IN SEARCH OF AN ALTERNATIVE DISCOURSE ON INTERNATIONAL MEDICAL GRADUATE ISSUES

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Poor planning in the past means that Australia faces a shortage of doctors. International medical graduates (IMGs) have been brought in on temporary visas to fill some of the gaps, especially in rural areas. Unfortunately, a few stories of bad outcomes from this practice have led to a negative picture of IMGs in the media, an image that is sometimes reinforced in more scholarly research. But most IMGs work hard and do well. We need to recognise our dependence on them and offer them more support in their role.

Half a century ago the influx of skilled workers from all over the world for a specific workforce shortage—the Snowy Hydro—was lauded as a crucible of multiculturalism. Today, Australia's medical workforce crisis presents a similar situation, with international medical graduates (IMGs) complementing and augmenting the Australian-trained medical workforce across Australia. Unlike the Snowy Hydro workers, the dominant narrative in public discussion about IMGs is one of panic about risk to safety and health care.

There are two themes emergent in current discourse on IMGs which this paper sets out to highlight. One pertains to the ways in which IMGs are represented and opinions are mobilised in both public and professional domains, and the other is in the way in which research into IMG issues are undertaken and the implications of such.

A literature search of both the professional literature and popular press brings two issues to the fore. Firstly there is a sense of mistrust about who is a 'good' or 'bad' IMG and secondly, much attention has been focused on how to make this assessment. The question this paper poses is: what has this translated into, and what potential is there for the future role of IMGs?

DISCUSSION

The history of the medical workforce in Australia over the last 25 years provides a narrative of government policies which resulted in a rising shortage of the medical workforce as medical degree places remained stable yet service demand steadily grew.[1] The resulting shortages have been most critical in rural and remote areas.[2] General practice workforce shortages have been the subject of much public, media and policy attention. One response to this has been intense debate about shifts in policy over the regulation, assessment and placement of IMGs to fill the gaps in Australia's medical workforce.[3] In turn, policy changes to accommodate our dependence on IMGs have brought with them debate about the effects such a dependence has on the quality of medical care.[4]

This dependence is at its most significant in rural and remote areas where IMGs make up to 37 per cent of the GP workforce.[5]

The necessity of a systemic approach to rural health sustainability has been highlighted, taking into account the interrelated roles of economic, professional, organisational, social, and environmental dimensions.[6] According to Humphreys et al., IMGs are a 'stop-gap' measure which fails to address the factors determining the under servicing of rural towns. As researchers we need to acknowledge that historically IMGs have been positioned as a threat to the Australian Medical Profession.[7] There has been a historic tradition of discrimination with doctors, as with other non-English-speaking-background (NESB) professionals, experiencing discrimination.[8]

In 2010 the main issues regarding IMGs concern a transparent and consistent assessment, registration and accreditation process, and an acknowledgment of some of the informal barriers that exist to their employment.[9] In my view, these barriers are sometimes difficult to articulate, but emerge as a result of the dominance of negative stereotypes and a dearth of academic and medical education research which might counteract such stereotypes.

Workforce saviours versus doctors of death

IMGs encompass medical practitioners whose primary medical qualification was gained in a country other than Australia. Though many come from the UK and other English-speaking countries an increasing share now come from non-Western countries, where English is, at best, a second language. The invitation, registration and integration of doctors trained overseas into the Australian medical workforce is a many-layered, often-changing, puzzle. Important recent changes have been introduced by the Commonwealth government.[10] Most important is the establishment of a medical knowledge test for those from NESB countries. The Australian Medical Council (AMC) describe this multiple choice questionnaire examination as a comprehensive examination of medical knowledge and practice. According to the chief executive officer (CEO) of the AMC, only about half of the IMGs who sat the test when it was being trialled passed.[11] It is unknown how much this new requirement is responsible for the decline in application numbers. However, it has probably contributed to the decline in the number of nominations for temporary work permits (visa subclass 457) for persons who were General Medical Practitioners from 1990 in 2007–2008 to 1708 in 2008–2009 and those who were nominated to positions as Medical Practitioners in Training from 1320 in 2007–08 to 1100 in 2008–09.[12]

Public discourse places IMGs precariously somewhere between being a solution to workforce shortages[13] and being potentially problematic,[14] with questions raised about communication, cross-cultural, and clinical skills.

There has been a stream of bad foreign doctor stories over the last twenty years, with one of the most recent being Dr Jayant Patel, located in the Queensland health system. The Queensland Public Hospitals Commission of Inquiry brought to the fore how inadequately Queensland Health had handled the substantially increased demand for medical services across the Queensland community due to population growth, and the poor remuneration, compared to wider Australian and international standards, for Queensland health specialists.[15] The report suggested that inadequate budgets led to poor appointments and poor administration, including the appointment and supervision of Dr Patel at the Bundaberg base hospital. These facts however tend to get lost in the context of new negative IMG stories.

The popular press has featured the stories of Patel and others such that, for many people, all IMGs are seen in a negative light. A positive campaign about the work of overseas trained doctors is urgently needed.

There is a disconnect between the construction of the image of the dangerous IMG in the media and the fact that, at the local level, IMGs are often GPs in areas of need. They work in small rural towns, with little, if any, locum support or supervision, no ties to their own culture, no family and a prickly relationship with the medical colleges responsible for GP accreditation.[16] A recent educational DVD aimed at IMGs, produced by the Rural Health Educational Foundation, goes quite a way to outline the complexities IMGs face when navigating the various pathways to working in Australia.[17] In doing so the difficulties can be seen to be painfully obvious, yet hands seem to be tied on so many levels to rectify the situation.

In addition to journalistic opinion the two themes of IMGs as workforce saviors versus doctors of death also emerge in literature examining issues of workforce and policy,[18] assessment and accreditation,[19] education and training[20] and learning needs and barriers.[21]

There are direct consequences of our failure to adequately represent the service done by IMGs to the media and the public. In the wake of the false terrorism allegations against Dr Haneef in 2007, there was an 80 per cent decline in the number of doctors applying to work in Australia.[22] One agency also reported a 40 per cent cancellation rate for doctors already recruited.[23] Whilst we need to take into account the effect that the introduction of the medical knowledge test had on reducing applications, the impact of the Haneef story on the Australian health system was one of the key themes associated with the media coverage.[24]

The Australian Medical Association's (AMA) position statement on IMGs succinctly situates them as a tool to fill the gaps in the medical workforce.[25] The AMA also acknowledges them as being a sub-group at greater risk of poorer health and wellbeing compared to their Australian trained peers.[26] However there does not seem to be any movement to initiate action to change the situation.

In response to the sudden decline in IMG applicants, the AMA's then president Dr Rosanna Capolingua reassured the public that entry criteria would not be lowered.[27] A more useful response may have been to improve the dialogue about IMGs, thus helping to overcome the positioning of IMGs as a threat, which subsequently deters them from wanting to work here.[28]

Research implications

The difficulties facing IMGs in Australia have been needs assessed many times over. The result is findings which repeat the social, cultural, and communication issues found in international studies.[29] These results affirm the need for better access to information; better orientation to our healthcare systems and the workplace; improved communication with patients and healthcare workers; standardised assessment of knowledge and skills; and education and training support. These needs have been repeatedly highlighted and research into how to meet these needs continues to be funded.

The most research activity is at the regional level, where problems to do with the training, support and integration of IMGs are most evident. However the outcomes of this activity aren't sufficiently mobilised so that other IMGs can benefit. Instead there is a lot of reinventing the wheel with Regional Training Providers, workforce agencies, colleges, all working independently on this topic. Whilst it does deserve local contextualisation much could be learned from sharing information gathered at a national level. Articulating this problem is difficult as much of this research is produced in the form of unpublished reports and conference papers and there is no cumulative effect from the knowledge that is being produced. A lot then depends on the networks of individual researchers to join forces.

It is therefore difficult, yet essential, to privilege the voices of IMGs in order to better inform policy makers and begin addressing the risk-based narrative.

CONCLUSION

There is some useful research activity into IMGs and strategies have emerged which are helping alleviate some of the potential problems they may face when trying to integrate into a new way of life and practice. But there is a need for professional bodies and medical institutions to honestly, and in the public domain, honour the achievements and contributions of IMGs. Without this, the demonisation of a component of the Australian medical workforce is likely to continue unchecked.

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