accreditation agency**
    The achievements of the Australian Medical Council (AMC) are significant. The AMC is a unique Australian institution which has mobilized millions of dollars worth of voluntary services by medical practitioners who desire to contribute selflessly to maintaining world-class medical standards in Australia. Its role should be supported and enhanced, not replaced by a taxpayer-funded bureaucracy.

    The quality assurance requirement in any system is for independent accreditation. In regards to Australian medicine, this has been successfully delivered by the AMC over many years. The COAG model, not only threatens the long-term existence of the AMC, but would see it rendered as a subsidiary to an overarching bureaucracy. This prospect alone should prompt all concerned legislators to reject the COAG model for the medical profession in the interest of patient safety.

Conclusion

The Australian Medical Profession is a national asset. Every practitioner is unique as are the needs and concerns of every patient. The special and unique qualities of the profession should be recognised and supported, not obliterated and subjected to added bureaucracy and needless regulation. Patients are not standard units of production. Medicine, as with all science is dynamic and self-critical. Any regulation of the profession will recognise these unique characteristics.

As Prof Paul Komesaroff and Assoc Prof Ian Kerridge have eloquently stated:

The fine details of the conduct of clinical relationships cannot be represented in a set of injunctions relating to styles or outcomes of behaviour, no matter how elaborate. Although clinical practice may refer to universal principles, in its details it is singular and specific, responding to individual circumstances and needs. Like other kinds of professional and moral behaviour, it thrives on diversity, discontinuity and difference.

Ref: Paul A Komesaroff, MB BS, PhD, FRACP, Professor of Medicine and Director, Centre for Ethics in Medicine and Society; Ian H Kerridge, FRACP, FRCPA, Mphil, Associate Professor of Bioethics and Director, Centre for Values, Ethics and the Law in Medicine, MJA (Vol 19 No 4 16.2.09)

COPS maintains that any policy which would erode the standing and reputation of the Australian medical profession is contrary to the national interest as well as the welfare of individual patients who rely on the expertise and support of medical practitioners in the efficacious treatment of serious illness and injury.
30.4.09