### THE REGULATION OF MEDICAL PRACTICE IN AUSTRALIA, CANADA, UNITED STATES AND BRITAIN

#### **Bob Birrell**

Overseas trained doctors (OTDs) are playing an important role as medical officers and specialists in the Australian public hospital system and as general practitioners in 'area of need' locations. This role is increasing as a result of the recruiting initiatives flowing from the Commonwealth Government's Strengthening Medicare program. Yet there are no requirements in Australia that these OTDs be first subject to a formal assessment of their medical knowledge, clinical skills and practice performance in a supervised hospital setting. A review of the situation in Canada, the United States and Britain shows that OTDs wishing to practise in these countries first have to undergo such an assessment. The reasons why Australia is different are explored. It is concluded that State and Commonwealth Government concerns about the supply of doctors have overridden worries within the medical profession about the readiness of OTDs to practice in Australia without formal assessment and further training.

Could the regulation of medical practice in Australia be in doubt? The question may seem absurd. Surely medicine is one of the most regulated occupations in Australia? The profession is internally organised within long established and prestigious colleges. It has the formidable Australian Medical Association (AMA) to lobby on its behalf. The Commonwealth Government and each of the State Governments employ large bureaucracies whose job is to manage the provision of health services. In addition, each State is served by a Medical Registration Board tasked to ensure that medicine is practised in an acceptable manner. The latter responsibility should not be too onerous because Australia's medical schools are justly proud of their training standards and their capacity to attract the best and brightest of students.

There are alternative routes into full registration within the Australian medical workforce. However, they are carefully regulated. One route is where an overseas-trained doctor (OTD) gains accreditation by passing the examinations run by the Australian Medical Council (AMC). These require the successful completion of an English language test, an examination of medical knowledge and

clinical skills, and a one-year period of supervised hospital practice equivalent to that required of interns who complete an Australian medical degree. Another route is via completion of the Royal Australian College of General Practitioner's (RACGP) post-graduate family medicine examinations. This requires that an OTD pass the same tests as those required of Australian-trained doctors who have completed the three year post-graduate family medicine training program.

Notwithstanding these regulatory practices, as was reported in the last issue of People and Place, there are currently several thousand doctors working in the front line of Australia's public hospital system as junior doctors or specialists, or in general practice, who have been trained overseas and whose medical knowledge and clinical skills have not been formally assessed in Australia. Nor have they had to undergo a period of supervised hospital practice in Australia before practising as medical officers or specialists in the hospital system or as General Practitioners. Most are in Australia on temporary visas.

One indication of the scale of dependence on OTDs is the number of visas

issued to principal applicants for visa category 422. These visas are issued to OTDs for temporary appointments (up to four years) to a medical position which has been approved by the respective State health department. The numbers have grown from 670 in 1993-94 to 1,419 in 1999-2000, 2,496 in 2002-03 and 2,429 in 2003-04.

Many additional visas are being issued to OTDs as occupational trainees under visa category 442. These OTDs have been approved to work for up to one vear in supervised training positions, which usually involve front line hospital work either as junior doctors or as trainee specialists. No tally of their numbers is kept by the Department of Immigration Multicultural and Indigenous Affairs (DIMIA). However, as shown in Table 2, the numbers entering Australia are large. There is a heavy reliance on these OTDs in NSW. As of 29 June 2004, some 1,202 occupational trainees were registered with the NSW Medical Board. Most are employed as hospital medical officers.

In addition, hundreds of OTDs who are permanent residents of Australia, who have not passed their AMC accreditation examinations are employed as doctors in public hospitals and General Practice (GP) clinics on a provisionally registered basis.<sup>1</sup>

The numbers of OTDs in question will grow, since, as part of its Strengthening Medicare package, the Commonwealth Government has liberalised the rules governing their recruitment and, as discussed in the previous *People and Place* paper, and further below, it is promoting an accelerated recruitment program.<sup>2</sup>

There is no secret about this situation. The Commonwealth Government, in its advice to OTDs who are considering working in Australia, states that: 'Currently there is no formal assessment of the level of theoretical and clinical skills

expected of TRDs [Temporary Resident Doctors]'.3 OTDs wishing to work in Australia on a temporary basis (visa category 422) or as an occupational trainee (visa category 442) only have to satisfy their prospective employer that they hold a medical degree and that they have the skills relevant to the task the employer wishes them to fulfil. As noted below, in several Australian states they do not even have to pass a formal English language test. For the 422 visa (but not the 442 visa) DIMIA requires evidence from the relevant Australian Medical Board that the medical qualifications of the OTD meet the Board's requirements for specific purpose registration. However, apart from checking the bonafides of the qualifications claimed. the Medical Boards do not require any additional assessment of the OTDs skills beyond that carried out by the employer.

Yet the need for a formal assessment of English language, medical knowledge, clinical skills and supervised practice is obvious. As shown in Tables 1 and 2, the source country of origin of doctors entering Australia under visa categories 422 and 442 has been trending towards nonwestern countries of origin. In the case of NSW, half the OTDs currently registered received their qualifications from non-English speaking countries.<sup>4</sup> The absence of a formal assessment process was less of an issue a decade or so ago when the numbers coming to Australia under these visa categories were small and most were trained in Britain or some other Commonwealth country. This is no longer the case.

It is true that all OTDs who practise in Australia must possess a degree-level medical qualification. Isn't this enough? It is sometimes said that all OTDs employed in Australia come from World Health Organisation (WHO) approved medical schools. But as the WHO acknowledges

Table 1: Medical Professionals Visa 422, Principal Applicants only, long and short-term arrivals by country of birth

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Papua New Guinea	1	0	1	5	1	8
Fiji	3	0	1	10	8	9
United Kingdom	492	601	391	485	476	415
Ireland, Republic of	80	33	72	67	62	61
Germany	6	10	10	10	29	32
Netherlands	2	14	9	52	23	27
Switzerland	2	1	1	3	2	5
Iran, Iraq, Saudi Arabia, Egypt	2	0	5	6	7	12
Malaysia	4	8	2	6	16	23
Philippines	2	2	1	7	9	17
Singapore	1	2	2	6	5	6
Thailand	0	1	1	0	3	4
China	0	0	1	2	3	5
Hong Kong	4	2	0	0	2	4
Japan	0	0	1	2	5	1
Bangladesh	0	0	3	11	12	13
India	32	31	37	49	67	123
Pakistan	3	3	17	27	21	26
Sri Lanka	3	4	4	17	33	25
Canada	3	21	8	2	18	17
United States of America	89	6	10	18	30	43
South & Central America, Caribbean	1	3	56	4	8	13
Kenya	2	0	2	3	6	8
South Africa	71	72	154	126	121	95
Other	19	32	62	72	82	109
Total	822	846	851	990	1,049	1,101

Source: DIMIA overseas arrivals and departures, unpublished

Note: Tables 1 and 2 are revised versions of the data in Tables 4 and 5 provided in *People and Place*, vol. 12, no 2 (see endnote 1 below). The revision was necessary because of sampling errors in the short-term arrival data.

on the front page of its World Directory of Medical Schools: 'The WHO has no authority to grant any form of recognition or accreditation to schools for the training of health personnel. Such a procedure remains the exclusive prerogative of the national government concerned'.<sup>5</sup>

# ARE AUSTRALIA'S ACCREDITATION RULES EXCEPTIONAL?

If other western nations allow a similar pattern of practice perhaps there is no basis for tougher assessment rules. As is well known, Australia is not alone in facing a shortage of locally trained doctors. Great Britain, Canada and the United States have all encountered severe shortages of doctors and all rely on OTDs to fill the breach. The following notes describe the assessment practices in place in each of these three locations.

#### Canada

OTDs resident in Canada cannot practise medicine until they have passed a French

People and Place, vol. 12, no. 3, 2004, page 42

Table 2: Medical professionals arriving as occupational trainees (visa 442), principal only, long and short term by country of birth

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Papua New Guinea	2	1	0	5	5	10
Fiji	4	2	24	3	9	3
United Kingdom	433	161	302	322	206	244
Ireland Republic of	11	12	19	16	15	7
Germany	13	15	13	32	13	16
Netherlands	3	20	4	11	5	2
Switzerland	9	6	5	2	5	5
Iran, Iraq, Saudi Arabia, Egypt	2	5	5	17	10	16
Malaysia	28	23	46	37	45	62
Philippines	6	6	11	17	14	19
Singapore	13	7	6	7	11	19
Thailand	3	15	25	18	11	25
China	36	30	11	67	57	63
Hong Kong (SAR of China)	57	17	3	1	13	16
Japan	11	9	14	12	18	16
Bangladesh	14	2	1	0	2	3
India	49	77	78	62	78	89
Pakistan	7	3	6	5	1	7
Sri Lanka	15	21	16	43	40	40
Canada	4	19	5	5	13	5
United States of America	10	10	6	18	14	12
South & Central America, Caribbean	4	4	6	3	6	8
Kenya	2	0	4	3	1	2
South Africa	4	7	11	5	10	9
Other	76	85	112	84	62	84
Total	816	557	733	795	664	782

Source: DIMIA overseas arrivals and departures, unpublished

or English language test, a medical knowledge and clinical test administered by the Medical Council of Canada, and then served in a residency position in teaching hospital. As in Australia, there are thousands of OTDs who have migrated to Canada through family reunion, humanitarian and skilled migration programs who are now permanent residents and who wish to practise medicine. However, unlike Australia, there is no pathway to medical employment until the OTD completes the Medical Council's examinations and hospital residency requirements.6 The Canadian Government, however, does allow provincial employers to bring OTDs to Canada on work permits if they work in under-serviced areas.<sup>7</sup> In this sense the Canadian situation is like that of Australia. However, according to Canadian sources, these doctors mainly come from Commonwealth countries.<sup>8</sup>

#### The United States

In the United States, OTDs, or International Medical Graduates (IMGs) as they are called, cannot practise medicine until they have passed a language test, and an examination in three steps (medical knowledge, ability to apply medical skills under supervision plus knowledge of

health promotion and disease prevention. and an assessment of the candidate's capacity to provide unsupervised patient management).9 In addition, an IMG must complete an accredited residency program which takes at least three years. IMGs who complete this process play a very important part in the US medical system. About 5,000 of the total number of around 22,000 doctors who fill first-year residency positions each year in American hospitals are IMGs who have completed their accredition examinations.<sup>10</sup> Many of these IMGs remain in the United States after completing their residency program. Those who came to the United States on Medical Student visas are supposed to return home for two years. But if they are prepared to serve in 'areas of need' they are usually granted waivers permitting them to stay on. Thus despite an increasing dependence on IMGs in the United States, there is no parallel to Australia's situation, where OTDs can practice without any preliminary formal assessment by U.S. medical authorities.

#### **United Kingdom**

In the UK, the situation is similar to the United States. There is a heavy reliance on IMGs in the British national health system. The proportion of hospital medical staff employed in the National Health Service in England whose medical qualifications were obtained in countries other than the United Kingdom or European Economic Area countries was 24 per cent in 1997, rising to 28 per cent in 2002.11 The British Government provides temporary visas to allow IMGs time to prepare for employment in the system. Nevertheless, before taking up a post they must pass the Professional and Linguistic Assessment Board (PLAB) test. This involves passing the International English Language Testing System (IELTS) test (with a minimum overall score of seven and at least six in each of the four segments) and a medical knowledge and clinical skills test. As the General Medical Council indicates in its statement of requirements: 'the PLAB test is designed to assess your ability to work safely in a first appointment as a senior house officer in a UK hospital in the National Health Service'.<sup>12</sup>

### WHY IS IT DIFFERENT IN AUSTRALIA?

# Perhaps OTDs are evaluated when they are recruited by employers?

When OTDs are employed in Australia, the employer (such as a hospital or GP clinic) will, of course, want to hire a doctor suitable for the position. Thus there will always be some sort of evaluation of prospective applicants. But discussions with persons familiar with recruiting practices indicate that, in most cases, recruitment decisions are based on reviews of the curriculum vitae (CVs) of applicants while the applicants are still resident overseas. A common practice is for commercial recruitment agencies to present batches of OTD CVs to employers who wish to make appointments. The employer, who may or may not involve medical staff in the selection process, then chooses the OTD considered to be most suitable, perhaps after a telephone interview. In most cases there is no systematic review of the applicants' medical knowledge or clinical skills parallel to the arrangements in the UK, United States or Canada. Alternatively, the employer may initiate the recruitment process. This commonly occurs where a commercial organisation or individual entrepreneur owns a GP practice — usually a bulk billing practice or locum service. The employer's interest is to ensure that the practice is staffed so that revenue from bulk-billed services is maximised. Concern about the skill, linguistic capacity and cultural sensitivity of the OTDs recruited may well be a secondary consideration.

The Commonwealth Government, as part of its Strengthening Medicare package, has designated certain recruitment agencies with expertise in the medical area which it encourages employers to use. The scheme began in July 2004 and will continue till June 2005, at which point it will be reviewed. The scheme covers OTDs recruited to General Practice positions in defined 'area of need' locations. If employers engage an OTD through these organisations the Commonwealth will pay the recruitment fee. This is normally between \$10,000 and \$25,000 per doctor. The goal is to facilitate the importation of more OTDs by reducing the costs to the employer. The state-based rural workforce agencies are among the agencies designated. They do work to strict selection criteria, including fly-in or telephone based interviews which allow medical panels to screen candidates for their communication skills and clinical antitude.

However, the designated agencies also include another ten recruiters, most of whom are commercial organisations. One of these is Recruit-A-Doc, an Adelaide based organisation. When questioned as to its selection procedures, the chief executive indicated that Recruit-A-Doc is a 'full-service' recruiter in the sense that it evaluates the English language and medical knowledge of OTD applicants on its books and their appropriateness for Australian conditions. This is done via an extended international telephone interview. About 50 per cent of those assessed by interview are not recommended for appointments in Australia. Where an appointment is made, Recruit-A-Doc arranges for the OTD's movement to Australia.

This procedure is a step in the right direction. But what is significant for the present analysis is that Recruit-A-Doc's protocols are exceptional. An examination of the websites of each of the designated recruiters indicates that (aside from the state based rural workforce agencies) not one of them states that the applicants will be subject to a formal review of their medical knowledge or clinical skills before being appointed.

# Don't worry because adequate supervision of OTDs is in place

When the State Medical Boards issue a provisional licence for the OTD to practise in Australia, they usually stipulate that the employer provides for supervision of the doctor in question. If these provisions were implemented there would be grounds for assuming that any deficiencies in the work performed would be identified. The reality is otherwise. OTDs frequently work in the frontline of the medical system in regional GP practices, or as hospital doctors in emergency departments. This means that they are required to be on hand overnight and during weekends. Or they may work as specialists in hospitals where few consultants are present. It is simply impractical for them to be closely supervised under these circumstances. The Medical Boards do not have the resources to audit the supervisory provisions, nor are they required to do so by the provisions of the Acts of Parliament that stipulate their powers.

### Don't be concerned because a 'doctor is a doctor'

There is an argument that medical consumers are better off with a doctor who has not been assessed than with no doctor

at all. There is also evidence that many of the OTDs serving in Australia are doing an invaluable job. But there is equally a raft of anecdotal accounts which indicate that some OTDs, by virtue of English language deficiencies, gaps in medical knowledge or lack of clinical experience relevant to Australian patient needs and cultural incompatibilities with Australian expectations, do struggle in the Australian setting. Even the most highly trained and literate doctor would have difficulty coping with the rules governing medical practice in Australia, as well as the local knowledge needed to deal with Australian patients. When OTDs are appointed on the basis of CVs incorporating untested claims of experience, such difficulties are all the more likely.

If something does go wrong, the OTD can simply exit Australia leaving the employer or the respective State Medical Board to cope with the legal consequences.

There is no publicly available audit of OTD performance. However, a review of the situation in Queensland was conducted during 2003 by Denis Lennox (a senior Queensland Department of Health official) under the auspices of the Medical Board of Queensland, the Queensland branch the AMA, and the Queensland Department of Health. His (unpublished) report recommended that a systematic assessment procedure be put in place. The grounds for this recommendation included: 'Evidence is increasing of increased risk of OTD recruits being insufficiently assessed and prepared for practice in Queensland'. 13 For reasons discussed below, the recommendations were not acted upon. Nonetheless the report was leaked to the Queensland press. Subsequent reporting highlighted alleged examples of medical negligence on the part of OTDs, including

two Fiji-trained doctors who had been performing orthopaedic surgical procedures at the Hervey Bay District Hospital. The results included an alleged 'exploding femur and hip fracture on the operating table'.<sup>14</sup>

No doubt any doctor is better than none in most circumstances. But this homily ignores well-founded concerns that, when it comes to medical services provided by non-assessed OTDs, the system is flying blind.

One indicator of the standards of OTDs employed in general practice work is their performance in the RACGP Fellowship exam. OTDs practising in Australia on temporary visas are encouraged to use the 'practice eligible' route to full accreditation as a general practitioner. If they succeed, they are permitted to change their status from conditional to unconditional registration and, in certain settings may apply for permanent residence. Australian medical graduates (unlike OTDs) have to complete a family medicine post-graduate training program before they are allowed to bill on Medicare as a GP (unless they are prepared to serve in an 'area of need' position). Since only a small minority of temporary resident OTDs take the examination, it is not an accurate guide to the overall standards of the majority. However, around 450 OTDs do currently take the examination per year — about the same number as Australian trained registrars and AMC graduates enrolled in post-graduate family medicine programs. Almost all of the latter pass. By contrast, only about a half of the OTDs are succeeding. It is a difficult test for OTDs because it is oriented to Australian clinical practice and disease patterns; patterns which OTDs are often not familiar with. Some also have English language difficulties. But that is the point. The family

medicine requirement has been put in place because the government wants GPs to practice to a high standard. Clearly many OTDs are practising without having achieved this standard.

This point also applies to OTDs on provisional appointments who are practicing as specialists. It is difficult to generalise across the various specialist areas. since the conditions of practice vary by specialty and by whether the OTDs is employed in a provisional position under visa category 422 or as an Occupational Trainee (visa category 442). Nevertheless there is an increasing dependence on OTDs in specialist areas, including surgery. In the case of surgery this involves appointments of OTDs with surgical training as non-accredited surgical registrars, often in public hospitals. This is occurring without a requirement that the OTDs be formally assessed by the Royal Australasian College of Surgery to ensure that his/her skills are appropriate for the position.

### What is the stance of Australian medical authorities on the issue?

To return to the question asked at the outset, how could a proud medical profession allow the situation described above to occur? Has the profession tried to point it out but failed? Or has it not tried particularly hard?

As far as the federal AMA is concerned it has had little to say. It was not until January 2004 that the AMA set up a committee to review the OTD issue. A report entitled *Position Statement on Overseas Trained Doctors* was released in June 2004. On the issue of the assessment of OTDs, it says that OTDs should possess 'the appropriate level of skills and competencies' needed to practise and that 'as far as practicable' this assessment should occur 'prior to arriving in

Australia'. However, there are exceptions for OTDs appointed to Areas of Need or Districts of Workforce Shortage. These exceptions concern OTDs who work in public hospitals where 'adequate resources for training and supervision are available'. Since they represent an important part of the OTD workforce, the AMA position appears to support the present arrangements for these doctors.

The Queensland branch of the AMA (AMAQ) has taken a tougher line. It has had a committee looking at the issue since 2001 and contributed to the initiative leading to the Queensland Department of Health report described above. In July 2004 an alliance of the AMAQ and doctors representing rural GPs (the Queensland GP Alliance) prepared an unpublished statement on International Medical Graduates. This states that, following an assessment of checks of medical knowledge:

An IMG applying for a GP position in Australia will undergo clinical, communication and cultural skills assessment upon arrival, to ensure the IMG candidate is matched with an appropriate job placement.<sup>16</sup>

This forthright position (even if unpublished) is unusual. The medical organisations one might expect to take a stance are conspicuous by their silence. The Royal Australian College of General Practitioners (RACGP) is a case in point. The College presents itself as a proud custodian of what it claims to be the high standards of primary care in Australia. It has embraced the Federal Government's 1996 legislation which made full registration as a GP in Australia conditional (for Australian medical graduates or for those completing the AMC examinations after 1996) on the successful completion of the Family Medicine postgraduate training program. This law has contributed to a significant advance in the preparation of doctors intending to practise as GPs. Yet, the RACGP has not taken a public stance on the increased reliance on OTDs for general practice in 'areas of need'. This is despite the fact that most of these OTDs have not undergone any formal assessment of their medical skills and may have not have completed any postgraduate training in family medicine at all.

While OTDs, as noted above, are encouraged to take the family medicine examination via the 'practice eligible' pathway, only a minority do so. More seriously, there is no requirement that an OTD in general practice must take the examination. OTDs on temporary visas can be employed in general practice for four years and then renew their visa for a further four years. Though the Health Insurance Commission does oblige such doctors to participate in a training program, they may never undergo or pass the RACGP family medicine examination.

This means that provisionally registered OTDs can practise family medicine, but that graduates from Australian medical schools since 1996 who have completed their internship cannot. The Australian graduates must first complete the post-graduate family medicine program. As noted, Australian graduates can avoid this requirement if they practice in an 'area of need' position. Very few take this route because there are plenty of career openings for Australian graduates in the various specialist areas.

A spokesperson for the RACGP, when interviewed for this article, indicated that the College is not happy with this situation. The RACGP has stated this view in its dealings with the Commonwealth Government, though not in the public arena. The RACGP's position is that all OTDs should have their skills assessed

before they are permitted to practise in Australia.

The respective State Medical Boards have also been silent. As indicated, none directly assess the capacity of OTDs to practise in Australia, though the Medical Board of New South Wales does run a videoconference based evaluation for 'area of need' applicants located overseas (but not occupational trainees).

One area where the medical boards are beginning to take action is on the issue of English language proficiency. The Medical Board of Queensland has announced that, from 1 May 2004 — in recognition that the Board has the 'responsibility of ensuring public protection by only registering persons in this State who are able to deliver health care in a professional, safe and competent way' — applicants must have achieved an overall score of seven or above on the IELTS English examination of English language proficiency.<sup>17</sup> This is a positive step forward. It is a step that the Northern Territory and Tasmanian medical boards have taken as well. No such requirement exists elsewhere, though the other state Medical Boards are considering putting a similar rule in place.

These actions are a positive step forward. But why stop at a language assessment? Why not also require that all provisional registrants have the clinical skills and experience to conduct 'safe' medical practice? As noted above, the Medical Board of Queensland supported the investigation of the OTD situation in Queensland which led to the Lennox report cited above. To understand why this support has not resulted in action requiring a formal assessment of OTDs the politics of the situation must be examined.

# The politics of OTD accreditation policy

The number one priority of the Commonwealth and State Governments and the bureaucracies involved in health matters is to get medical services to constituents. Shortages of doctors have become a crisis for the Coalition Government, especially as the shortage has been accompanied by a steep decline in bulk billing rates. The Strengthening Medicare initiatives reflect this crisis. In regard to OTDs, the Commonwealth action has been about 'streamlining' the recruitment process as by 'removing red tape'. The designation of eleven recruitment organisations whose services the Commonwealth will pay for, as described above, is an example. These measures are all about improving supply.

Action on the accreditation process, would, from the Commonwealth's point of view, impede its priority of expanding the OTD medical workforce in Australia. This explains the silence on accreditation at the Commonwealth level. Fear about holding up supply is also the key to understanding the lack of action on the part of State Governments and their health bureaucracies. Two case studies of the latters' priorities will illustrate the situation.

In Victoria there is a structurally based chronic shortage of junior hospital doctors in the public system. Each year about 330 medical students graduate from Melbourne and Monash universities. But the State Health Department has to fill some 565 positions at the second-year intern (or junior hospital doctor) level each year in order to satisfy the workforce demands in the public hospital system. Where is the 300 shortfall to come from? In future, overseas students completing a medical degree in Australia will help fill the gap. In the meantime there has been no choice but to employ OTDs. Most have been drawn from the ranks of permanent resident OTDs who have not completed their AMC examination.

When this situation was publicised two years ago, the Victorian Labor Government announced that it would fund a study which would establish an assessment procedure involving a formal assessment of OTDs employed in the public hospital system, whether drawn from the ranks of permanent resident OTDs or recruited from overseas as temporary resident OTDs.

A Safe Practice Assessment Project was established in 2003, which was headed by Barry McGrath, an academic from the Monash Medical school with long experience in medical workforce issues. The project reported in September 2003. It recommended an assessment process for all OTDs which included a medical knowledge test, a structured interview to assess clinical management skills, cultural issues and linguistic proficiency, and a practical test to assess clinical skills. The response of the Victorian Department of Health has been to pigeon-hole the report. It seems that reluctance to interfere with the recruitment process is a factor. If Victoria introduces an assessment procedure, officials worry that this will reduce the number of OTD appointments because some will fail the test or will not apply in Victoria because they can go to other states and gain immediate employment without being assessed.

Meanwhile the Victorian Government continues to rely heavily on OTDs. According to the 21 July 2004 registration log of the Medical Practitioners Board of Victoria, there were 184 permanent resident OTDs registered on a provisional basis under the 8(1)(b) category. This covers doctors who are candidates for the AMC examination. There are also another 712 OTDs registered as Occupational Trainees and 122 in 'area of need' positions. None of these would have had

to pass a formal assessment in Australia of their medical knowledge or skills.

The situation in Queensland parallels that of Victoria. The number of graduates from Queensland medical schools has barely increased over the past decade or so, yet the Queensland population is growing by around two per cent per annum and, in recent years by about 80,000 a year. As a result there is a chronic shortage of hospital doctors, as well as of locally trained GPs willing to serve in regional areas. This has prompted a high dependence on OTDs. By 2003, nearly half the 900 Resident Medical Officers employed by Queensland public hospitals were OTDs.<sup>18</sup> In the 1980s and early 1990s, when this dependence began to deepen, most of the OTDs were British trained. In more recent years there has been increased dependence on graduates of non-western medical schools.

This situation prompted the Lennox Report. The report recommended the establishment of a formal review process for OTDs before they were permitted to practice. This recommendation has not been acted upon. After the report was leaked to the press, the Queensland Health Minister, Wendy Edmond refused to endorse or accept the report — despite the fact that it was initiated by her Department and written by one of its senior officers. According to the press commentary: 'She and the Queensland Medical Board said there was nothing to suggest any problems with the standards of overseas doctors'. 19

#### CONCLUSION

All the medical authorities with whom this issue was discussed agree that the present situation regarding the assessment of OTDs is unsatisfactory. All agree that, as a minimum, there should be a formal assessment of the English language and the medical and clinical knowledge of OTDs before they are allowed to practise in Australia. The existing arrangements arose out of a longstanding practice of drawing on British-trained doctors to fill temporary gaps in the Australian medical workforce. But as all the major players with a role in the regulatory system know, this comfortable arrangement no longer works. This is because of the recruitment of OTDs trained in non-western medical schools, where the standards of the training and their relevance to clinical practice in Australia are highly variable. That is why there is universal agreement that a formal assessment system should be introduced.

The implementation of such an assessment has not happened because these same medical authorities (the AMA, the Medical Boards, the RACGP and other specialist colleges and medical academics) are not campaigning hard enough to bring it about. For their part, the Commonwealth and State health bureaucracies have taken no action because their priority is supply. The introduction of a formal assessment system would take time and resources and would slow down the recruitment process.

It is not as though there are not firm precedents in place, as the commentary on the situation in Canada, the United States and the United Kingdom cited above show. Australia needs a similar national scheme of assessment. It should be a national system, because current experience shows that the states will not act unilaterally as long as they fear that other states are likely to drag their feet. A national system would also remove the present anomaly that an OTD assessed as inadequate in one state can simply apply in another. This assessment system should include a period of supervised

hospital practice (as in Canada, and the United States). All informants agree that reviews of OTD CVs, along with computer based medical and clinical knowledge tests, are an unreliable guide to a doctor's ability to deal successfully with Australian patients. A supervised period of hospital practice as an intern is required of Australian-trained graduates. This is also required of OTDs who complete the AMC examinations. The

case for including such an assessment period for other OTDs is even stronger given the uncertainties about their medical knowledge and experience.

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