

Rural Doctors Association of Victoria



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Position Statement.

The Supervision of Doctors working in General Practice prior to Registration as Specialist General Practitioners.

Safety.

1. The safety of the Public is paramount and depends on provision of quality medical care at point of first contact. Since much illness presents in an early and undifferentiated form to medical practitioners working in community practice, the goal of training should be high quality diagnosis and management of acute medical conditions as well as high quality ongoing and chronic medical care.
2. In the interests of public safety and well-being the RDAV therefore advocates a single standard for high levels of supervision and mentoring of Doctors working in General Practice not listed by the Medical Board as Specialists.

Process of Vocational Training.

1. General Practice Vocational Training with specialist registration has been progressively implemented since 1987. To maintain a world-class service, the conditions of training have been set and policed at a single level for all candidates.
2. The system of training involves tuition and mentoring for a period of some years culminating in examination assessment by the **Royal Australian College of General Practitioners (RACGP)** or the **Australian College of Rural and Remote Medicine (ACRRM)**.
3. The quality of tuition and mentoring plays a significant role in the development of skills and capability far beyond those measurable in examination conditions. Whilst tuition can be provided in a didactic setting, mentoring and assistance is hugely more effective if physically available while the person in training is consulting, so that assistance can be sought while the patient is physically present or management subsequently being effected.
4. At present 3-4 year training pathways are available within registrar training programs licensed by **Australian General Practice Training (AGPT)** or through informal programs operative during employment. AGPT programs are only available to Australian citizen or doctors with permanent residence.

Doctors who have satisfactorily completed GP training are registered by the AHPRA as specialist General Practitioners. Registration is based both on fulfilment of training requirements and a pass in the Fellowship Exam.

Supervision of Trainees

1. The generally accepted level of supervision in AGPT approved training consortia is for one accredited supervisor in an accredited teaching practice to formally mentor a maximum of 2 candidates, and for the supervisor to be practising in the same building.
2. Physical presence of the supervisor or an alternate specialist GP is required for all candidates for the first 12 months of time in General Practice until an acceptable level of capability is attained.
3. Visits by accredited members of consortia staff occur to police supervision and ascertain confidential feed back from candidates about their satisfaction with the level of supervision.

RDAV Position on Training and Supervision.

The RDAV supports the AGPT system as world's best practice.

1. All teaching practices should be robustly accredited as such.
2. All teachers should be accredited by relevant bodies with necessary powers to withdraw accreditation.
3. Doctors in training should have physical access to appointed mentors, teachers and other Vocationally registered specialist GPs full time within the same practice to assist them with their work for at least the first 6-12 months of training, and thereafter for significant periods.
4. A dedicated period each week should be provided by the formally appointed Supervisor for teaching and review.
5. Remote telephone supervision and mentoring should continue to be allowed but only in special circumstances where isolated small towns are unable to obtain any vocationally registered medical practitioners.
 - a. The Commonwealth funded Remote Vocational Training Scheme RVTs allows 1 candidate only for each supervisor in the first year and 2 thereafter.
 - b. It should not be allowed as a bona fide system of supervision for non-remote larger practices.
 - c. Special arrangements for remote supervision are detailed in the ACRRM Standards for Teaching Posts and Teachers in Rural and remote Medicine.
6. Supervision should be policed by robust and enforced mechanisms.
7. RDAV fully supports the 2005 RACGP "Standards for General Practice Education and Training – Trainers and Training posts", which greatly amplify the above principles and enumerate:
 - a. Educational standards, commitment to the profession, personal qualities and commitment to educational professional development necessary for approval as a teacher.
 - b. Physical onsite supervision and hours of tuition.
 - c. Standards for practices and conditions of tuition and supervision are specified in detail.

8. RDAV likewise supports the 'ACCRM Standards for Teaching Posts and Teachers in Rural and Remote Medicine', which are equally detailed in requirements for on-site supervision except where this is impossible because of remoteness.
9. Robust mechanisms are in place to enforce these standards, including accreditation of consortia.

Current Medical Board Guidelines for Limited Registration GPs.

The Medical Board of Australia, operating within the Australian Health Practitioner Regulatory Authority, issued guidelines in June 2011 for supervision of limited registration IMG/OTDs.

Specifically

1. These are temporarily resident medical practitioners.
2. They have an examination pass only in the AMC multiple choice examination.
3. There is usually no assessment of clinical skills.
4. The AHPRA/MBA guidelines appear to be generic for hospital and General Practice IMG/OTDs. They:
 - a. Do not acknowledge Australian standards, particularly those of the RACGP and the ACRRM.
 - b. Allow supervision ratios of 1 in 4 or more.
 - c. Do not provide limits to remote telephone supervision.
 - d. Rely on self-declaration by Employers, risking conflict of interest.
 - e. Do not address Supervisor and Practice quality and accreditation.
 - f. Do not take into account RACGP and ACRRM standards for supervision in General Practice.

Reaction of the RDAV to the Medical Board Guidelines in relation to Limited Supervision

1. The Medical Board of Australia (MBA) has acknowledged to the Federal Parliamentary Inquiry that it is unable to police even these quite basic guidelines.
2. The work of Prof Birrell suggests that the AHPRA guidelines are being applied to very substantial numbers of LROTDs, **2,732 in GP, and 3,430 in Hospital.** (Referenced below.)
3. (2010 GP sector workforce was 26,613, with 19,729 FTE).
4. It is not stated that the RACGP and ACRRM have signed off on these guidelines with respect to the GP sector.
5. The RACGP and the ACRRM are responsible for eventual recommendation for specialist registration following FRACGP or FACRRM acquisition. The 2005 RACGP guidelines and those of the ACRRM are very clear as to the needs of proper supervision through accreditation and collaborative methods of policing. For example: "Accreditation is essential to ensure that the standard of training is uniformly high throughout Australia with suitable

- role models, experience, supervision, teaching and access to proper resources and facilities. The college sees the process of accreditation of trainers and training posts as a collaborative one – working with all concerned to continually improve the training of our future GPs. (Introduction to RACGP guidelines)”
6. There are thus now currently two very different sets of standards for limited registration IMG/OTDs on the one hand and both Australian Graduates and other IMG/OTDs on the other.
 7. Very large numbers of IMG/OTDs are achieving eligibility to work by passing only the AMC MCQ test.
 - a. A substantial expansion of doctors working in GP is occurring.
 - b. Entrants are mainly directly from overseas.
 - c. In the year 2010-11, DIAC 457 Visas were issued to 1190 LROTDs to work in General Practice.
 - d. Details of their status is not provided to patients as it is for registrars.
 - e. There are also some thousands of unemployed IMG/OTDs resident in Australia who aspire to to enter GP.
 - f. Australian Medical School Output will have multiplied (including overseas fee-paying students) to perhaps 3,500 in 2014 from about 1,400 in 2007.
 - g. Advanced systems of education and supervision in hospitals have been evolving over the last 10 years.

Opinion:

1. The interests and safety of the public are paramount.
2. Standards in GP have to be maintained at the highest possible level to meet the diagnostic challenges of early undifferentiated serious illness, and the increasing challenges for community care of chronic and complex illness.
3. The Rural sector will continue to need advanced training for GPs providing combined community and emergency hospital and non-hospital care, together with specialised procedural services.
4. Effective Health Reform, with development of community team health management in which GPs would play a major part, will need ongoing quality training of GPs.
5. In annual entry to the GP Workforce, IMG/OTDs continue to outnumber domestic Australian trained entrants considerably, even though the workforce is already, by Dr Bob Birrell’s reckoning, in oversupply.
6. There is mounting concern in the profession especially amongst teachers.
7. Substantial oversupply underpinned by lower training standards will have a deleterious effect on the workforce.
8. Many IMG/OTDs have taken the responsible path of first gaining acute hospital experience also required for for specialist GPs. These IMGs stand to be disadvantaged in their career pathway.
9. The needs of IMG/OTDs for proper supervised postgraduate training in GP are not less than those for Australian Graduates, and having not had Australian undergraduate medical education, which is attuned to General Practice, are likely to be higher.

10. Proper, collaborative, policed supervision by doctors would provide a preferred method for initial observation following arrival.
11. It may be necessary for details of the status of doctors working in General Practice to be provided to the public at the clinic rather than on the AHPRA website.
12. Entry into properly supervised GP training should require Full AMC examination accreditation or equivalent overseas qualification.
13. Methods designed for *Remote supervision* are being used inappropriately.
14. The *AHPRA level of supervision* of limited registration IMGs in GP is not acceptable. The needs for physical supervision in the general practice setting are far greater than in hospitals as GP practices are often small, with much less oversight by nursing staff and other doctors than in hospital practice.
15. The situation is allowing rapid expansion in the corporate sector, where a lack of understanding of training and the need for profit margins can compromise arrangements for supervision.
16. Whilst competition can be healthy, the predominant role of the non-corporate sector in the operation of the profession, the training of medical students, and the generation of specialist GPs, must remain in consideration and not allowed to degenerate.
17. All Guidelines should therefore be developed in collaboration with and signed off by the Specialist GP Colleges (RACGP and ACCRM).

Recommendation. In the interests of public safety and well-being, the RDAV advocates a single standard for high levels of supervision and mentoring on site of Doctors working in General Practice not listed by the Medical Board as Specialists.

AHPRA Requirements for Supervision of Limited Registration OTDs
<http://www.medicalboard.gov.au/Registration-Standards.aspx> (scroll down)

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.

ACCRM supervisor policy 2010. Website, or google.

Dr Bob Birrell, Director Centre for Population and Urban Research. **Australia's New Health Crisis – Too many doctors. 23.9.11.**

<http://arts.monash.edu.au/cpur/staff/bbirrell.php#publications>

Recognition of specialists under section 3D of the Health Insurance Act

http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s3d.html