Overseas Trained Doctors

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Dr Wroth has chaired the GP Area of Need panel for the New South Wales Medical Board since 2002. She is an occasional member of the NSW Medical Tribunal and an assessor for the Postgraduate Medical Council of New South Wales.

Last night I had a really anxious dream that I was giving a talk on the New South Wales State budget, so it is really nice to be awake and talking about a more comfortable area. The other would have been a very short speech.

I am going to describe the process by which we assess Area of Need doctors for rural and remote general practice. Peter has already described the mechanism by which the position is declared an Area of Need.

The catastrophic rural GP shortage

Sometimes these positions don't have a GP at all, but are being serviced once a week or once a fortnight by a GP from a neighbouring town. Sometimes patients are travelling several hours to get to a GP.

The logistical problem for local GPs is trying to cover areas that are too large. The problem for patients is ha ving to decide whether they are ill enough to need help now, or can wait a week, or how they will get to services up to two, three, or four hours away. The 'need' is quite clear.

The positions for which we interview vary hugely. Some are semi-urban. For example, a practice of eight GPs in under-supplied Dubbo might apply for an Area of Need doctor in this obviously well-supported position. There will always be a well-qualified colleague on site, the local hospital is only two minutes away, the ambulance service is fantastic; it is a good working environment.

Area of Need positions are occasionally attached to the Royal Flying Doctor Service or to Aboriginal medical services. There are some single-person practices, where the supervisor of the Area of Need OTD may be two hours away and only available by phone. It is clear that the level of supervision, one of the key things we look at when assessing whether or not a doctor is suitable for a position, varies hugely, as does the working environment. Our assessment takes these things into account.

The information we have about the practice

The information we have available before we see an applicant is the exact nature of the practice, what local services are provided, how close the hospital is, how large the hospital is, whether there are x-ray services available 24 hours a day or only once a week, or whether patients have to go elsewhere for an x-ray. How long it takes to get to a hospital is important, as it the exact extent of supervision the supervising practice can provide. Some of the Area of Need doctors work in practices with satellite practices which they visit once a week. When in the main practice, they have on-site supervision, but there is no on-site supervision when they are in a satellite practice.

Some positions require the doctors to work after hours, to do emergency medical service and retrieval work, to do VMO-type work in hospitals, or to man the local emergency departments on a roster system. All these positions require different levels of expertise and different levels of competence. We take into account that information, as provided by the practice making the application.

The curriculum vitae

The applicant's c.v. is noted in great detail because the medical culture from which the person comes is really relevant in general practice. For example, there are some countries in which there is no health screening. These doctors, unless they have subsequently familiarised themselves, may be ignorant about prostate, breast, cervical cancer and neonatal screening. This needs to be taken into account in our supervision requirements.

In some cultures, male doctors do not do any obstetrics and gynaecology. Some have never done a Pap smear because they are not routine in that country, or are performed only by women or they haven't got the backup laboratory facilities. We need to know these things. They are not necessarily excluded from practice here if they have never seen a Pap smear done, but we would note it. We would recommend that they should not attempt Pap smears until they have had adequate training by their supervisor to both doctors' satisfaction.

Three types of applicants

The applicants themselves broadly fall into three types:

- the experienced, older GP who may have been practising for a long time in another country and can't face the wide-ranging AMC exams. Some are quite happy to settle for longer-term GP positions in rural Australia;
- the larger group sitting the AMC exams, or planning to sit them. They prefer to attempt these exams from a position of local employment where they are maintaining their skills and obtaining an income; and
- people still working overseas, who have never been to Australia, but would like to work here. Being prepared to go to a remote position is an easier route to gain residency and employment.

Together, they form a hugely varied and really interesting group. They are usually multi-lingual. They often have fascinating medical and cultural experiences. Some have done humanitarian work, war zone work, refugee work, or World Health Organisation work. Many are high achievers in non-medical activities: national kick-boxing champions, downhill ski champions, South African rugby internationals, and people who have climbed Mt Everest. The male to female ratio is approximately 3:1.

Where do they come from?

The countries they most commonly come from are India, Sri Lanka, South Africa, Iraq and Egypt. Slightly less commonly from Bangladesh, Pakistan, Peru, Zimbabwe, Namibia, Syria, Fiji, the Netherlands, the Ukraine, Germany, the United Kingdom and, curiously, although not recently, the United States and Canada, who seem to have dropped off. It would be really good to spend time talking about things other than their GP skills, but there isn't the time.

Our panel

We have four panel members, chaired by one of the GPs or by me. The other three are all rural-based GPs, with extensive rural or remote experience. All are involved either in teaching GP trainees, assessing performance, or as examiners for the College of General Practitioners.

The interview

We conduct face-to-face interviews, occasionally by video conference, which is not as satisfactory as interviews in person. It is difficult, for example, to show them ECGs. We first ask them more about their c.v. and their general practice experience. The c.v.s can be quite misleading. Some might say that they have been working for 10 years as a GP in a hospital in India. This is really a semantic problem. All their medical practice there may be hospital based. They are not, in fact, primary carers, they don't do follow-ups and they see only patients who have been referred to the hospital.

We let them know that, if they are successful, their registration is for only the position they have applied for. We make sure that this is clear, and we let them know that the interview is being recorded. The recordings are transcribed only if there is a dispute or a later problem. I have no evidence to support my view, but we sense that challenges to our recommendations have been fewer since we started recording two years ago.

If they have previously attended a panel interview and been unsuccessful, we look at their areas of deficit and what they have done in the interim. Have they since had any experience in Australian medicine? Have they visited the practice where they now wish to work?

Our questions

We use previously formulated questions. We would always include one obstetrics and gynaecology scenario, one in paediatrics, and one in adult medicine or surgery. The fourth is variable, but within one of the four there will always be an emergency and resuscitation component. We do not ask the same questions of each applicant. If somebody intends working in a women's Aboriginal health service, we probably won't go into detail about prostate cancer. We adapt the questions for the specific position they are applying for.

We would like to feel that the scenarios are those they can reasonably be expected to experience during their time in the designated practice. We would like them to demonstrate that they would be safe in that particular position if that type of patient presented. Almost all the scenarios are based on patients we have seen recently.

They are presented to the applicant in a way which gives us a good idea of how that doctor would conduct the consultation. We want an insight into the thought processes driving the consultation and to be sure that all important aspects are covered. Public safety is our number one priority. Would the outcome of this consultation be safe?

Not knowing

It is quite acceptable for anyone to reach a point in any consultation where one really does not know what next to do. How one behaves in that situation is really important: whether or not one asks a colleague or a supervisor, looks up the information appropriately (for instance, when unfamiliar with drug dosages for a child of a particular age), what resources would be used, if and when a patient would be referred to a hospital or a specialist.

Not knowing something is acceptable if one's management of the situation is appropriate. Guessing or under-referring, ie not asking for help, are not acceptable.

Any GP should know that a good history is needed, including the patient's background, medical history, medications, other illnesses, and specific information about the current symptoms. Without all that information, it is very difficult to decide what is likely to be causing the problem. Then a good, but appropriate examination, is needed.

It is not really appropriate for the candidate to just say, "I would do a full examination", because a full medical examination could take two hours! Absolutely not practical in general practice. If a 15-year-old girl comes in with a cut finger, it is not appropriate to do a pelvic examination; but if a 60-year-old comes in with post-menopausal bleeding, it is not appropriate to omit an internal examination.

Examples of our scenarios

A farmer in his fifties comes to see you. He cut his foot three days ago on a dirty piece of metal. His foot is now red and swollen. How will you manage him?

We would expect the doctor to say that they would examine the foot and find out a little about the person's background. It will turn out, later, if the right questions are asked, that this patient has as-yet-undiagnosed diabetes. The applicant should take a medical history, look at the foot, assess the severity of the infection, decide whether it is local or has spread into the whole system, be alert to the possibility of diabetes (particularly in Aboriginal communities where it is extremely common), should ask about tetanus immunisation and make sure the patient is covered, be able to justify a reasonable choice of antibiotic (including dosage or where they would look this up), and explain the criteria they would use to send the patient to hospital for antibiotic treatment. Those are the areas we would like covered.

A 15-year- old girl comes to your surgery stating that she is worried that she might be pregnant and requests the 'morning-after' pill.

If the candidate ask the right questions, they will be told that she has had her current boy-friend for six months and is happy with the relationship, has had regular periods since the age of 12, the last being normal about two to three weeks ago. The doctor I can remember as being the most outstandingly poor, answered that he would do a pregnancy test. We asked, "Blood test or urine test?" "Either", he said. We said, "Let's assume the urine pregnancy test was negative." He said, "I will reassure her and send her away."

He should have been aware of the important issues. At 15, she is a minor. Are her parents involved? Does she want them involved? What if she doesn't? He should find out more about her partner, and if there has been any coercion or abuse. He should take a good sexual history, as she might have had many partners. He should take an obstetric and gynaecological history. She may already have a baby. She may have had sex only once. A social history is very important: whom she is living with, does she take drugs or alcohol? Contraception should be discussed. Sexually transmitted diseases should be excluded and counselled about. A Pap smear should be discussed. We would expect him to be aware that a negative pregnancy test means nothing this early in the course of a possible pregnancy.

As you can see, our emphasis is on assessing what the candidate would be thinking and doing in this scenario, relating it, when possible, to the specific practice they are applying for.

Recording the interview

I make a written record of the interview. The panel members independently fill in a form for each scenario. The form has a 'positives' space where we can fill in everything that impresses us

and is correct. Anything they omit or which is incorrect is put in a 'negatives' column. Each response to a scenario is rated as excellent, satisfactory, not competent or unsafe. By the end of the interview, our four panellists have each filled in a form with individual ratings for each of the four scenarios. At the end, we fill in an overall assessment, rating interviewing, physical examination, clinical judgment, treatment and advice, and communication skills. Communication includes language skills and a counselling and sympathetic approach to the patient.

Making the assessment of safety

After the applicant leaves the room, the panel discusses, collates, decides whether their decision is by consensus or unanimous, and what recommendation should be made. If the candidate is assessed as not suitable, detailed reasons are given. If they are assessed as suitable, there may be provisos on their registration, eg they may practise only when a supervisor is present on site.

Sometimes, in times of difficulty, we use the informal 'granny' test: Would I be happy if my granny were seeing this doctor? It is much more reliable than the 'mother-in-law' test.

After the interview

We write a really detailed, structured report for the Medical Board. A draft is first circulated to all panel members. Apart from the scenarios, the report, once ratified by the Board, is forwarded to the practice making the application. The Board notifies the candidate as soon as possible. Obviously some people are desperate to get these doctors on the ground. We aim to complete our process within a week.

The supervising GP sends in regular reports on all aspects of the doctor's performance. These are reviewed by the Board and any unsatisfactory areas followed up.

How good have our applicants been?

Our applicants have varied from absolutely excellent to atrocious. We regret not having videoed some interviews which we could have used as teaching tools. We have sometimes had to look up what the doctors have told us-if they were right, they have taught us! We have had some so poor that panel members have written on the bottom of their form, not only "Overall poor", but "Does this person really have a medical degree?"

We are often unpleasantly surprised after looking at a c.v. which sounds really good. It is impossible to pre-judge on the paper work. Some of the best candidates come from really difficult backgrounds, while some others, who sound like they have had a lot of very relevant experience, don't seem to have a clue.

Criticisms of the system

I have heard criticisms of the process since people have known I am involved. When I was in Gulargambone a couple of years ago, they were saying, "Send us a doctor, we need a doctor, any doctor is better than none, how bad can they be?" I have heard GPs, whose OTD applicant has been knocked back, say, "But that candidate was better than some Australian graduates I know." That is probably true, but is not the concern of our panel. There are other mechanisms for addressing poorly performing Australian graduates.

One GP felt that our finding the applicant unsuitable must mean that we didn't understand how desperately he needed somebody. He wanted to talk to us about this on Christmas Eve. We declined.

We have also had unsuitable applicants who were previously working in remote areas in Queensland. The recruiting agency was very cross about that. They argued that New South

Wales should automatically register a doctor who had been working in an Area of Need in Queensland. It is a while since we last heard that criticism!

What are the shortcomings of our process?

The main one, I think, would be that we are not witnessing an actual consultation. We try to present the scenario in a manner as close as possible to how a GP consultation would go, but we can't watch them examining a patient. We do ask them, at times, to detail exactly what they would do. We hope that that gives us a fair idea. We also rely on these positions being supervised. If we are concerned about any aspect of the interview, we can ask for closer supervision for a longer period of time.

Reporting by the supervisors is a potential shortcoming. We are aware that some of these practices are really desperate; they might be very reluctant to report an under-performing GP to the Board for fear of losing this extra pair of hands.

Another is the potential for the doctor to be taken advantage of. The employing (and supervising) doctor will know that the OTD is "stuck" in this position. If the OTD is not being rewarded well enough financially or is being overworked, they might feel that there is very little they can do about that. So we do try to emphasise that they can change positions by re-applying to the Area of Need panel. If there have been no standards problems and the other position is relatively similar, we will usually recommend them for transfer to that position without a second interview.

The process is rigorous but not without its potential shortcomings.