

ASSESSMENT OF OVERSEAS-TRAINED DOCTORS— THE LATEST CHAPTER

■ **Bob Birrell and Andrew Schwartz**

There have been repeated government promises to establish a nationally consistent assessment system for overseas trained doctors (OTDs). No such assessment has been put in place. As a result, each year, thousands of OTDs are being appointed to practice medicine in Australia without a preliminary systematic test of their medical knowledge and clinical skills calibrated to Australian standards. This article explores why the medical authorities, including the Australian Medical Council and the state Medical Registration Boards allow this situation to continue. It also examines some of the consequences for medical service provision in Australia.

Readers of *People and Place* will be aware of our previous reports on this issue.¹ These reports have documented Australia's growing dependence on overseas trained doctors (OTDs) and our concern about deficiencies in the assessment of these doctors prior to their practice of medicine here.

The reason for returning to the issue is that there is still no resolution to it. This is despite successive official promises to rectify the situation and increasingly frantic calls for these promises to be implemented. The latest official promise is that of the Council of Australia Governments (COAG) which stated that the federal and state governments will establish a national process for the assessment of OTDs by December 2006.² The most recent call for action comes from a report of the Joint Standing Committee on Migration of the Commonwealth Parliament, which recommended in September 2007 that:

in the light of the serious concerns raised during the inquiry about skills assessment processes for overseas trained doctors (OTDs) the Department of Health and Ageing, together with the Department of Immigration and Citizenship, will work to ensure initiatives announced by the Council of Australian Governments to establish a national process for the skills assessment of OTDs are implemented as a matter of urgency.³

There is no compulsory assessment of OTDs on a nationally consistent basis because Australia's dependence on OTDs is increasing in the face of a chronic shortage and maldistribution of doctors trained in Australia. In these circumstances the state and federal health authorities are reluctant to require a compulsory assessment for fear that it would jeopardise future flows of such OTDs. The chronic shortage is evident among specialists, particularly surgeons in regional locations, among hospital medical officers and among general practitioners. The Australian government has recently increased the level of domestic medical training, but it will be a decade before this increase helps solve the present shortage problem. Even then there is no guarantee that the additional doctors will go into the specialties and regions that have the worst workforce shortages.

We first ask whether there are any other solutions to this shortage besides increased recruitment of OTDs. The answer is that there may be but, as suggested shortly, they are not politically acceptable and/or feasible. This still leaves the question, if Australia must depend on OTDs, why does the supply imperative trump concerns about medical standards, especially in the aftermath of the 'Dr Death' affair in Queensland? There are two organisations in Australia whose task it is to protect

medical standards—the Australian Medical Council and the various state Medical Registration Boards. There is nothing in their charters that allows them to compromise standards in the interest of supply.

GOVERNMENT MEASURES TO MAKE BETTER USE OF DOCTORS TRAINED IN AUSTRALIA

Doctors trained in Australia receive a massive subsidy from the taxpayer to finance their education, and once they begin employment most of their (substantial) income comes from the taxpayer via the Medicare system. Few medical service consumers would question this arrangement. Nonetheless, just as teachers in the government's employment are deployed where they are needed, there is a case for ensuring that doctors too, serve where they are most needed.

The Australian Commonwealth could ration provider numbers to this end, thus stopping excessive numbers of doctors from servicing general or specialist practices in the metropolitan areas. The evidence of maldistribution of general practitioner (GP) services is palpable. Typically, non-metropolitan divisions of general practice show at least 50 per cent higher numbers of people to full-time work equivalent (FWE) GPs than is the case for metropolitan divisions. For example, there were 763 people per FWE GP in the Eastern Sydney division compared with 1647 in the NSW coastal division of Hastings Macleay and 2157 in the North West Slopes division in northern NSW.⁴

The Commonwealth has not been prepared to ration provider numbers, perhaps because of fears that such measures would be challenged on constitutional grounds. Alternatively, the Commonwealth could reward regional providers with substantially higher service fees than those available for metropolitan

services. It has not been prepared to do this either, perhaps because of the cost. These measures would also be fought by organised medicine in Australia. There are a range of Commonwealth and state programs that provide financial incentives for doctors to locate in regional areas, but these appear to be having little impact in prompting domestic doctors to move from metropolitan areas.

One strategy being implemented is to tie the allocation of new medical school places to students willing to accept a bond requiring them to serve in a district of workforce shortage when they have completed their medical degree and vocational training. There are currently hundreds of medical students on such bonds. Whether this arrangement will work remains to be seen. This is because those affected, and those who accept medical scholarships tied to subsequent rural service, who prefer to remain in a metropolitan area are likely to have the resources to buy themselves out of the bond once they are employed.

RELIANCE ON OTDs

In practice, the Commonwealth and state governments have prioritised the recruitment of OTDs as the prime solution to medical shortages outside metropolitan areas. Employers with vacancies defined as in 'areas of need', where the relevant state health departments believes no resident doctor can be attracted on the financial terms offered, can sponsor these doctors to Australia on four-year (renewable) temporary visas—usually the 457 visa—without any formal assessment of their medical knowledge or clinical skills. Once in Australia the OTD is required, as a condition of the visa, to work in the particular hospital or GP practice specified by the employer. In the case of OTDs sponsored as occupational trainees, where the employer must specify a training program,

the employers (usually public hospitals) can sponsor OTDs on temporary visas of two years duration, without regard to whether the location is defined as an area of need or not. Thousands of OTDs are entering Australia each year on these temporary visas.

An additional advantage of this strategy, from the point of view of employers, is that it is cheap. OTDs can normally be employed at much lower rates than would be required to attract a fully registered domestic doctor. This is one of the reasons why very few locally-trained doctors, including recent graduates, not subject to geographical restrictions are taking up rural practice. The more that OTDs dominate the rural medical workforce the less likely it is that domestic doctors will move to the bush.

A major problem with this strategy is that at least half of the OTDs taking up these positions have been trained in non-western medical schools and have worked in non-western medical settings. Their training and experience may not be relevant to or meet the standards expected in Australia. Such OTDs are, of course, assessed by employers before any appointment is made. But the rigour of the assessment measures varies greatly across Australia. It is far more exacting in regard to area-of-need general practice appointments than it is for appointments in the public hospital system. However, in no case do these OTDs have to pass a systematic test of their medical knowledge or clinical skills.

The extraordinary aspect of this situation to an outside observer is that it is occurring in a context where domestic doctors are subject to increasingly rigorous and lengthy training programs before they are granted full medical registration, and thus the right to bill on the Medicare system. In the case of GPs, those trained at Australian medical schools must first

complete their intern training, then participate in and pass the three-year general practice postgraduate training program before they can bill on the Medicare system as GPs. This provision also applies to permanent resident OTDs. They must first pass the Australian Medical Council accreditation examinations that cover medical knowledge and clinical skills, then win a place in and satisfactorily complete the postgraduate general practice program before they too can practice as GPs. There is one significant exception to this rule. As detailed further below domestic-trained and AMC graduates can provide GP services without the postgraduate qualification if they work in a regional area. By contrast, an OTD with a non-western medical degree and limited experience can be appointed to an area-of-need GP position on a temporary basis without any assessment by Australian medical authorities of their medical knowledge or clinical skills.

The AMC was set up in 1984 precisely to provide some insurance that OTDs wishing to practice in Australia meet the same rigorous standards as those applied to Australian trained doctors. As indicated, it still performs this role as regards OTDs who have migrated to Australia, who are permanent residents and who wish to gain medical registration in Australia as GPs or hospital medical officers. Thousands of OTDs have migrated, mainly by entering Australia as the partner of a migrant, or being sponsored by a spouse or other relative in Australia, or by entering Australia via New Zealand after having gained New Zealand citizenship (which means that no visa is required to enter and work in Australia).

However, the AMC has been dealt out of the picture as regards the assessment of the thousands of OTDs appointed from overseas to temporary medical positions or as occupational trainees. These doctors are

not required to sit the AMC examinations before taking up such positions.

The AMC has been further sidelined with the development of new pathways to full medical registration in Australia. One of the most important is that provided by the Royal Australian College of General Practice (RACGP) which allows OTDs with experience in general practice to apply to become a Fellow of the College via a 'practice eligible' route. This option allows the OTD to avoid the route described above, which involves passing the AMC examinations and satisfactorily completing the general practice postgraduate training program—at which point the doctor will become a Fellow of the RACGP. The practice eligible route, detailed below, is a form of on-the-job assessment by the RACGP, in which the OTD is required to prove that his/her practice standards are equivalent to those required of Australian-trained doctors.

One final element of reliance on OTDs to solve the medical service crisis is the mobilisation of OTDs who are permanent residents of Australia. During the 1990s there were attempts to enforce a tight quota on the number of such doctors who were allowed to complete the AMC examinations. While the quota rule did not survive, the number of OTDs completing the examination remained fairly low, at around 300 per year at the turn of this century. This was largely because of the limited capacity within the AMC system to examine them, particularly in the clinical component. In the past few years the AMC has expanded its operation, such that the number of completions has doubled to around 600 per year. The significance of this number can be seen by comparing it with the total number of completions of domestic medical graduates in Australia in 2005 of 1348.⁵

These AMC graduates are now becoming an important part of the solution

to doctor shortages in regional areas. As a consequence of legislation passed by the Coalition Government in 1996 all permanent-resident OTDs arriving since that date are subject to a 'ten year' rule that prohibits them from billing on the Medicare system until ten years after full registration, which involves completion of the AMC examinations and, depending on experience, an intern year in Australia (OTDs on temporary visas are treated as exceptions to this rule). In the case of AMC graduates, they have three choices. One is to serve out their time in the hospital system in a metropolitan area. Alternatively, if they take up a hospital position in a regional area and do so for five years this is regarded as fulfilling the ten-year requirement. A second option is that AMC graduates can apply for places in any of the specialist training programs. A large number are doing so in the postgraduate general practice training program. In 2006 some 200 of the 600 places in this program went to OTDs with permanent resident visas who had completed their AMC examinations. After finishing their training they must serve in a regional area or area of need because of the ten-year rule governing access to the Medicare system. Again, if they do so for five years this will fulfil the ten-year requirement. A third option is that if AMC graduates or domestic graduates without postgraduate qualifications are prepared to work in GP practices in regional areas the Commonwealth will allocate a provider number which allows them to bill on the Medicare system, though the Medicare payment is lower than that received by vocationally-qualified GPs.

All three of these options have been crafted by the Commonwealth and state governments to help provide medical services in shortage areas. In effect, OTDs are being conscripted to work these areas.

The result of all these measures is that OTDs—both those on temporary visas and

permanent residents—now play a crucial role in Australia’s medical workforce. They provide most of the growth in the numbers of doctors employed in hospitals and general practices in regional areas. They are also playing an increasing part in filling the junior doctor positions in metropolitan hospitals. In Sydney, for example, there has long been heavy reliance on occupational trainees and temporary resident OTDs at the junior doctor level. More recently, hospitals have begun employing permanent-resident OTDs on temporary contracts who have not completed their AMC examinations. This is a practice that is widespread in other states but has been avoided, at least until recently, in Sydney.

It is surprising, given the seriousness of the shortage of doctors and the willingness to rely on temporary entry OTDs, that the Commonwealth and states have not made more effort to draw from the ranks of permanent-resident OTDs already residing in Australia. There are thousands of permanent-resident OTDs in Australia who have delayed entering the AMC examination process, or who have been unable to complete it, perhaps because of lack of financial or study support. The record of the few programs addressed at this constituency is promising. The most significant program is that run by the RACGP, which provides a bridging course to selected participants designed to prepare them for the AMC examinations. When the RACGP initiated the program a few years ago it received well over a thousand applications from whom it selected 240 who were granted \$10,000 in loan assistance to help cover the costs of the course. The successful candidates do not receive any cost of living funding. The great majority of those selected went on to pass the AMC examinations. Two further groups have since been taken on. Unfortunately, Commonwealth funding for the project may not continue.

WHY IS THERE NO PRELIMINARY TEST OF OTDS’ COMPETENCE?

There has been a surfeit of evidence concerning the shortcomings of some OTDs, the best-known example being that of Dr. Patel. He was appointed to the Bundaberg base hospital as a hospital medical officer with surgical experience. As with most such appointments the only examination of his medical skills was by the commercial recruiting company that managed the arrangement. There was no systematic assessment of his medical knowledge, clinical skills or procedural skills in surgery either by the AMC or the Royal Australasian College of Surgeons.

To the extent that the health authorities respond to questions about arrangements of this kind they usually assert that such cases are exceptional. The real reason, however, is that the health authorities think that if OTDs were subject to systematic testing this would have a severe impact on supply. It would do so because there is no guarantee that all states would introduce the test. Also, there is concern that some prospective applicants would be put off applying for an Australian position by the need to take the test and because many would fail.

These concerns help explain why the Commonwealth and state governments, in July 2007, put in place a new ‘competent authority’ pathway for the assessment of certain OTDs. This decision arose in the context of the 2006 promise on the part of COAG to set up a national assessment of all temporary and permanent resident OTDs wishing to work in Australia. The competent authority pathway applies to OTDs who have trained in the United Kingdom, Canada, the United States, New Zealand and South Africa. These OTDs will not have to take the AMC examinations if they enter Australia as permanent residents. All that is required is that they be subject

to a workplace assessment while working in Australia under supervision. The details of this assessment have not yet been made public.

What about the majority of OTDs who will not be eligible for the competent authority pathway? The 2006 promise to establish a national testing regime still applies to them. Yet, as the following short history shows, no such test has been implemented.

In 2005 the Commonwealth Department of Health and Ageing set up a Steering Committee on the Assessment of Temporary Resident Doctors wishing to enter general practice. The committee was made up of all the major stakeholders and given the task of deciding on the form of the assessment. After the COAG announcement noted above that it wished to establish a national process to evaluate OTDs, the committee took on the role of recommending how this should be done. The AMC was delegated to establish and pilot a medical knowledge test that could be the basis for the assessment of medical knowledge. The AMC has prepared such a test (in cooperation with the Canadian health authorities), which can be completed electronically by OTDs wishing to take up appointments in Australia while overseas. The AMC's test is now available and is being taken by some OTDs, not because they have to, but because if they pass this enhances their prospects of gaining employment in Australia (though failure does not prevent a subsequent appointment). The AMC has also prepared an online test of clinical skills, which could be implemented as well should a decision to require a compulsory test be made.

Neither the medical knowledge nor the clinical tests have been made compulsory. This is because some states have refused to sign-off on implementing them, the most notable standout being the New South Wales Government. As long as one or more

state governments nod out the others will be reluctant to go ahead for fear that the recalcitrant states will soak up the best available OTD talent.

As indicated, the reluctance to establish such tests is based on health authority concerns about their impact on OTD supply. Long experience with the AMC examinations have shown that it is not easy for OTDs from non-English-speaking backgrounds to get through the AMC examinations.⁶ According to the AMC only about 50 per cent of the OTDs who have taken the recently-established international test for medical knowledge are passing.⁷ If these OTDs are representative of those coming to Australia on temporary appointments, the implication is that a high proportion would not be eligible for such placements if they had to face a compulsory test. It also implies that many of the OTDs currently being visaed do not have the medical knowledge necessary to practice in Australia.

Another indicator of the preparedness of OTDs to practice, in this case as GPs, is the results of the RACGP practice eligible examinations. As indicated the practice eligible route is an alternative to the three-year postgraduate general practice program, which most domestic graduates and those completing their AMC examinations and who wish to be GPs must complete. Thus the practice eligible route is a far less onerous pathway to vocational registration as a GP and, not surprisingly, has attracted large number of OTD applicants.

The purpose of the practice eligible assessment is to determine whether the applicant is 'competent to practice unsupervised general practice in Australia'.⁸ Those who reach this standard are awarded a Fellowship with the RACGP. The assessment includes videotaped consultations conducted with patients by the candidate in Australia, a short viva examination and a clinical visit by a

RACGP examiner.⁹ To be eligible, an OTD must have the equivalent of four years experience in general practice overseas and at least one year's experience in Australia. Most candidates have been working in Australia in GP practices in area-of-need positions on temporary resident visas. The number of OTD candidates has grown from 86 in 1999 to 334 in 2004. In 2004 only 40 per cent passed. This means that the other 60 per cent continued to practice in area-of-need general practices despite the RACGP judgement that they are not 'competent to practice unsupervised'. The RACGP has not released the results of examinations since 2004.

Again, these results imply that the OTDs who are unable to pass the RACGP assessment would struggle to pass an offshore clinical knowledge examination and perhaps the medical knowledge test as well, should it become a compulsory prerequisite to practice in Australia.

THE CURRENT STALEMATE

The situation described above helps explain why successive calls for a national assessment of OTDs have come to nought. There may well be a case for putting supply ahead of quality—in the sense that a community without any doctor may be considered worse off than one with a doctor who has not been rigorously assessed as meeting Australian standards before being allowed to practice. But errors in medical practice can have serious consequences. For this reason, Australian governments have put in two frontline guardians of medical competence. The first is the AMC. As noted, it has been largely bypassed by the arrangements that allow temporary resident OTDs to practice without any formal assessment. The second line of defence of medical standards in Australia is the state Medical Registration Boards. They have been charged by each state government to determine whether a doctor is fit to practice.

Without their imprimatur it is illegal for a doctor to practice.

In the past the boards have been prepared to accept the judgement of the sponsoring employer as regards the capacity of OTDs to practice on a provisional basis. This has been so whether the OTDs are permanent residents and have not yet passed the AMC exams or whether they have been appointed on temporary entry visas. The boards have been unwilling to defy the pressure from state health department to give priority to their supply concerns. This may be about to change. As indicated, the medical boards and the state health departments participated in a Commonwealth Department of Health and Ageing review of assessment standards of OTDs during 2005 and 2006. The review recommended that the AMC develop the medical knowledge test described above. During 2007 a sub-committee of this review, which included Medical Registration Board membership, continued to meet. It recommended the establishment of the competent authority pathway noted above, which is in the process of implementation. The sub-committee also recommended that a medical knowledge test be required from July 2008 for all other OTDs, including occupational trainees.

However, once again, the state health authorities have not yet signed off on this provision. These authorities and their respective Medical Registration Boards appear to be on a collision course with each other in regard to the implementation of a national assessment of OTDs. The health authorities may prevail given their influence over Medical Registration Board policy and the impracticality of enforcing the medical knowledge test if some states do not sign off on the arrangement.

CONCLUSION

The continued stalemate on compulsory assessment of OTDs is disturbing, given

the commitment to quality care that has marked the medical profession in Australia in the past. It is a stalemate that reflects the priority given by health authorities to supply. In our view, it is not inevitable that any shortages resulting from a formal assessment of OTDs will be longlasting. The recent British experience indicates why this may be the case.

In the UK, a similar shortfall in the supply of doctors trained in UK medical schools prompted the National Health Service to open the doors over the past decade to large scale recruitment of OTDs trained in non-western medical schools. However, in the UK case, such doctors were all first required to pass the Professional and Linguistic Assessment Board (PLAB) English language, medical knowledge and clinical skill tests before they took up posts with the National Health Service.

Until recently OTDs could and did move in large numbers to the UK on temporary visas that allowed them to prepare for the assessment. This option was closed off when the British government recently introduced a skill-based migration system with some similarities to Australian practice called the Highly Skilled Migrants Program (HSMP). This permitted professionally qualified persons in some fields, including medicine, to migrate to the United Kingdom on a temporary visa, which could subsequently be converted to permanent residence if they obtained employment in skilled occupations. Thousands of OTDs have taken up the opportunity. In the meantime, the British government, in response to the doctor shortfall, decided—like its Australian counterpart—to increase domestic medical enrolments, which occurred in 1999 and 2000.

By 2006 the combination of large number of willing OTDs, plus the influx of additional domestic graduates, has

swamped the number of specialist training places available within the British hospital system. In 2007 there were 32,649 candidates for 19,797 places. These places are highly sought because they are an indispensable foundation to a career as specialist in the British system. Of the 32,649 applicants 16,670 were UK-qualified and the other 15,979 were non-UK qualified mostly from non-western medical schools. Some 10,014 of the latter were OTDs who entered under the HSMP program. Most of the available places were allocated to the UK-qualified but, even so, several thousand missed out.¹⁰ This outcome has generated controversy in the UK, given the incongruity that thousands of taxpayer-supported British graduates missed out on places which were allocated to OTDs.

The situation was much worse for the OTDs, since only a minority obtained a training place in 2007 and there is little prospect of any improvement in the immediate future. This is because these OTDs have made a heavy commitment to move to the UK and to prepare for the PLAB test in the expectation of a medical career in the UK.

This extraordinary story has many lessons for Australian policy. It tells us something about the eagerness of OTDs from non-western countries to get to a western country to practice medicine and about the numbers prepared to apply themselves to pass the accreditation test. The implication is that there is a huge stock of such OTDs who would be prepared to take up similar opportunities in Australia. It means that in the long run Australian health authorities will be able recruit those best suited to medical service in Australia. We do not have to accept people who cannot meet basic medical knowledge and clinical skills tests.

The British story also indicates that there are thousands of OTDs in Britain

who, in effect, constitute a reserve medical army on the look out for a post in another western society. It is likely that Dr. Haneef was a case in point. He was looking for a training post as a physician after apparently failing to gain such a post in Britain. To this end he took up a hospital registrar appointment at the Gold Coast Hospital, which our enquiries indicate gave him entry to a basic training program in this field.

There may be some temporary disruption to the flow of OTDs should a national accreditation system be introduced. But any inconvenience will surely be recouped many times over in

benefits to both patients and doctors alike. OTDs need to be confident that their expertise is respected. This cannot happen if the present shambles continues. OTDs attracted to practice in Australia, whether from the ranks of permanent residents or from overseas on a temporary basis should do so with the security that people know they have been accredited carefully. They also need to be assisted in entering Australian practice with bridging courses which ensure that they understand the legal, social and linguistic setting they are about to enter. Such courses barely exist at present. Patients will be the obvious beneficiaries of such arrangements.

References

- ¹ See B. Birrell and A. Schwartz, 'Accreditation of overseas trained doctors; the continuing crisis', *People and Place*, vol. 14, no. 3, 2006, pp. 37–47.
- ² Cited in Joint Standing Committee on Migration, *Negotiating the Maze: Review of arrangements for overseas skills recognition, upgrading and licensing*, Parliament of the Commonwealth of Australia, Canberra, September 2005, p. 124.
- ³ Joint Standing Committee on Migration, *Temporary Visas—Permanent Benefits*, Parliament of the Commonwealth of Australia, August 2007, p. 30
- ⁴ General Practice Survey, Annual Survey of Divisions, Primary Health Care Research and Information Service <www.phcris.org.au>
- ⁵ C. Joyce, 'Riding the wave: current and emerging trends in graduates from Australian university medical schools', *Medical Journal of Australia*, vol. 186, no. 6, March 2007, p. 309
- ⁶ L. Hawthorne, G. Hawthorne and C. Crotty, *The registration and training status of overseas trained doctors in Australia*, Executive Summary, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, February 2007, p. 21
- ⁷ AMC Executive Officer, personal communication
- ⁸ K. Atkinson, A. Salmone, and A. Nasso, 'Practice based assessment', *Australian Family Physician*, vol. 33, no. 9, September 2004, p. 697
- ⁹ *ibid.*, pp. 698–699
- ¹⁰ G. Winyard, 'Medical immigration: the elephant in the room', *British Medical Journal (BMJ)*, vol. 335, September 2007, pp. 593–595

