THE REGISTRATION AND ACCREDITATION OF INTERNATIONAL MEDICAL GRADUATES IN AUSTRALIA—A BROKEN SYSTEM OR A WORK IN PROGRESS?

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Australia's policy for registering and accrediting overseas trained doctors (OTDs) is dysfunctional. Some OTDs, who are well qualified and here on permanent visas, are being denied registration and accreditation. This is despite the acute shortage of medical manpower and the fact that OTDs on temporary visas, with similar qualifications, are being actively recruited and put to work. Current reforms may improve the situation but these must address problems of accountability and the potential for conflicts of interest that mar the present system.

'Shallow understanding accompanies poor compassion, great understanding goes with great compassion'.
Thich Nhat Hanh

Australia's new national accreditation and registration scheme for health professionals will consist of four major components:

- Ministerial council
- Health workforce advisory council
- National Agency
- Nine separate professional boards representing the major health professions including medicine.

The ministerial council will consist of the commonwealth and state/territory health ministers. The council will have a range of responsibilities including the appointment of members to other key bodies including the health workforce advisory council and the profession-specific boards. The council will also be responsible for approval of registration and accreditation standards proposed by the specific professional boards including those involving overseas trained practitioners. Decisions will ideally be made by consensus. If consensus cannot be achieved the matter will then be referred to the health workforce advisory council whose main role will be to provide independent advice to the ministerial council at its request. The professional boards will assume a range of registration and accreditation functions relevant to the profession including the assessment of qualifications and skills of overseas trained practitioners to determine their suitability for registration in Australia. Finally, the National Agency will be responsible for overseeing the administrative and business aspects of the scheme to ensure efficient operations and will have a presence in each state and territory.[1]

In Australia a doctor must be registered by one of seven state or territory medical boards to be eligible to practice medicine. This registration is not portable across state or territory borders, which hinders the effective deployment of critically needed medical manpower.

On 26 March 2008 the Council of Australian Governments (COAG) signed an intergovernmental agreement for the establishment of the national registration and accreditation system outlined above for the nine major health professions including medicine which would standardise the registration process.[2] Opposition to this scheme has been publicly expressed by the Australian Medical Association (AMA), which argues that the proposed system poses a serious threat to patient care and is largely driven by a desire to engage in workforce reform rather than by concerns about patient safety.[3] The Royal Australian College of General Practitioners (RACGP) has also voiced its concerns.[4] While these organisations acknowledge the need for reforms, particularly more consistent

national standards, they argue that the basic organisational framework of the current registration and accreditation system should remain intact.[5]

Missing from the RACGP and the AMA statements was acknowledgement of the predicament of those caught within the web of the Australian registration and accreditation system, particularly international medical graduates (IMGs). My own journey reveals a system that is confusing, complicated, fragmented, and inflexible.

In this paper I review current Australian policy for registering and accrediting overseas trained doctors, outlining its impacts on recruitment of doctors trained overseas. I present my own experience as a case history in the complexities of accrediting and registering a qualification from overseas, in this case a vocationally trained Canadian family physician/general practitioner qualification. Mine is one of many stories of overseas trained doctors who have been unable to navigate the registration and accreditation system satisfactorily, and consequently are temporarily or permanently lost to clinical practice.[6] I discuss how the proposed COAG reforms have the potential to significantly improve this system for IMGs. I conclude by indicating areas that need to be addressed to ensure the COAG scheme is successful.

AUSTRALIA'S CURRENT SYSTEM

What do we mean by the terms accreditation and registration? In general, accreditation refers to the establishment of specific standards for professional education and training in educational institutions and assessment of the degree to which these standards have been met.[7] Registration, on the other hand, largely involves assessment of an individual's fitness to practice, a large component of which involves determining the degree to which the individual has attained the predetermined standards set out in the accreditation process.[8] With regards to IMGs, the processes of accreditation and registration are often blurred. This is because assessment of IMGs' education, training and their fitness to practice in an Australian context is often done concurrently.[9] For the purpose of this paper accreditation will refer to the assessment of an individual's educational and professional qualifications whereas registration will refer to the process by which a doctor is granted entry into the Australian medical system.

Australia's current accreditation and registration system (hereby to be referred to simply as the 'system') is highly complex. In December 2005 the Productivity Commission and the Australian Health Workforce Advisory Committee tabled a research report on the Australian Health workforce to the Council of Australian Governments. The report identified a number of problems with the existing system of accreditation and registration, including fragmentation of responsibilities, difficulties in coordination, rigid regulatory arrangements and entrenched workplace behaviours.[10] While the report was referring to all the major healthcare professions, the system for the registration and accreditation of medical professionals are singled out for being particularly complex. The report concluded that, in order to address the current health workforce shortages in Australia: 'it is critical to increase the efficiency and effectiveness of the available health workforce and improve its distribution'.[11]

IMGs themselves have expressed concern about direct and indirect discrimination against them in the current system.[12] In 1997 permanent resident IMGs staged a 21-day hunger strike in NSW to lobby the government for changes to the existing system. Similar hunger strikes were also held in Melbourne and the ACT.[13]

At that time permanent resident overseas trained doctors, who did not meet the criteria for general medical registration, were prohibited from working in areas of unmet medical need positions while overseas trained doctors with similar qualifications were being actively recruited to fill these positions under temporary visas. This meant that an IMG's ability to work was largely determined by their visa status rather than their qualifications. One of the outcomes of the hunger strike was an agreement by the NSW government to commission a research report into the employment of IMGs in that state. This report, *The Race to Qualify*, issued 32 recommendations and confirmed that the differential treatment of IMGs holding temporary visas from those on permanent visas could be considered unlawful discrimination.[14] It also recommended that standards for assessment of medical workforce qualifications be separated from those used to determine the composition of the medical workforce.

Australia's accreditation bodies for medical professionals

In Australia there are three bodies involved in the accreditation of IMGs: the Australian Medical Council (AMC), state/territory medical boards, and the specialist medical colleges. In general the AMC and/or the specialist medical colleges have responsibility for accreditation, while the medical boards register those with accredited qualifications as fit for practice. However, in regard to area of need (AoN) positions filled by temporary or permanent resident IMGs, state/territory medical boards also take on accreditation responsibilities.[15]

An IMG has one of two avenues to obtain unconditional medical registration: the standard AMC pathway or the pathway provided by the specialist medical colleges. In the standard AMC pathway, the AMC accredits the primary medical qualifications of overseas trained doctors. Doctors who undertake the standard AMC pathway are not accredited as specialists.

In the specialist pathway the AMC assesses the doctor's primary medical qualifications but then refers the case on to the relevant specialist college for assessment. The role of the specialist college is to assess whether that individual has the skills and knowledge to be deemed a specialist.[16]

If the IMG is not successful in getting his or her specialist qualifications accredited by the specialist colleges, the only other route to unconditional registration is through the AMC pathway which involves a two-part exam followed by 12 months of supervised training at an Australian hospital. The two-part AMC exams are a significant hurdle for IMGs.[17] One of the reasons for this is that the exams are designed to assess the level of knowledge expected from a new Australian medical school graduate, including their knowledge of basic medical sciences.[18] Most IMGs, however, are experienced clinicians. Medical education research shows that there is an inverse relationship between clinical expertise and knowledge of basic medical sciences in comparing the performance of medical students with experienced clinicians.[19] This is thought to be the result of a process called encapsulation through which, with increasing clinical expertise, basic knowledge becomes so integrated into a clinician's complex knowledge base, that after a while they are no longer able to recall the specific details.[20] An analogous situation might be to ask an experienced expert in biomedical engineering to take an exam on Newtonian physics. Interestingly, the Australian accreditation process for overseas trained engineers does not consist of an examination that tests entry-level skills, but rather competencies required at the level of performance for which the engineer is applying.[21]

The state and territory medical boards do have discretion over accreditation of IMG qualifications, however, particularly with respect to those applying to work in areas of unmet medical need. In the current system if an employer is unable to find a doctor with unconditional medical registration within a specified time-period they can apply for their region to be recognised as an area of unmet medical need (AoN).[22] In general, doctors who apply to work in areas of unmet medical need do not need to go through the AMC or specialist pathways; rather their qualifications are directly accredited by the relevant state or territory medical boards.[23] Consequently, it is possible to have someone who is judged to be fit to practice in one state or territory but not another. This two-tiered accreditation system results in variable assessment standards within and across states and territories. The impact of this system on patient safety, particularly prior to 2005, has been a primary area of concern with the system.[24] Another significant concern has been the lack of support, orientation and supervision for IMGs recruited to work in these AoN positions.[25]

Until recently permanent-resident overseas-trained doctors were prohibited from working in AoN positions. This ensured that only doctors who were in Australia with temporary visas took up these positions. New South Wales abolished this policy shortly after the release of the *Race to Qualify* report and the other states and Northern Territory have since followed suit. While permanent-resident overseas-trained doctors can now take up these positions, problems still remain. Standards for practice and levels of supervision still vary between the jurisdictions, although improvements have been made in these areas following the case of Dr Patel in Bundaberg.[26] In addition, AoN positions are generally only meant to be temporary. In the Australian Capital Territory (ACT), for example, it is only possible to work in an area of need position for two years.[27] This means that area of need positions for most IMGs provide a stop-gap measure until alternative pathways to accreditation can be secured.

The role of the specialist colleges

The Australian Competition and Consumer Commission (ACCC) and the Health Workforce Official Committee submitted a research report on the role of the specialist medical colleges to the Australian Health ministers in July 2005: Review of the Australian Specialist Colleges. A number of recurrent themes were identified: lack of procedural fairness, lack of transparency, unreasonably restricted entry to College Fellowship, and rigid assessment processes based on similarities of programs rather than competency-based assessment.[28] The review listed 20 recommendations including the development of competency-based criteria for the assessment of IMG qualifications and the involvement of jurisdictions in the development of accreditation and processes (see reference number 28, overview pp. viii–x).

While the colleges were encouraged to adopt these recommendations no mechanisms were put in place to ensure that they were enforced, except for the Royal Australian College of Surgeons (RACS).[29] In 2003 the ACCC imposed 21 conditions on the RACS's accreditation authority following a two-year investigation into allegations of unfair restriction to fellowship and training positions.[30] At present, the colleges are private bodies which are largely accountable only to their members. There are no external processes or bodies in place to monitor or enforce the implementation of recommended reforms regarding accreditation of IMGs.[31] The AMC does accredit the college's training programs but

grants the colleges relative autonomy regarding their IMG accreditation policies and decisions.[32] This lack of external accountability makes it difficult to challenge the colleges on the rationale for their policies and decisions. The current situation also creates the potential for conflicts of interest to arise when the interests of a college are not aligned with other key stakeholders, including the state and territory jurisdictions, federal government and even the public.

Difficulties with registration and accreditation are of concern as Australia is heavily dependent on its overseas trained doctor workforce and has had problems with recruiting IMGs in the wake of the Haneef affair.[33] While measures have been taken to increase the supply and improve the distribution of Australian trained doctors these measures are unlikely to translate into a meaningful increase in the supply of medical manpower for at least a decade.[34]

A personal experience

I am a Canadian Family Physician with 15 years experience as a General Practitioner and academic physician. My family and I moved to Australia in May 2006 after I accepted a position as a Senior Lecturer in General Practice at the Australian National University (ANU).

As of 1 May 2008 I am still not working in general practice. The problems that I have encountered with the Australian registration and accreditation system reflect the problems outlined in this paper and include the following:

1. *Complex and fragmented registration/ accreditation system*—This issue has been well documented in the Productivity Commission's report.[35] A personal example was that I was unable to register with a medical board (that is, to be vocationally registered) until I had my family medicine qualifications accredited and I could not get my family medicine qualifications accredited until I was registered with a medical board.
2. *Inefficient bureaucracy*—I needed to prove my proficiency in English despite the fact that I am a native English speaker from a English-speaking country. I also needed to get my Primary Medical degree translated by an official government translator. It was extremely difficult to get a classical language, Latin, translated let alone by a government approved translator. There are many examples in the literature of IMGs feeling similarly marooned in an administrative no-man's land.[36] Complex bureaucracy has also been identified as a problem with the current system in the Productivity Commission report.[37]
3. *Lack of transparency and clarity regarding accreditation criteria and processes*—I found the wording of a key accreditation policy posted on a College website regarding my Canadian qualifications ambiguous. When I tried to clarify my eligibility for College fellowship, I was told that I would need to go through the assessment process first before it could be determined if I was eligible. Lack of transparency regarding College accreditation policies was another theme identified in the ACCC report.[38]
4. *Irregular accreditation processes*—The wording of the College's accreditation policy described above was changed just prior to a meeting to discuss whether I met those accreditation standards. Problems with irregular due process followed by the Colleges in their assessment of IMG qualifications have been well documented in submissions to the ACCC as well as in the *Race to Qualify* report.[39]

5. *Lack of clear criteria underlying the rationale for accreditation policies*—One of the key recommendations to come out of the 2005 ACCC report was that Colleges should outline the criteria and rationale for their accreditation policies.[40] Despite a request for this information, I was not provided with any specific details as to the specific criteria for the College accreditation policy, specifically how my training and assessment compared to the Australian pathway, except for a generic statement about equivalency in training and assessment.

In general, my primary concerns were not with the standards as such but rather with the nature of the processes and procedures in place to assess those standards, particularly the lack of accountability. *The Race to Qualify* report voiced strong concerns about the lack of accountability of the specialist colleges, particularly given the evidence that factors other than medical standards largely influenced the accreditation process.[41] The ACCC report has also issued a number of recommendations to improve accountability.[42] Despite these long standing concerns and the recommendations outlined in these reports, the colleges are still not directly accountable to the public or government for their accreditation policies despite the fact that these policies have a significant impact on the delivery of health care.

Accreditation and registration in other countries

Many other western countries, including New Zealand, Canada, United States and the United Kingdom, are heavily dependent on IMGs to deliver healthcare to key sectors of their populations.[43] They also have complex and varied systems in place for the registration and accreditation of IMGs. A full discussion of the key differences between countries is beyond the scope of this paper. Nonetheless, a few notable differences do merit discussion, particularly with regards to the accreditation of GPs.

Easily accessible information about accreditation

One of the challenges that I encountered was trying to figure out the Australian system. New Zealand has a number of comprehensive web-based resources for IMGs who are interested in working in New Zealand which clearly outline eligibility criteria for the different registration categories.[44] The New Zealand College of General Practitioners also publishes a very useful resource, 'Your Guide to New Zealand General Practice', which provides an excellent overview of working as a GP in New Zealand.[45] They also have a dedicated contact person to field questions about working as a GP in New Zealand.[46]

Australia also has an excellent web-based resource, the Doctors Connect site, established by the Department of Health and Ageing in 2004. It provides a comprehensive overview of the Australian healthcare system and advice for IMGs considering working in Australia.[47] Unfortunately, its ability to address specific queries about working in Australia is limited because of the fragmented nature of the Australian system. Also, given the complexity and number of organisations involved, it is next to impossible to ensure that the website linkages are kept up to date.[48]

Policies for underserviced medical areas

Like Australia, New Zealand and Canada have specific registration categories for overseas trained doctors wsho do not qualify for the full registration that would allow them to work in areas of medical workforce shortages. These 'temporary/conditional'

positions vary significantly between countries however. In Canada an IMG can obtain a defined license to work in an area of need, however in contrast to Australia they may be eligible to transition to full registration after a specified period of time.[49] While the Canadian system has also been extensively criticised it has been acknowledged that it would be a disservice to IMGs and the Canadian public alike to dislodge doctors who have become valued and integral members of the community.[50]

Criteria to assess competency

In New Zealand, the Royal New Zealand College of General Practitioners (RNZCGP) is the New Zealand Medical Council's branch advisory board responsible for the assessment of vocationally trained IMGs with GP qualifications. Like the RACGP, the RNZGP has listed a number of qualifications that are considered equivalent to New Zealand's. In contrast to Australia, an IMG can also apply for formal recognition of training and assessment that are not formally recognised by the college to be counted towards fellowship. Consequently, even if an IMG does not have what are considered equivalent qualifications, they still may be judged to be as good as a New Zealand graduate based on a holistic assessment of their qualifications. An IMG may also apply to have their training and experience counted towards fellowship of the RNZCGP.[51] Finally, the Medical Council of New Zealand lists a range of possible pathways towards provisional specialist registration, including those that involve summative assessment as well as those based largely on supervision.[52] This provides for additional flexibility as well as potentially constituting more valid measures of competence.

The RACGP also have the Practice Based Assessment pathway as an alternative route to their standard pathway to fellowship. This route involves a multifaceted approach to assessment involving practice audits, patient videotaped interviews and a viva or oral examination. This reflects a more comprehensive competency-based approach to assessment as it focuses on actual performance in the context of clinical practice. Currently however, the pathway is only available to IMG GPs who have worked for at least one year in Australia and therefore is not an option for new IMGs to have their qualifications accredited.[53]

THE COAG AGREEMENT: A WAY FORWARD?

The establishment of a national registration and accreditation system as outlined in the 26 March 2008 intergovernmental agreement (see introduction) has the potential to address many of the longstanding problems inherent in the current system particularly with respect to the accreditation of IMGs.[54]

Potential for improvement

Establishment of clear consistent national standards for accreditation and registration

The establishment of national standards for the accreditation of IMG doctors will largely abolish the current problem of variable standards for practice in different parts of the country. This will facilitate the deployment of Australian and internationally trained doctors at a time of critical shortage. It may also make Australia a more attractive destination for the skilled IMG health workers in that the criteria for standards of practice will be clear and consistent across states.

Improved efficiency and effectiveness

My experience indicates that individual organisations are relatively unaware of the roles and responsibilities of the other key organisations that make up the system. The centralisation and/or establishment of an overarching body to oversee these process-

es should help to identify and rectify these problems. In the new scheme a national agency will be established which will be responsible for the establishment of procedures and business rules for efficient and quality operations.[55]

Improved key stakeholder input into the development and oversight of processes and policies for the accreditation of IMGs
Under the new system there will be multiple avenues for stakeholders to provide input into the direction and specifics of emerging policies on IMG registration and accreditation. The ministerial council will have a range of responsibilities including final approval of profession specific competency and accreditation standards.[56] The involvement of the state and federal governments in the registration scheme has been a very contentious issue.[57] Governments are ultimately responsible for the quality of health care delivered to the Australian public which makes them major stakeholders in the process.

In addition, each health profession, including medicine, will be represented by a national board. While the majority of each board will be members of the relevant profession, at least two members of the board will be community representatives. In addition, at least one third of each board will be made up of non-professional representatives. Balanced membership should help to bring a range of different perspectives to bear in the formulation of policies and processes.[58]

Improved accountability and reduced impact of organisational self interest on policy development
One of the major problems with the current system is the lack of external accountability of many of the organizations, particularly with regards to the accreditation of IMGs. The national scheme should promote accountability at a number of levels. First, as already mentioned, all final policies regarding IMG accreditation would need to be approved by the ministerial council. This council in turn will take advice from the independent health workforce advisory council which would advise it on matters referred to it as well as on issues that the ministers feel appropriate. The independent advisory council will consist of a balance of professional and non-professional expertise.[59]

Under the new scheme the national medical board (one of the nine boards to be set up under the COAG agreement) will ultimately be responsible for accreditation of IMGs. Initially, the board may delegate this responsibility to other agencies. Nonetheless, the delegated agencies will need to operate according to set guidelines including providing defensible rational accreditation criteria, and will be accountable to the board. It would be appropriate for the national board to also investigate complaints about unfair policies or failure of the delegated body to follow due process.

Unanswered questions
While this scheme is in its early infancy there are a number of unanswered questions the answers to which will largely shape its success or failure.

Role of existing accreditation bodies?
One of the key unanswered questions is will the ministerial council assign registration and accreditation functions to the new bodies or will they enlist the help of existing accreditation bodies. The intergovernmental agreement does state that the new national board will/can assign accreditation functions to existing accreditation bodies but that, to be assigned the accreditation functions of the board, these bodies must meet established standards and criteria. There are significant set-up costs if new bodies are established, and goodwill may

be squandered. A key issue that needs to be addressed is the extent to which the problems with the current system are attributable to the organisations themselves and, if these organisations are incorporated into the new system, how will the existing problems identified in this paper be addressed. In particular: how will the problems of lack of accountability and the potential for conflicts of interest be addressed? How will the government ensure that accreditation policies reflect valid competency-based criteria?

The role of the current state and territory registration boards in the new scheme has not yet been clarified. The proposed national agency will have a national office and 'representation in each jurisdiction'. Will the current state boards assume the role of representing the national agency or will they simply be dissolved? Despite the problems inherent in the current system, there is a collective wealth of expertise and experience housed in these state and national organisations particularly with respect to jurisdictional issues. It would be important for the new professional board to incorporate this expertise into the new scheme effectively while also identifying means of improving efficiency, transparency and accountability.

Future of reforms in progress?

Thirdly, what is to become of the reforms already in progress? The AMC is in the process of implementing a number of reforms for the accreditation of IMGs seeking general registration which are still planned to go ahead.[60] One of these pathways, the new competent authority pathway, will exempt doctors who have trained and/or obtained specific qualifications in some western countries like Canada, the U.K., and the United States from the AMC exams. These IMGs will still need to undergo some form of workplace assessment and supervision, the nature of which will be determined by the relevant jurisdiction.[61]

While the introduction of the competent authority pathway may be a step in the right direction, its impact on the recruitment of skilled western IMGs is still questionable, particularly for the non-tourist jurisdictions in Australia which do not tend to attract the young British doctors who want to spend some time in exotic Australia. The AMC is only exempting those doctors who have sat the most recent version of their national professional qualifying exams.[62] This excludes a large proportion of experienced western IMGs who passed the earlier versions of these exams. Also, many of the doctors who qualify for the competent authority pathway are already eligible for registration in Australia under the RACGP fellowship program.[63]

In some ways the attempt to establish fairer and more flexible accreditation and registration standards for IMGs will make the situation even more complex. For example in the ACT it is expected that there will be four potential pathways for registration and accreditation of IMG GPs established over the next year: 1. The standard pathway (AMC exams and one year of supervision); 2. Competent Authority Pathway; 3. Specialist College pathway; and 4. New 'Standard Pathway for workplace based assessment'. The last pathway will require IMGs to take an 'international screening exam' which is similar to Part One of the AMC followed by a workplace assessment, the nature of which will be determined by each jurisdiction.[64]

Concerns have been raised that, at a cost of A$1800, the screening exams will act as a further deterrent to IMGs, particularly where many of them will have to travel significant distances. Currently, the exams are planned to be held every few months.[65] While all stakeholders agree that in principle standardised assessment of IMGs is essential for ensuring appropriate

standards, Australia also needs to acknowledge that this may exacerbate its current shortage. At the very least consideration should be given to making these tests much more accessible.

Increased bureaucratic red tape and inefficiency?

While the national registration scheme should improve consistency and therefore improve efficiency by establishing national standards, because of the number of organisations involved, it has the potential to evolve into an even more complex bureaucratic machine than the current system. An effort will need to be made to ensure that organisational linkages and the respective roles and responsibilities of the various players that compose the new system are efficient and clearly delineated. Clear lines of communication also need to be established to prevent the fragmentation that characterises the current system.

Inappropriate level of government interference?

In the new system the federal and state/territory governments will occupy the upper echelons of decision-making. There is the potential, as suggested by the AMA, for government to exert undue influence over accreditation and registration policies in order to meet other political agendas at the expense of the health professions. On the other hand, it is likely that the ministerial council will largely take its direction from the health workforce advisory council. Of concern to this author however is the fact that the advisory council members will be appointed by the ministerial council. This carries the danger for the ministerial council to appoint members to the advisory council whose views are aligned with those of the government.

It may be more appropriate for members of this advisory council to be recommended or at least approved by other key stakeholders. This issue needs to be addressed if key stakeholders, particularly medical organisations, are going to be reassured that the new scheme will not be used or rather abused as a tool for the government to exert its power over the health professions.

It needs to be explicitly acknowledged that the national registration scheme potentially threatens the monopoly that a number of organisations currently have on particular aspects of medical accreditation and registration in Australia and that they may be very reluctant to relinquish this control. The challenge for the national accreditation body will be to use this organisational expertise effectively while also exploring new avenues to improve the current system.

Integration of IMG expertise?

One omission in the proposed scheme is the role of IMG expertise in the development of fair and rational accreditation standards for IMGs. Australia has a wealth of IMG professional and educational expertise, and a large proportion of our IMGs have also acquired Australian qualifications. These doctors are familiar with the complications and frustrations of attempting to navigate the current system. This gives them an important area of expertise that other key players do not have.

Making the effective transition from equivalency to competency based standards?

A larger problem with the current accreditation system is a rigid comparison between the training and assessment methods used in Australia and other countries in contrast to the demonstration of competence per se. This issue has also been identified in a number of reports.[66] Rather than asking the question 'how does a particular training program and/or assessment method compare to the Australian model(s)', a better question would be 'how can we best deter-

mine whether a doctor is competent to practice in the context of the Australian healthcare system'. Asking the second question may expand the range of assessment options to include practice audits and vocational assessments which may be more valid measures of actual performance than summative exams. Some movement is being made in this direction with the proposed AMC reforms but this author would argue that these reforms could be taken further.

CONCLUSIONS

No one would dispute the fact that in an ideal world Australia should aim for self-sufficiency with respect to its medical manpower. The reality is, however, that countries like Canada and Australia with vast geographical distances and sparse populations have always relied on IMGs to provide medical services, particularly to rural and remote regions.

Once a country has established the need to recruit an IMG because they are unable to secure the services of a domestic graduate, it has an ethical responsibility to ensure that the recruit encounters a fair system. Arguably, Australia also has a moral obligation to use the expertise of its own IMG citizens and permanent residents first rather than draw from the precious medical manpower resources of other countries, particularly those from the developing world.[67] This is not only ethical but cost effective given the huge expense of recruiting temporary doctors to Australia. A fair and transparent system also needs to be established for the transition from temporary to general registration.

The proposed national registration system is an exciting opportunity to explore these options and build a better system for Australia in the future. The success of these reforms will largely depend on the ability of the individual stakeholders to put aside their differences and self interest to work together towards a common goal—the establishment of a healthcare system that ensures high quality and accessible health care for all Australians: a system that supports and respects all healthcare workers that deliver that care, Australian and internationally trained alike. The Australian public deserves nothing less.

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Disclaimer

The views expressed in this article are solely those of the author and do not represent the views or opinions of any affiliated educational and/or professional organisation(s).

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