Author's response to reviews

Title: Modernising medical migration: making the move from monopolies to markets

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Author's response to reviews: see over
Authors’ responses to Reviewer 1’s comments

R: This paper...implies that all of the opposition are stupid, mendacious, or worse... Having said that, I am happy to see strongly argued positions against the status quo.

A: The sensitivity expressed here highlights how difficult it is in practice to argue against the status quo. Systems evolve as they do for good reasons - processes are painstakingly developed over many years by well-intentioned people. Perhaps for this reason, even suggesting that future change can be debated may ignite defensiveness as an understandable reaction in many, perhaps even most, people. In the revised manuscript, we have tried to defuse such sensitivities by examining the general antecedents of the problem (see p. 4 of the revised manuscript) with the aim of reassuring readers that our criticisms are systemic rather than personal, and that our intentions in provoking further debate are constructive rather than destructive.

R: Whether there is even a problem of any magnitude [that these proposals would solve] is not clear to me.

A: This is a key point of difference between the Authors and the Reviewer. On p. 4 of the revised manuscript we now detail our own take on the underlying “problem” - viz., the pace of globalisation, and the challenges which this presents for nation-based bureaucracies (including, though not limited to, medical licensing councils). To this end, we have included a new section explaining our view that there is a generic conflict between globalisation/digitisation on the one hand - the ‘irresistible force’, in our metaphor - and the ‘immovable object’ of the nation-based bureaucratic culture.

R: The paper itself... at present is brief to the point of missing many arguments.

A: This is a valid point. We have lengthened the revised manuscript to address many of the missing points and arguments which the Reviewer has constructively noted. The main additional material is now highlighted on p. 4 and p. 7-8 of the revised text.

R: The literature review is limited, and mainly critical. By all means say, on p.3, that the GMC has been criticised, but not to say that that was in 1989 before major reorganisations at that organisation, is to mislead the reader. Not to cite obvious works (such as Sir Donald Irvine’s The Doctors’ Tale, written by the former GMC president who instigated most of the changes, or Peter Lens' Problem Doctors, which cites a range of empirical material looking at the issues) reinforces a perception that the literature review was mainly cursory.

A: We would clarify that this submission is not a systematic Review, and does not aim for comprehensive bibliographic coverage. Rather, it is an opinion piece designed to provoke thought among Journal readers, who we believe are intelligent enough to form their own conclusions even when considering a viewpoint which they may not share.

We were deeply concerned to learn that the Reviewer has interpreted the article as an attack on the GMC, which was only mentioned once in the original manuscript, as this
was certainly not our intention. To remedy this unintended impression, we have erased this single mention of the GMC from the text of the revised manuscript.

R: The paper essentially proposes a series of 'credit ratings' of doctors; these would seem to have all the advantages and all the disadvantages of the current secret credit ratings produced by banks and the like, often based on little more than gossip or typographical errors, which bedevil many people trying to get credit cards or mortgages. How private hospitals, insurers and the like, working together, are to avoid such a problem is not clear.

A: This is a very fair point (though we doubt that banks would agree with the Reviewer's description of their modus operandi). We should clarify that the 'market forces' to which we refer in the article are not confined to commercial matters such as those relevant to banks, but rather denote the dynamic balancing of supply and demand at all levels in an increasingly interconnected world. We would counter-argue that the change we have proposed is more akin to 'currency deregulation' than to 'credit ratings', i.e., it is a decentralizing initiative rather than an alternative attempt to impose a top-down judgement. In some respects this is already occurring, with EU doctors now licensed to work in different countries across Europe, yet with local considerations still impacting heavily on employment decisions.

R: "The populist fear that all professions represent a conspiracy against the public" (p.4). It may be popular currently, but it goes back to Adam Smith, of course, and was popularised by George Bernard Shaw, who attacked doctors, like other professions, as they "are all conspiracies against the laity". He does though carry on, "I do not suggest that the medical conspiracy is either better or worse than the ... legal conspiracy, ... [and] the innumerable industrial, commercial, and financial conspiracies .. which make up the huge conflict which we call society." Surely Shaw would know how to repudiate the present proposals, with their seeming lack of safeguards in the great database of the internet?

A: We loved this allusion to Shaw! However, we suspect he may have had more sympathy with our own arguments than with uncritically defending the status quo.

R: p.6 "a faceless bureaucracy, neither elected nor answerable to any elected body". Maybe in Australia, but the UK GMC is none of those – it is elected in part from the profession, it has lay members, and its responsibilities are enshrined in statute. A review of somewhere other than Australia would make the suggestions more impressive. Likewise, Jayant Patel may be infamous in Australia, but that infamy has not noticeably spread to where I live – some description would help avoid the suggestion of parochialism.

A: Yes, the writing of this article was stimulated in part by the recent shortcomings of the Australian system, as described. But no, we do not imply that all non-Australian regulators are "tarred with the same brush" in relation to these shortcomings. In the highlighted lines 13-14 on p.6 of the revised manuscript, we clarify at the outset of this section that the problems in Australia are typical but not necessarily identical to the
challenges now emerging worldwide. In addition, the specific reference to the Patel case, in the text and citation list, has now been deleted from the revised manuscript.

R: p.6. "a disruptive impediment to the global mobility of most well-qualified practitioners". The presumption of the benefits of globalisation and of mobility are not clear to me; Africa and India are being demedicalised precisely because of those processes, to the benefit of almost none of their citizens, despite those citizens having educated the doctors who then migrate. What is the overall good that is being looked for here? It seems rather like yet another example of "the societal shortcomings of market-based systems".

A: We agree that increasing medical mobility has its problems - as indeed do market-based systems, as already acknowledged. In lines 17-23 on p.7 and lines 1-13 on p.8 of the revised manuscript we have discussed further the example cited, in a new section examining the 'brain drain' and other negative effects of migration. Still, we believe it would be overstating the argument to claim that the medical problems of Africa and India are primarily (or even, perhaps, significantly) related to 'poaching' by developed countries, as distinct from the overwhelming problem of endemic poverty. Such perceptions are an important political and ethical issue, we agree, but whether tighter migration restrictions by overseas regulatory Boards would measurably improve medical standards in poor countries must surely be doubtful, in our view.

R: "Since most malpractising medical practitioners are repeat offenders" (p.7). p.877 of the cited paper says that 9.7% and 20% of those receiving sanctions in one five-year period, received further sanctions in the next four-year period. Hardly "**most**". There is indeed an increased risk (less than 1% of those not getting sanctions in the first period received them in the second), but that is not what is being stated in the present paper. The majority of doctors with a sanction do NOT go on to get sanctions in the next period. In all likelihood the majority of doctors who make a single major practice error do not go on to make other errors (just as most drivers who have a major accident do not go on to have further major accidents, for a host of psychological and statistical reasons).

A: Thank you for pointing this out. In lines 20-21 on p.8 of the revised manuscript, the text is rephrased accordingly, and the relevant conclusions are expressed more conservatively.

R: p.8. "local medical committees who work hand-in-glove with employers and insurers to ensure quality and value of patient care as their focus". It is a charming picture in the final lines, as remote from a global health economy as Adam Smith's cottage industry where a worker does everything from growing crops to selling worked-up produce. The reality is surely to be an under-staffed, over-stretched hospital, whose profitability is insecure, who receives a job application from a doctor who has trained on one continent, worked on a second, and now wishes to come to a third, and whose local medical committee has no specialist knowledge of any of it, and no resources, be they of knowledge of finance, for finding out. Short of putting roses around the door of the local hospital, the proposals surely need more justification than is provided here?
A: As a 'logical extreme' counterargument, this is a fair objection. However, the short answer to the above scenario in 'reality' would surely be that the hospital in question would not rush to employ someone about whom they were doubtful due to lack of supporting information. If they could only identify one candidate of uncertain ability who was willing to apply, they would face the same dilemma that any employer faces in this situation. At the other logical extreme, the authors are aware of many medical and nursing candidates who hold productive positions in respected medical institutions in one country, but who are debarred (often permanently) from moving/returning to a position in another country - notwithstanding support from professional colleagues in that country - for reasons that often seem to relate more to bureaucratic inflexibility and local power plays than to any objectively proven "need to protect patient safety".
Authors' responses to Reviewer 2’s comments

R: I found this a difficult paper to review as it was generally vague, speaking about professional regulatory systems without referring to “medicine” or “health professionals”.

A: We have addressed this point in the revised manuscript by specifying in multiple sections of the text - p.4, lines 9-10; p.7, lines 20-21; p.8, lines 9-11 - that both medical (physician) and nursing professions are pertinent to the concerns expressed.

R: I believe that the intention of this manuscript is somewhat “political” in that it presents a model that takes the power and regulation away from national boards and places the decision-making within the hands of stakeholders (e.g. employers) who have identified a need for particular services.

A: That is correct, although our primary concerns are professional, not political.

R: Unfortunately, the paper does not do a good job at describing this. There is more information contained in the abstract about the model than in the manuscript itself. The model is described in the abstract and depicted only as a figure in the manuscript... [Without an explanation, the model provided is left to the interpretation of the reader].

A: We have refrained from describing the new model in detail, as we admit that such changes are evolutionary in practice, and would not wish to imply that immediate change to an alternative model is feasible or desirable. The more important message we have argued is that the rising dominance of national bureaucracy has gone too far, and the pendulum needs to swing back.

R: The word “nursing” appears only in the abstract and not in the manuscript.

A: In the revised manuscript, nursing issues relating to the article’s concerns are covered in the ‘brain drain’ section, and elsewhere in the text, viz., p.4, lines 9-10; p.7, lines 20-21; p.8, lines 9-11.

R: What is the difference between councils and bodies? Again, vague and no clear descriptions.

A: These wordings vary between countries and jurisdictions. In general we have tried to balance the use of the words "Council" and "Board", but with similar meanings.

R: The key issue is patient safety and this has not been mentioned.

A: The revised manuscript refers more specifically to this issue - e.g., p.2, line 14; p.4, lines 11-14; p.8, lines 5-9. Unfortunately, as pointed out in the article, there are few hard data upon which to base conclusions about changes in patient safety, whether related to licensing strategies or revalidation/CPD mandates. Again, we point out that
A pillar of the present system is the assumption that it is the best support for patient safety, but that hard evidence backing up this assumption is lacking.

R: Table 1 should be redone for the two columns to reflect: Current problems and Proposed solutions.

A: Thank you for this suggestion. In the revised submission we have reworded these columns on p.11 for greater clarity, but have elected to maintain their current content. The "solutions" we have suggested consist only of removing the current areas of authority mentioned in column 2.

R: Is the use of “bureaucratic” appropriate? We usually use this in a negative context.

A: In lines 14-26, p.4 of the revised manuscript, more space is given to defining pivotal terms such as 'bureaucracy', 'globalisation', and 'market forces'. An examination is made as to why the term bureaucracy has acquired its present unpopularity despite the undoubted usefulness of such an organisational system in a large society.

R: “Government agencies” is used in the model but in the manuscript there is a reference to Colleges arguing that registration should be in the hands of “clinicians” rather than government bureaucrats, suggesting that perhaps there were no clinicians in government?

A: Our view is that the agendas and priorities of (academic/training) Colleges are closer to that of practising clinicians than are those of the Government or its appointed Boards and Councils. We assume that the priorities of (ex) clinicians employed in Government offices will mainly reflect those of the Government.

R: I am somewhat confused as to where the authors see regulation/registration. If as they suggest that there needs to be an international register, then governments and professional bodies would both need to be involved.

A: We agree with this point. Our model proposes that a digital online international register would be open-access, pending agreement of the clinician in question. Not only governments and professional bodies, but insurers and potential employers could access this registry data if permitted to do so by the applicant/candidate in question. It is the official authority of the centralized agencies that would be diminished by this change, not the involvement or contributions of the stakeholders.

R: The authors base their manuscript on the Australian experience. Does reflect the international status quo?

A: In lines 13-14 of p.6, we have revised the manuscript to clarify that we simply regard the Australian problems to be typical of the sorts of challenges now affecting all globalizing constituencies. Moreover, many of the citations in the text refer to North American and other global constituencies. We were not able to access the IMG web page suggested, so cannot comment on this.
R: The title is not appropriate. ...“Facilitating health professional (or should this be physicians) migration and registration in a modern world”

A: Thank you for this suggestion. However, we have made a minor further modification of the article’s title on p.1, but feel that this is the most appropriate title to attract the attention of interested readers to our article.