For further information contact:
Centre for Population and Urban Research
P.O. Box 11A
Monash University
Clayton, Victoria, 3800
Australia.
Phone: 61 3 9905 2965
Fax: 61 3 9905 2993
peopleandplace@arts.monash.edu.au

VICTORIA'S DEPENDENCE ON OVERSEAS TRAINED DOCTORS IN PSYCHIATRY

David Barton, Lesleyanne Hawthorne, Bruce Singh and John Little

This paper analyses Australia's growing reliance on overseas trained psychiatrists (OTPs) for provision of public sector mental health services, particularly in rural and regional Victoria. A number of critical issues are highlighted, including State Governments' and the Royal Australian and New Zealand College of Psychiatrists' failure to provide appropriate preparatory and concurrent training to assist OTPs in professional adjustment and reaccreditation, and the failure of governments to pro-actively address the adequacy of future supply.

THE EXODUS OF AUSTRALIAN PSYCHIATRISTS FROM PUBLIC SECTOR PSYCHIATRY

By 1991 Australia's professional workforce was characterised by growing dependence on overseas-born professionals, including 49 per cent of mechanical engineers, 43 per cent of computer scientists, 40 per cent of doctors, 35 per cent of dentists and 26 per cent of nurses.[1] This dependence is replicated in select medical fields such as psychiatry, where the public sector is experiencing significant difficulty in attracting and retaining specialists. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) currently has approximately 800 candidates in training at any one time, graduating up to 100 psychiatrists per annum. Low numbers of these graduands continue in public sector work after the first few years, with most moving into the private sector. The resulting shortfall in the public sector necessitates constant replacement by overseas trained psychiatrists (OTPs), in addition to growing reliance on overseas trained doctors (OTDs) who are untrained in psychiatry but may be required to work in related positions, typically at junior levels such as resident medical officers or as psychiatric registrars.

The reasons for the exodus of Australia-trained psychiatrists from the public sector are multiple. Under the First National Mental Health Plan (1992) there was a significant reconfiguration of mental health service provision in Australia.[2] Community service provision has since expanded from 29 per cent to 46 per cent of all mental health spending, as the number of beds in mental hospitals has been reduced by 42 per cent.[3] In terms of treatment, public sector psychiatry has become focused on the treatment of psychotic disorders (mainly schizophrenia, mania, and psychotic/ severe depression — the 'seriously mental ill'). This process has been described by the eminent British psychiatrist, David Goldberg, as 'asylum psychiatry now practised in the community, focusing on the same group of patients who previously required institutional care'.[4]

The majority of patients admitted to an in-patient facility in Australia are currently there against their will, under the auspices of the Mental Health Act. Most are severely ill, requiring the highest level of care from skilled staff. A decade ago the typical length of in-patient stay was a month. Now it is more in the range of six to 14 days — despite the fact that anti-psychotic and anti-depressant medications typically take at least two weeks to work, and that patients may have exhausted any network of psychosocial support to assist them

following discharge. This discharge may be in fact driven by a shortage of beds — a result of significant bed closures occurring over the past decade as part of the de- institutionalisation process.

Within this stressful environment, public sector psychiatrists are under repeated pressure to admit seriously unwell patients into already full wards, at the cost of discharging other patients who are still significantly unwell. Full-time public sector psychiatrists may feel they are becoming de-skilled, since they lack adequate exposure to mood and anxiety disorders along with other high prevalence conditions. In consequence many move to a mixture of public and private work, or more often into full-time private practice. The narrow focus of public sector psychiatry is simultaneously affecting the quality of training that registrars receive, with trainees having limited exposure to the high prevalence disorders which constitute the majority of mental illness in the community. The Victorian funding system exacerbates this situation, given that it rewards public psychiatrists better for part-time than full-time work. Analysing the impact of these recent changes on the Victorian public sector, Goldberg notes:

> There has been an exodus of Fellows… since the fiscal changes introduced earlier this year. In Ballarat, for example, only four of the eight Fellows remain — the others having moved to private practice. The AMWAC (Australian Medical Workforce Advisory Council) Report gives the reasons cited by 39 Fellows who had made such a move, the commonest reasons being dissatisfaction with the work environment, poor pay and decreased patient contact.[5]

The process described above is ongoing and minimally addressed to date by governments, despite the obvious importance of retaining full-time psychiatrists who can provide continuity of care while contributing to service development, research, education and training.

Fleeing to private sector practice, psychiatrists perceive that they gain greater control over their work. This includes the capacity to work one-to-one rather than within a team, and to secure a level of remuneration directly related to the time spent seeing patients (in contrast to the public sector's pressure on throughput), as well as the opportunity to treat a broader range of conditions. These attractions of private sector psychiatry are unlikely to be offset in the future by growth in local trainees.[6] Intakes to the College's training program have remained stable over the past 10 years, with positions often left unfilled due to lack of suitable applicants. The College of Psychiatrists sees its role as to maintain standards and accreditation, rather than to address labour market needs. The public sector psychiatry shortages described above are thus at risk of becoming chronic.

RURAL VERSUS URBAN PSYCHIATRY PRACTICE

Beyond supply versus demand and the drift from public to private sector practice, there is the further issue of rural versus urban location in psychiatry — as profoundly significant as in relation to general medicine.[7] Australian psychiatrists typically locate in large cities in affluent suburbs, close to the private hospitals where they admit their patients. Rural psychiatrists by contrast may be denied access to urban amenities, quality schools and spouse employment. They may be on call 24 hours per day seven days a week across multiple locations. Given the relative poverty of rural

Australia, the capacity of their patients to pay above bulk bill or scheduled fee rates may be limited. Identical factors prevail in comparable western countries: the US, Canada, the UK and New Zealand are all characterised by over-supply of medical professionals and specialists in the city, and gross under-supply in the majority of rural areas.[8]

Within this context, which governments have minimally addressed, competition for trained psychiatrists willing to work in public sector and regional or remote locations has become global. The shortage of Australia-trained professionals is currently exacerbated by a steady outflow to the UK, where incomes are significantly higher (even allowing for the increased cost of living), especially for locum work. Australian mental health authorities in turn have compensated by 'topping up' through the recruitment of two categories of OTDs:

- Overseas trained psychiatrists attracted to Australia on a temporary or a permanent basis from a wide range of source countries (the main focus of this paper); and
- Permanent resident OTDs who typically lack any specialist psychiatric training, but can secure positions as public psychiatry registrars or medical officers on a demand-driven basis (briefly considered at the conclusion).

THE RECRUITMENT OF OVERSEAS-TRAINED PSYCHIATRISTS TO WORK IN VICTORIA

Australia has a long history of recruiting overseas trained doctors and specialists to work in relatively stigmatised medical settings — not merely in psychiatric institutions but in the Antarctic and Papua New Guinea.[9] By 1996, 41.4 per cent of the Australian psychiatry workforce was overseas-born, including 24 per cent who had completed their first degree outside Australia.[10] A two-tiered psychiatry system is currently developing in Australia. Prestigious city hospitals remain characterised by strong training programs, a high degree of registrar loyalty, world- class research and a tradition of collegiality. By contrast mental health services in the outer rims of Australian cities as well as in regional and rural locations are increasingly characterised by a gross shortage of psychiatrists. According to Goldberg, the 'exodus of Fellows' from public sector psychiatry in Victoria has resulted in the recruitment of psychiatrists from overseas who frequently 'do not possess the benchmark qualification for Australian psychiatrists'. A recent AMWAC survey of 52 of these overseas trained psychiatrists noted that 'no fewer than 45 per cent were employed in the state of Victoria'. Such OTPs were overwhelmingly concentrated in rural areas: 43 per cent of those surveyed, compared to just nine per cent of RANZCP Fellows across Australia.[11] In January 2001 the participation of OTPs in Victorian public sector psychiatry was as summarised in Table 1. The level of dependence in rural and western metropolitan[12] locations is particularly striking.

In addressing these public psychiatry shortages, mental health authorities recruit from a number of source countries, including the UK, South Africa, Canada, the US, select Commonwealth nations (often psychiatrists committing to Australia for only brief periods of stay), and a group of medically under-resourced nations. There are serious ethical issues here, including the appropriateness of wealthy western nations recruiting from countries in desperate need of their services.[13] The global context however is of

Table 1: Victorian dependence on overseas-trained psychiatrists as of January 2001 (public sector)

Service location	No. of public sector psychiatrists	% overseas-trained
Rural psychiatrists	43	43
Rural medical officers and trainees	40	43
Metropolitan psychiatrists	78	13
Metropolitan medical officers and trainees	104	24
Western metropolitan psychiatrists	24	38
Western metropolitan medical officers and trainees	36	33
Non-western metropolitan psychiatrists	54	6
Non-western metropolitan medical officers and trainees	81	16
Total Victoria psychiatrists	121	26
Total Victoria medical officers and trainees	144	29

sustained migration from south to north, from east to west, and from developing to developed nations.[14] This movement shows no signs of abating. This dynamic process is driven by individuals' freedom of choice, plus the determination of those with tertiary education to relocate to contexts offering greater opportunity for personal and/or professional safety or reward. Comparable trends are underway in many medical specialisations, including surgery where attractors to select individuals may include initial generous salaries.[15]

Overseas trained psychiatrists are typically attracted to Australia by international recruitment, which in some states is coordinated by the Chief Psychiatrist or the central mental health bureaucracy. A list of applicants is circulated, with local services approaching applicants directly. No overseas psychiatry qualifications gain automatic recognition in Australia, though there are less stringent entry and examination requirements for applicants from the established English-speaking-background countries of training (the US, the UK, Canada, South Africa), and for more senior and/or eminent psychiatrists.

Once offered psychiatric employment, OTPs are registered in Australia by the relevant state Medical Board to practise for a year or more in a defined public health setting. Given the intensity of demand for mental health services most have been expected to 'hit the ground running'. No period is provided for acclimatisation, training, or induction into the particular local skills required for the practice of psychiatry in Australia (including its focus on an integrated hospital and community service). While recognition protocols differ from state to state, OTPs are nominally required to complete the College's requirements within a period of four years, though this timeframe is increasingly lenient now because of chronic undersupply.

Inevitably, the clinical experience and type of training received by the incoming psychiatrists varies considerably. Differences in practice are likely to be multiple, in addition to the challenges posed by language or cultural differences in a speciality that is communication and value-based. Practice differences may include:

- The importance of consumers and carers within Australian mental health service provision;
- The range of medications in use, including the funding mechanisms required to support these;

- Transcultural differences in the prevalence and types of mental illness (including treatment approaches), for example related to anorexia nervosa or borderline personality disorder;
- Aboriginal health and cultural issues, especially in rural and regional areas;
- Past training in application of ECT (a treatment whose practice has become significantly more complex in Australia in recent years);
- Referral processes for both pathology and radiology (controlled by Commonwealth funding, and not always accessible to OTPs on temporary visas);
- Understanding of the local health care system, including the complexity of Commonwealth/ state health responsibilities, Medicare, Work Cover, TAC (Traffic Accident Commission) and third party insurers as they apply in Australia; and
- Professional responsibilities for continuing medical education, peer review, clinical governance and quality improvement, in a less hierarchical administrative structure.

Within this complex service provision context, overseas-trained psychiatrists must simultaneously come to terms with the legal and ethical requirements relevant to the Mental Health Act in the relevant state, as well as the rights of the individual, when it is appropriate to commit a patient, and the need for treatment to occur within the least restrictive environment possible. Such knowledge must be attained at speed, while OTPs assimilate themselves and their families socially to the new country, and deal effectively with the inevitable stressors of migration.

THE ISSUE OF TRAINING IN VICTORIA

There are 21 Area Mental Health Services across Victoria, spanning Melbourne, regional cities like Geelong, Warrnambool, Ballarat and Shepparton, and remote and regional sites. By April 2002, Victoria's North Western Mental Health network (the largest Mental Health program in the country involving four area mental health services, three aged care services and a regional youth program) was employing 29 psychiatrists who had qualified overseas. India was the dominant source country (38 per cent), followed by Sri Lanka (21 per cent), the UK (10 per cent), plus one or two psychiatrists each from South Africa, Switzerland, Canada, Malaysia, Bangladesh and Nigeria. OTPs from developed western nations typically see their sojourn as transitory. OTPs from developing countries, by contrast, are likely to have permanent residence as their ultimate aim, for which a pass in the College's exams, preferably within four years, is mandatory.

At point of arrival, most OTPs will have been deemed 'suitable for practice', but little more may be known. Within days the majority will find themselves consumed by the demands of public sector practice. In some instances they may be appointed Acting Director of Area Mental Health Services — perhaps as the sole authorised psychiatrist responsible for the Mental Health Act's implementation. Some may become the only trained psychiatrist in the public sector service, on call 24 hours a day seven days per week, across a vast geographical area. Due to shortages these OTPs may juggle the workload of two to three psychiatrists, with other positions remaining unfilled. There may in fact be little incentive for employers to recruit the appropriate number, since the minimal requirements of the Mental Health Act have been filled, and there are considerable cost savings from not hiring

a full complement of psychiatrists. In Victoria there is no benchmark for the minimum number of psychiatrists required to run a service safely.

OTPs are dependent on their employer approval for renewal of visas each year. This means that they may be reluctant to oppose the level of service demanded of them. Nor will most challenge the fact that they have minimal access to the level of training required to access the RANZCP Fellowship, despite the fact that this is vital to their ultimate goal of achieving permanent residency in Australia. Placed from the start in specialist positions, the majority of these psychiatrists are expected to train themselves — regardless of Directors of Clinical Services 'guaranteeing' that they are under some form of supervision. If it is available, such supervision may have to be sourced external to the service, and is therefore an expense that must be separately negotiated with each employer. The Victorian Medical Board in fact has no guidelines to govern the nature of the actual supervision. In consequence this process is left to the discretion of each supervisor. As he or she has limited funding adequate supervision and training may seem 'unaffordable'.

While there is little doubt that many such OTPs perform very competently, there must also be concern about the potential quality of care for patients. In select mental health services, up to 60 per cent of positions may be filled by OTPs. When summarising the state of play in Australian psychiatry in 2000, Goldberg noted:

> No accurate figures appear to exist for the numbers of those employed by the public sector as consultant psychiatrists who do not possess the benchmark qualification for Australian psychiatrists… However, shortage of Fellows is not confined to deeply rural areas — in one public sector service in Melbourne a single Fellow (foreign trained) was working alongside 5 non-Fellows among the 6 consultants employed by the service…. There appear to be serious problems with the public sector, which ought to offer more to the Australian public.... The service also urgently needs the skills of trained psychiatrists and psychologists if it is to be successful…[16]

PREPARING TO TAKE THE RANZCP FELLOWSHIP EXAMINATIONS

As indicated, while grappling with multiple practice issues and excessive workloads the vast majority of OTPs hoping to stay in Australia must prepare to sit for the RANZCP oral and written exams. Successful candidature requires in-depth understanding of not only psychiatry but of Australian psychiatric practice, ethics and service delivery. In the consultancy viva, for instance, candidates will be examined by two psychiatrists on ethical and service development topics including some unique to Australia, such as Indigenous and refugee mental health. Questions will address a range of issues a candidate may come across as a consultant, many of which are culture-specific. Written examinations may present similar challenges for overseas trained psychiatrists, concerning cases such as eating or personality disorders which may be rarely seen in non-western cultures. Further questions will probe current health sector change (for example, 'We are getting managed care in Australia — please comment'). While access to preparatory training can be of significant benefit, this opportunity is not easily and generally available in psychiatry. Comparable barriers in other Australian health professions have been successfully addressed through the provi-

sion of bridging programs. For example in 1989 74 per cent of overseas qualified nurses failed their pre-registration exam in the state of Western Australia — an outcome transformed to an 89 per cent pass rate the following year, once government-funded preparatory training had been provided.[17]

For OTPs in regional locations, even discovering the College's examination requirements may be problematic. This involves applying to the College for assessment of previous experience, with the College then determining what extra training and examinations may be required. There remain differences of opinion as to who has the responsibility to provide such training and support: the College, the Department of Human Services, or the local mental health network that recruited the OTP (the consensus is the local mental health network). Others believe this training should be partially or fully funded by OTPs themselves.

A POSSIBLE SOLUTION

Without doubt individual OTPs will benefit from training designed to improve their skills, and assist them to remain permanently in the country once they have achieved Fellowship status. The community will also significantly benefit, by having access to senior and often skilled psychiatrists willing to provide services in areas of great need. In one rural service the OTPs currently employed include psychiatrists who, in their countries of origin, have been Deans of Medicine, Professors of Psychiatry, Members of World Health Expert Committees, Consultants to United Nations, British and United Sates Development/Overseas Aid Programmes, a CEO of a large private psychiatric hospital, and a Vice Chancellor of a University. Others have performed quality research for the World Health Organisation or established postgraduate psychiatry training programmes. Psychiatrists of such calibre in one service alone contribute significantly to the quality of care available anywhere let alone in a rural area. They should be welcomed to our country and their acculturation, migration and path to Fellowship should be facilitated as much as possible. An interaction between psychiatrists of such broad experience with our trainees can provide a unique perspective and training opportunity especially for a multicultural nation such as Australia. Should OTPs be assisted in their professional transition, further benefits would include:

- More rapid understanding by OTPs of Australia's mental health services, including principles of practice and ethics;
- Better supported and less stressed individuals, with a capacity to provide higher quality care in already difficult environments;
- Enhanced loyalty and gratitude from OTPs more likely to remain in both public sector and regional/rural employment;
- Greater retention long-term of a higher proportion of these overseas trained fully accredited psychiatrists in Australia; and
- Consequent improved quality of care for Australians with mental health problems and their carers.

The provision of such training is currently dependent on the administration of each health service, with only some services actively embracing a comprehensive approach. A coordinated state-wide approach would not only achieve economies of scale but would ensure equitable access for OTPs in each state. Such a program could provide training and supervision through both face-to-face and

video/teleconferencing modes, commencing as soon as an individual was employed. Each psychiatrist would undergo structured skills assessment, including analysis of prior level of training, and definition of professional strengths and weaknesses.

A preliminary orientation program would be provided, designed to ensure OTPs understood the relevant Mental Health Act, drugs and prescription practices across Australia, appropriate interface with community services, the structure and funding of the medical and health insurance systems (and so on). Sessions would combine elements of peer review, clinical supervision and examination preparation. Traditional didactic teaching would be provided by select experts in specialist fields, with one-on-one call support to allow for individual case mentoring. Candidates would be bridged into the broader education system across each state, including access to specialist psychiatrists with a capacity to visit and teach on exam-relevant topics (for example, neurology). A capital city based mentor could visit OTPs' actual locations of work, accompanying each on ward rounds, providing a second opinion on cases, strategies for working with multidisciplinary teams, and appropriate prescribing practices.

Most importantly, a program such as this could be tailored to each OTP's professional and Fellowship preparation requirements. Its provision is viewed by two of the authors (Barton and Singh) as integral to providing equitable psychiatric care to all Australians. Graduates of the system, once they had achieved Fellowship and permanent residency, would in time take responsibility for peer mentoring subsequent groups. The structured support provided for OTPs preparing to sit the College exams would create a win-win strategy, maximising the number achieving permanent residency, and thus allowing them to contribute further to psychiatry in Australia. The cost of the program would be relatively modest: an estimated $5-7,000 per year, of which individual OTPs could contribute half.[18] The benefits to the quality of psychiatric service provision would be significant, an improvement certain to be quantifiable should any independent evaluation be undertaken.

A common criticism of such programs is that once overseas trained psychiatrists have secured their Fellowship, residency and Medicare provider number they will flee to the city and private practice. A similar program to the model outlined above however has been operating in Warrnambool and Shepparton (Victoria) for the past three years. Of the six OTPs originally inducted into the program, five have achieved Fellowship and remain in full-time public sector employment, with four still in their original rural location. The fifth successful candidate has just moved to the city, 18 months after attaining the Fellowship. He is currently working in a public sector position full time. Even should successful candidates ultimately move, the quality of care they will have provided in the transitional period will have been substantially enhanced by their systematic training and mentoring.

DEPENDENCE ON OVERSEAS TRAINED DOCTORS FOR JUNIOR PSYCHIATRY-RELATED POSITIONS

The above analysis relates to overseas trained doctors who have completed specialist qualifications in psychiatry. As established by Hawthorne and Birrell,[19] there are also multiple points of entry to lower level psychiatry positions in Victoria (typically psychiatric registrar or

house medical officer positions). Such positions are filled by permanent resident OTDs with no specialist training, and with minimal or no Australian Medical Council (AMC) status in terms of passing the mandatory pre-registration examinations.

Many such OTDs are 'sojourners'. They accept psychiatry-related positions as an essential means of re-entering medicine in Australia and then move to more desired positions once these have become available. For example an OTD may migrate to Australia from a developing country in 1994, pass the AMC's Multiple Choice Question examination[20] by 1998, but fail the Clinical exam on repeated occasions. Moving interstate to take an AMC preparatory course, he or she may secure a public sector psychiatry-related position — shifting to 'Area of Need' GP work in regional Victoria once this preferred option becomes available. Another pathway occurs when a doctor qualified in a developing country, arrives in Victoria, then after multiple AMC attempts, secures a regional HMO position in psychiatry. Later, the doctor secures work based in a capital city, once again based in psychiatry. After finally passing the MCQ the doctor swiftly leaves psychiatry to move into 'Area of Need' GP employment.

The above pathways represent common career paths for overseas trained doctors. It is important to raise concerns about the level of support provided to these OTDs, who may have limited training or experience in psychiatry, yet fulfil important frontline psychiatry-related positions. As Resident Medical Officers they will assess patients entering hospital in emergency situations (including attempted suicides and people who are acutely psychotic).

CONCLUSION

As should be clear from the above analysis, overseas trained psychiatrists fill essential gaps in Australian mental health services. Many rural mental health services would not be able to function at all without them. In the process these OTD's accept major work responsibilities with minimal support, often in highly stressful circumstances. This phenomenon is a global one, the field of psychiatry in Australia and the state of Victoria being merely an example. In Canada, for instance, it is currently estimated that by 2011 net growth in all professions will derive from migration. In a range of immigrant- receiving western nations, new credentialling strategies are being developed to facilitate and support migrant professionals' labour market entry. In the context of reduced birth rates and the anticipated looming 'war for skills' in western nations, European Union countries such as Germany and the UK recognise that they too in future will encourage skilled migration — a process inevitably requiring the emergence of professional readjustment systems.[21]

Returning to psychiatry in Australia (the current case study), appropriate support and credentialling mechanisms must be established. State governments, as the ultimate employers of OTPs, have an obligation to provide them with initial and ongoing training and supervision — a process that is vital, we argue, to assuring the delivery of quality patient care. Such OTPs have a capacity to quickly acclimatise to Australian service provision needs, and may choose to remain in rural public psychiatry service even once they have a chance to shift to the city and private practice.

In addition, the College has a responsibility not merely to examine these psychiatrists but to assist in their training —

arguably an essential part of its community responsibility. University training schemes[22] should structure psychiatry courses so that these can be offered by distance education, addressing the clinical as well as academic skills which particularly relate to OTPs' professional development needs. (The Master of Psychiatry program offered by the University of Melbourne will move toward meeting this need from 2003 — replacing the previous bloc-mode five year Melbourne-based course, which was too lengthy to assist OTPs trying to secure the Fellowship in the mandatory four years.) Finally, OTPs reaching Australia with extensive experience in varied service environments have a clear potential to enrich local psychiatric registrars' training experience. Their expertise should be recognised. To date, however, minimal interaction has been facilitated between the two groups, to their mutual disadvantage.

For too long overseas trained psychiatrists have been treated as a necessary but neglected part of the Australian psychiatry workforce, serving the community largely isolated and unsupported. It is vital that they be recognised in future as an essential element of mental health service provision. With this comes an obligation for employing and credentialing bodies to develop and fund appropriate preparatory and concurrent support programs. Failure to do so could render these stakeholders vulnerable from a medico-legal perspective, failing to fulfil their duty of care to their employees, as well as to the vulnerable public sector patients for whom they are responsible.

Finally, it is necessary to emphasize that the measures recommended in this paper for meeting the training and/or reaccreditation needs of OTPs are merely a short term palliative solution to what has become an intractable national problem for public psychiatry. If the issue is to be properly addressed, Australian governments, mental health services and the College must take a pro-active rather than a passive stance on the issue. They must develop collaborative strategies designed to ensure a more adequate supply and distribution of Australian psychiatrists, which include ensuring sufficient numbers for public sector work in regional and rural as well as urban areas as a priority. There is simply no excuse for the current inertia, which is leading to a reliance on overseas qualified professionals in the absence of appropriate working conditions to attract and retain Australian trained psychiatrists into the public system. The recent funding of rural medical schools will, we hope, increase the number of rural practitioners over the longer term and go some way to alleviating the professional isolation of rural practice. Most developed countries are displaying inertia and are not facing up to the similar retreat of highly trained psychiatric clinicians from public work in urban and rural areas. But this fact should not inhibit Australian authorities from trying to develop creative solutions to the problem.

References

1. B. Birrell and L. Hawthorne, *Immigrants and the Professions in Australia*, Monash University, 1997
2. G. Meadows and B. Singh, 'Victoria on the Move. Mental Health Service in a Decade of Transition 1992-2002'. *Australasian Psychiatry*, (in press)
3. D. Goldberg, 'Impressions of Psychiatry in Australia', *Australasian Psychiatry*, vol. 8 issue 4, December 2000, p. 407
4. B. Singh, 'Commentary 1' to 'Impressions of Psychiatry in Australia' by D. Goldberg, *Australasian Psychiatry*, vol. 1 issue 4, December 2000, p. 312
5. D. Goldberg, op. cit., p. 308; and Australian Medical Workforce Advisory Committee, *The Specialist Psychiatry Workforce in Australi:, Supply and Requirements 1999-2010*', AMWAC Report 1999-7, 2000.7, Canberra, p 115
6. For a detailed analysis of psychiatry workforce requirements, see ibid.
7. L. Hawthorne and B. Birrell, 'Doctor shortages and their impact on the quality of medical care in Australia', *People and Place*, vol. 10 no. 3, 2002, pp. 55-67
8. See for example J. R. Barnett, 'Where Have All the Doctors Gone? Changes in the Geographic Distribution of General Practitioners in New Zealand Since 1975', *New Zealand Medical Journal*, Aug 28, vol. 104 no. 918, 1991, pp. 358-60; S. Mick, S. Lee and W. Wodchis, 'Variations in Geographical Distribution of Foreign and Domestically-Trained Physicians in the United States', *Social Science Medicine*, Jan, vol. 50 no. 2, 2000, pp. 185-202; D. Square, 'Storm of Protest Greets Motion to Restrict Specialty Exams', *Canadian Medical Journal*, Apr 15, vol. 156 no. 8, 1997, pp. 1188-9
9. See for example E. Kunz, *The Intruders: Refugee Doctors in Australia*, ANU Press, Canberra, 1975, and E. Kunz, *Displaced Persons: Calwell's New Australians*, ANU Press, Canberra, 1988.
10. Australian Medical Workforce Advisory Committee, op. cit., p. 29
11. D. Goldberg op. cit., p. 308; and Australian Medical Workforce Advisory Committee, op. cit., p. 113
12. Western metropolitan refers to Footscray and a range of other western suburban and regional locations.
13. For differing views re this, see Singh, 2000, op. cit., p 313, and S. Henderson, 'Commentary 2' to 'Impressions of Psychiatry in Australia' by D. Goldberg, *Australasian Psychiatry*, Volume 1 Issue 4, December 2000, p. 314.
14. See for example C. Stahl, and R. Appleyard, 'International Manpower Flows in Asia: An Overview', *Asian and Pacific Migration Journal*, vol. 1 nos 3-4, 1992, pp 417-476; R. Appleyard, *International Migration: Challenge for the Nineties*, IOM (International Organization for Migration), Switzerland, 1991; R. Appleyard, 'Emigration Dynamics in Developing Countries', *International Migration Quarterly Review*, vol. XXXIII, nos 3-4, Geneva, 1995, pp. 293-311.
15. See, for example, Chapter 3 of L. Hawthorne, *Labour Market Barriers for Immigrant Engineers in Australia*, Australian Government Publishing Service, Canberra, 1994, for a detailed analysis of motivating factors in skill migration to Australia.
16. Goldberg, 2000, op. cit.
17. International Institute for Policy and Administrative Studies (IIPAS), Bridging Programs for Migrant Nurses: An Evaluation Report, IIPAS, Perth, 1990; B. Scott, A Profile of Overseas-Qualified Nurses Seeking Registration in Western Australia and Identification of Common Problems as Perceived by Applicants, Working Party for Bridging Training Arrangements for Overseas Qualified Nurses, Perth, 1989; for detailed discussion of this issue see L. Hawthorne, 'Qualifications Recognition Reform for Skilled Migrants in Australia: Applying Competency-Based Assessment to Overseas-Qualified Nurses', *International Migration Review*, Geneva, vol. 40 no. 6, 2002.
18. This would be equivalent to the costs paid by Australian psychiatric registrars, who contribute roughly $3,000 of their training fees per annum, with the remainder being paid for by select mental health services.
19. See Hawthorne and Birrell, 2002, op. cit.
20. As stated in ibid. overseas trained doctors seeking full registration in Australia need to pass a Multiple Choice Question examination of medical knowledge, and a Clinical examination designed to assess their competence with patients. Both examinations have high failure rates, with select countries of origin particularly disadvantaged.
21. Content at workshop entitled 'The Emergence of New Credentialling Systems', the Seventh Metropolis Conference on international migration, Oslo September 9-13 2002; additional information related to future European Union dependence on skill migration provided to L. Hawthorne by senior researchers at the Institute for Migration and Ethnic Studies, University of Amsterdam, 4-5 September 2002.
22. For a recent analysis of academic psychiatry training in Australia, see B. Singh, 'Academic departments of Psychiatry in Australia: a need for reinvention', *Australasian Psychiatry*, vol. 10 no. 2, June, 2002.