PEOPLE AND PLACE

Copyright notice

For further information contact:
Centre for Population and Urban Research
PO Box 11A
Monash University
Clayton VIC 3800
Australia
Phone: (+61 3) 9905 2965
Fax: (+61 3) 9905 2993
email: <peopleandplace@arts.monash.edu.au>

ACCREDITATION OF OVERSEAS TRAINED DOCTORS: THE CONTINUING CRISIS

Bob Birrell and Andrew Schwartz

Thousands of overseas trained doctors (OTDs) are being recruited each year to practice medicine in Australia who have not had to pass a formal test of their medical knowledge or clinical skills. These include OTDs recruited on temporary entry visas to 'area of need' positions in general practice or as hospital registrars (some of whom perform specialist services), those recruited as Occupational Trainees, and OTDs who hold permanent residence visas who have been appointed to temporary positions in the public hospital system. There have been various statements from Australia's health authorities to the effect that a national assessment system will be put in place by the end of 2006. This article examines action towards this end and concludes that these promises will not be met.

This is a subject that the writers have explored on numerous occasions.[1] Why revisit the issue? The answer is that in the aftermath of the 'Dr Death' catastrophe at the Bundaberg base hospital,[2] it is all the more important that Australian patients can be confident that the medical knowledge, clinical skills and English language ability of the overseas trained doctors (OTDs) they encounter have been assessed carefully by Australian medical authorities. There have been numerous statements on the part of medical authorities that such tests should, and indeed, are about to be put in place. But have they been?

Our interest in this matter comes from various perspectives. Birrell and Hawthorne drew attention to the inadequacies of OTD assessment well before the early 2005 revelations concerning Dr Patel. They noted the incongruous situation that doctors trained in Australian universities must complete a rigorous set of curriculum and practice standards, including a full year as an intern at a training hospital, yet a growing number of temporary resident OTDs had been permitted to practice in Australia without any test of their medical knowledge or clinical skills. This is despite the fact that in recent years a high proportion of the OTDs have trained in non-Western medical schools where their education and experience is likely to be quite different from that of Australian trained doctors.

This situation came about because of a serious shortage, and maldistribution, of doctors in Australia, which OTDs are now playing a major role in alleviating. For at least the next decade there will be a continuing and perhaps increasing need to attract OTDs to Australia. The problem for the medical authorities in Australia is how to balance the urgency of the further supply of OTDs against the maintenance of the skill standards expected in Australia.

The central issue is the enormous variability of training standards in the non-Western medical training institutions from which OTDs appointed to practice in Australia are being drawn. By March 2005 1,981 medical schools were listed by the International Medical Directory as operating in 170 nations. There is very little information available on the calibre of student selection and curricula, the length of training, or the level of clinical infrastructure in many of the Asian and African sites.[3]

It is true that the OTDs coming to Australia have only been registered by the State Medical Boards on a provisional basis and can only work in specified positions detailed by their sponsor (usually the Australian medical employer). Nonetheless

these OTDs are permitted to practice and, from the point of view of Australian patients, are no different from their Australian-trained medical counterparts. Yet there are prima facie concerns about the quality of the care OTDs provide if there has been no assessment of their capacity, and if they come from a country where little is known about the standards or focus of the medical training they have received.

Schwartz has campaigned over many years on behalf of OTDs who hold permanent residence in Australia but who have not been accredited to practice in Australia because they have not completed the requirements of the Australian Medical Council (AMC). Since its establishment in 1984 the AMC has been responsible for accrediting medical training in Australia and New Zealand. The AMC also administers a test for medical knowledge and clinical skills for permanent residents with overseas medical training who wish to practice in Australia. For full registration a permanent resident OTD must satisfactorily complete these two tests as well as a one-year intern position in an Australian training hospital. Schwartz's concerns have been that permanent residents (who are often citizens of Australia) cannot practice until they have finished the accreditation process just described, yet OTDs entering Australia on a temporary resident basis have been allowed to practice without any equivalent test.

Schwartz believes that permanent resident OTDs offer a readily available potential source of supply of additional doctors that the Australian medical authorities have tended to ignore. This is indicated by the paucity of funds provided to help permanent resident OTDs complete the studies needed to pass the AMC assessment. This is despite evidence showing that, where such bridging courses have been provided, as with the program run by the Post Graduate Medical Council in Victoria, OTDs taking the courses have achieved very high pass rates in subsequent AMC examinations (over 90 per cent). There are thousands of medically qualified OTDs living in Australia as permanent residents and citizens, who wish to practice medicine but have been unable to pass the AMC accreditation examinations, often because of the costs of the required preparation. They provide a potential reserve workforce already resident in Australia and unlikely to leave. Yet Australian medical employers are spending millions recruiting OTDs on a temporary basis, most of whom will leave after a short period of service, thus requiring a further expensive recruitment cycle. The final irony is that such is the shortage of doctors, as detailed below, that hundreds of OTDs who hold permanent residence are actually working in Australian hospitals on provisional appointments without having passed, or in some cases even having begun the AMC accreditation process.

The Australian Government has responded to concerns about the growing dependence on OTDs for medical care in Australia. It has increased the number of fully funded medical places in Australian universities substantially and has permitted an increase in the number of full-fee students who can study medicine to 25 per cent of domestic intakes. However, it will be at least a decade before this increase in local training will have much effect on the shortage of doctors currently evident in Australia. As a result there will be a continuing and increasing reliance on OTDS over the next decade.

COMMITMENTS TO THE ESTABLISHMENT OF AN ASSESSMENT REGIME

There have been numerous recommendations from medical authorities and State Governments that a formal assessment procedure be established for OTDs before they

take up temporary medical positions. For example, in 2005 the Australian Rural and Remote Workforce Agencies Group (ARRWAG) noted that: 'some jurisdictions allow doctors to practice with very limited assessment of their qualifications, experience and capabilities. Worse still, doctors who are unable to practice in one part of the country will be deemed suitable to work in another'.[4] The organisation recommended that:

> The state Medical Registration Boards agree on nationally consistent criteria and processes for granting Area of Need (AoN) registration, to ensure that all OTDs granted AoN registration have a minimum level of skills and experience for rural general practice in Australia.[5]

The Council of Australian Governments (COAG) has recently announced that the Federal and State Governments will establish national accreditation and registration boards and, more particularly, establish a national process for the assessment of OTDs by December 2006.[6] The Joint Standing Committee on Migration in its September 2006 report on overseas skills recognition 'strongly supports' this action by COAG.[7]

Perhaps this is the end of the matter. However past experience suggests that it would be premature to make this judgement. In an important paper prepared for the Joint Standing Committee's Inquiry, Ian Frank, the CEO of the AMC, records some of the past history of such declarations. He notes that, in 1991, the Australian Health Ministers' conference agreed on a national standard for registration for independent practice which limited access to those who were graduates of medical schools in Australia and New Zealand and to graduates of other medical schools (including the UK) who had passed the AMC examination.[8] However each State and Territory retained the discretion to 'grant registration with conditions to individual medical practitioners, who did not meet the agreed national standards for independent practice in circumstances where it was deemed by the relevant Board to be "in the public interest"'. These circumstances included 'area of need' positions. As Frank notes, these 'area of need' numbers have exploded from 600 in 1992 to over 4000 in 2002–03.[9]

Later in the 1990s, in response to concerns about the numbers of OTDs locating in 'area of need' positions, the AMC was asked to provide advice on a national approach to the assessment of these doctors. The AMC reported to Australian Health Ministers Advisory Council in May 1996 advising that 'open processes for assessment and registration' should be established. The report was not accepted. According to Frank, the reason for the lack of support 'was due primarily to concerns about the potential negative impact of the proposed assessment process on the medical workforce'.[10]

Frank concludes on the basis of this experience that: 'Talking about nationally consistent approaches is terrific—if they are national and if they are consistent. Up to now the track record has been that we have agreed on these nationally consistent approaches but they have not been implemented in that way because everyone has taken on their discretionary provisions. … Constantly we hear from the health authorities: "It does not matter what the standard of this guy is. We need to have a doctor in that town"'.[11]

In the case of specialists, the AMC and the specialist colleges agreed in 1993 that the AMC would become the first point of contact for OTDs with specialist training. Previously, specialists had normally been required to complete the standard AMC medical knowledge and clinical skills tests. Henceforth the AMC was to act as a clearinghouse—channelling OTDs with specialist training to the relevant specialist

college for an assessment of whether their training and experience were satisfactory. The relevant specialist college would then advise the State Medical Board as to its decision and the Board would register or not register according to this advice. From 2001 there was a further agreement in which Commonwealth and State Health Authorities decided to establish an agreed pathway for OTD specialists seeking accreditation. The AMC's role was to determine the eligibility of applicants to proceed to an assessment with the relevant college. But despite this 'agreement' Frank reports that a 'significant' number of OTD specialists have been registered by the Medical Boards to practice in 'area of need' positions without lodging an assessment application with the AMC.[12]

In his oral evidence to the Joint Standing Committee, Frank estimates that those who do not lodge an assessment application make up about two-thirds of OTDs actually working as specialists.

> There is a large cohort of these people who are coming through the system and are being registered to our knowledge without anybody having assessed their skills at all. They may have done a paper review of them and that may be okay ... But if that is the case then you would think you would get them through and linked up into the fellowship programs of the colleges, so you could get them tied into the ongoing peer review or peer assessment type of programs. But they are not appearing in those areas.[13]

Frank is acknowledging what other observers have been saying for several years. Birrell and Hawthorne, for example, drew attention to this practice in the course of their study of the Australian surgical workforce in 2003.[14] They interviewed a number of senior surgeons who registered their concern about the incidence of OTDs who were appointed as hospital registrars but who were doing surgical work without any prior assessment of their skills by the Royal Australasian College of Surgeons (RACS). This was exactly the situation of Dr Patel at the Bundaberg hospital.

The 'arrangement' between the AMC and RACS regarding pathways for OTDs wishing to practice as surgeons was that RACS would provide rapid recognition where the OTDs' qualifications and experience were equivalent to those in Australia. Where it was determined that the applicant only needed 'topping up' to achieve this level, a two-year process of work and training was to be provided, after which the applicant would normally be accredited as a fellow of RACS. All other applicants were expected to complete their AMC accreditation examinations like other OTDs seeking to practice in Australia. In practice, as Frank indicates, a large but unknown number of OTDs have been appointed as hospital registrars and provide surgical services without either completing the AMC examinations, or being obliged to submit their skills to a review by RACS. A similar situation exists in other specialist areas.

WHY THE AMC HAS ITS NOSE OUT OF JOINT

It is easy to see why Frank has expressed himself so forthrightly. His organisation (the AMC) and the Australian medical education institutions that it represents has been allocated the task of ensuring that doctors practicing in Australia meet high training standards. Yet the AMC is increasingly being by-passed.

There are various categories of OTDs who are practicing in Australia without a formal assessment of their medical knowledge and clinical skills. The main group is those who enter on temporary resident visas and take up 'area of need' positions which the Australian health authorities declare cannot be filled by local doctors. This group includes OTDs

appointed to work as general practitioners and as hospital registrars where they may be doing specialist work. In the past, most of these doctors entered under a special temporary entry visa subclass 422, which catered just for OTDs. In 2003–04 there were 2,428 visas issued to primary applicants in this visa subclass, and 3,074 in 2004–05. In 2005–06, that is after the publicity surrounding the 'Dr Death' scandal, similar numbers of visas were issued.[15] In other words, the events of early 2005 at the Bundaberg Hospital and the accompanying pronouncements from health authorities that things would change, seem to have had little effect on levels of recruitment of OTDs, or on the way in which they are assessed. During 2005–06, as before, there was no requirement that the OTDs recruited undergo any formal assessment of their medical knowledge or clinical skills.

A second (though smaller) source of appointments is the stock of permanent resident OTDs who have not yet completed (or in some cases have not begun or been unable to pass) the AMC accreditation assessment. Some of these have obtained provisional appointments in 'area of need' positions as described above. A larger number, running into hundreds, are filling junior doctor positions on a provisional basis, in both metropolitan and regional hospitals. In the past these positions were mainly filled by Australian graduates after completion of their intern year, but such is the demand at the junior doctor level that major shortages have arisen. In some of the hospital systems, as in the western suburbs of Sydney and Melbourne, a third or more of the junior doctors employed, including those working in emergency departments, are being drawn from these permanent resident OTDs. Their growing role in the hospital system is a good indication of the seriousness of the doctor shortage.

A third group of OTDs consists of those who have postgraduate training or experience in general practice and who may be registered to work in designated rural general practice positions. They, too, are not required to undergo the AMC assessment. However they are supposed to complete the Fellowship of the Royal Australian College of General Practitioners (RACGP) within a two-year period. In reality some do not actually take the test, and a high percentage of those who do take it fail.[16] Table 1 indicates that the pass rate for this group (defined as the practice-eligible OTD group) has fallen from 61 per cent in 1999 to 40 per cent in 2004 (compared with 90 per cent for the Australian trainees).

Finally, there are OTDs who enter Australia on Occupational Trainee visas (visa subclass 442). These OTDs are sponsored by Australian employers to particular hospital positions, sometimes at the level of junior hospital medical officers and sometimes with specialist teams. The Department of Immigration and Multicultural Affairs (DIMA) will only issue an Occupational Trainee visa if the sponsoring employer provides a specified training program and if the respective State Medical Board agrees to register the OTD on a provisional basis. Occupational Trainees are attractive to medical employers because they can be appointed without the necessity of establishing an 'area of need' designation. They are being employed in large numbers as hospital medical officers (essentially as junior doctors in the front line of medical care) by NSW Health and Queensland Health. There were 1400 Occupational Trainees registered by the NSW Medical Board in 2004-05. Table 2 gives an indication of the diversity of the fields of medicine and countries of citizenship of those granted Occupational Trainee visas over the past four years.[17]

To repeat, the OTDs included in these four groups have bypassed the Australian medical assessment authorities specifically

set up to ensure that the doctors in question are capable of practicing at a level comparable to Australian-trained doctors. Despite this, these OTDs have been registered to practice by the State Medical Boards. These Boards are tasked to act as guardians of the quality of medical care in Australia. As indicated, DIMA will not issue an Occupational Trainee visa or a 457 visa to an OTD unless the applicant is registered by a state Medical Board.

What basis do the Medical Boards have for registering an OTD if the AMC or one of the specialist colleges have not accredited him or her? They simply accept the assurance of the sponsor that the OTD is appropriate for the job. In some instances there is a careful pre-appointment screening process. This is the case for OTDs appointed through the Rural Workforce Agency of Victoria and the Western Australian Centre for Remote and Rural Medicine. However, in many cases the appointment process falls well short of the standards applied by these agencies. Whatever the recruitment process, the Medical Boards do not second guess the employers' judgements. The Boards' examination of the medical record of OTD applicants is limited to a check of their medical credentials (with much more attention to detail since the failure of the Queensland Medical Board to discover Dr Patel's record of censure from previous employers), a requirement that applicants provide certificates of good standing with their previous employers and, since mid-2005, a mandatory requirement that applicants prove they possess professional-level English communication skills.

This is unsatisfactory. The Medical Boards' responsibilities are to ensure that people registered to provide medical care are capable of providing that care. The reality is that the Medical Boards are not in a position to make this judgement in the case of the OTDs who by-pass the AMC or RACGP. The Boards always say that they require that OTDs should practice under the supervision of doctors with full registration. Yet in many cases the OTDs they register

Table 1: RACGP examination candidates and pass rates 1999 to 2004 by eligibility category

Year	Alternative pathways program	Practice-eligible (Aus qualified)	Practice-eligible (OTD)	Training (Aus qualified)	Training (OTD)	Overall
			Numbers			
1999	0	80	86	305	77	548
2000	0	56	145	313	64	578
2001	0	70	226	333	90	719
2002	25	69	279	351	92	816
2003	33	59	386	339	114	931
2004	36	50	334	325	150	895
			Per cent			
1999	0	79	61	96	72	85
2000	0	86	64	98	83	87
2001	0	74	39	95	71	72
2002	25	87	55	96	87	79
2003	73	78	47	96	80	72
2004	58	78	40	90	63	65

Source: Royal Australian College of General Practitioners (RACGP), 2005[16]
Note: Practice-eligible includes those taking the examination while employed as GPs.
Training refers to those who are part of Australia's family medicine training program.

Table 2: Numbers of principal applicants who were doctors granted Occupational Trainee Visas 2003–04 to 2005–06 by field and proportion born in main English-speaking and other birthplaces

Country of birth	Medical practitioner	Surgeon	Specialist physician	Paediatrician	Anaesthetist	Other	Total number	Per cent of total*
United Kingdom	1034	38	1	3	3	17	1096	36
India	229	18	10	17	8	20	302	10
Malaysia	201	9	1	3	7	22	243	8
Irish Republic	125	4	0	0	0	2	131	4
China, Peoples Rep. of	85	10	5	2	1	17	120	4
Sri Lanka	112	0	0	0	0	1	113	4
Thailand	66	1	1	0	0	15	83	3
Germany (Federal Rep.)	38	6	23	4	1	9	81	3
Canada	52	7	0	0	2	4	65	2
Philippines	36	6	10	3	1	6	62	2
Singapore	44	2	0	0	4	10	60	2
Japan	44	1	0	0	1	2	48	2
South Africa, Republic of	30	1	0	0	7	5	43	1
United States of America	18	6	10	0	0	4	38	1
Saudi Arabia	24	3	1	4	1	3	36	1
Other	345	43	52	10	9	68	527	17
Total	2483	155	114	46	45	205	3048	100
Main English-speaking countries	1259	56	11	3	12	32	1373	45
Non-English-speaking countries	1224	99	103	43	33	173	1675	55
Total	2483	155	114	46	45	205	3048	100

Source: DIMA, unpublished.
Note: * Per cent of principal applicants who were doctors granted Occupational Trainee Visas

on a provisional basis serve in single-doctor towns or in small hospitals where supervision is only available sporadically.

Why have the Medical Boards accepted this situation? They are not financed by the State or Federal Governments, but rather draw their revenue from registration and related fees. The legislation establishing their authority is State-based, but generally guarantees their authority. Their reluctance to play an active role in requiring more systematic assessment of OTDs skills seems to reflect the priority that the State health authorities place on assurance of medical supply vis-à-vis assurance of standards.

A NEW NATIONAL ASSESSMENT PROCESS

The announcement from COAG, cited above, and welcomed by the Joint Committee on Migration, that a national process for the assessment of OTDs will be put in place by December 2006 might seem to resolve the matter. But this is unlikely.

There has been some progress on the mechanics of setting up a national assessment system. On 20 April 2005 the Commonwealth Department of Health and Ageing hosted a forum on the assessment of temporary resident OTDs. Subsequent to this forum a Steering Committee on the Assessment of Temporary Resident Doctors entering General Practice was established. The Steering Committee included representatives from the AMC, the Medical Boards, the Australian Medical Association (AMA), as well as various other medical interest groups, including the Australian Doctors Trained Overseas Association. Since the announcement on the part of COAG that it wishes to establish a national process to evaluate OTDs, the Steering Committee has taken on the role of recommending how this should be done. Its terms of reference, however, only cover OTDs entering general practice. There is no parallel committee looking at how other OTDS are to be assessed.

To understand the likely outcome of this limited process requires some background to COAG's intervention in the matter. The existing medical accreditation arrangements have long been in the political firing line because of their presumed contribution to shortages in the supply of doctors. These shortages have become a political hot potato as, first, regional constituencies, and then some metropolitan areas, have been beset with shortages of doctors. As these concerns have mounted so has criticism of the alleged restrictiveness of the accrediting authorities, particularly the specialist colleges. The Medical Boards, too, tend to be seen as part of the problem because of the way their rules restrict interstate movement of doctors. Even the AMC has its detractors because of its requirements that the same assessment process must be applied for all OTDs, regardless of the medical standards of the country of training. The common theme here is concern about supply. By implication, the focus on standards on the part of the existing accreditation authorities has been seen as unnecessarily inhibiting supply.

The Productivity Commission opened up the reform process by recommending that a new national accreditation agency in the health field be established. According to the Commission this agency should 'assume responsibility for the range of existing accreditation functions carried out by such bodies as the AMC, Postgraduate Medical Education councils, the Australian Dental Council, the Optometry council, and the allied health accreditation agencies'.[18]

This radical recommendation has since been taken up the Commonwealth and State Governments and has been endorsed by COAG. The announcement that there should be a national process to evaluate OTDs is consistent with this overall reform agenda. The existing role of the AMC and the specialist colleges in accrediting OTDs

is thus under the pump because it seems likely that the new national assessment authority will take over all, or some of, the functions performed by the current authorities. Since these functions are regarded by their critics as being excessively restrictive, it would be surprising if any new test to evaluate OTDs ended up being tougher than the arrangements currently in place.

So far this expectation appears to be correct. The Steering Committee on the Assessment of Temporary Resident Doctors has not made any public announcements as yet. However, it is known that the Steering Committee will build on the existing work of the AMC to develop a test of medical knowledge (in a multiple choice format) that can be administered overseas. The AMC has developed this test with its Canadian counterpart. The Canadians have a similar need for such a test because they, too, have become increasingly reliant on temporary resident OTDs. Some 2104 temporary resident specialist physicians and 822 general practitioners and family physicians were visaed in Canada in 2005. The new Australian test will be trialled in 12 international centres in November 2006[19] and should be ready for implementation by 2007.

This test could serve as a medical knowledge screening test for OTDs whom employers wish to attract to Australian 'area of need' general practice positions. The test is interchangeable with the existing Multiple Choice Question (MCQ) medical knowledge test, which the AMC already conducts in Australia as part of the overall accreditation process for permanent resident OTDs who wish to practice medicine in Australia.

There appears to be no intention to make this new test mandatory for OTDs seeking General Practice positions or for any of the other streams of OTDSs. The state health authorities represented on the Steering Committee are, for the most part, adamantly opposed to such screening for the reasons detailed above. They are worried that a mandatory test would deter many prospective OTDs from applying, because of the effort needed to pass. Other OTDs, particularly recent graduates from the UK and Ireland, will probably go to some other destination. The options for OTDs are rapidly growing. In parts of the Middle East and Africa up to 85 per cent of the medical workforce are expatriates. The UK, US, Canada and Australia have all become major 'consumers' of OTDs.

Some OTDs may take the test overseas when it becomes available because it will help them gain medical employment in Australia. But otherwise the immediate prospect is no change to the present unsatisfactory lack of mandatory testing arrangements. Worse, when the new national accrediting authority does take shape, it is likely to be charged with the task of 'reforming' the existing accrediting standards. There may well be scope for some rationalisation, such as more flexible accrediting for OTDs from countries where the family medicine and specialist practice standards are close to Australian standards.

For these to occur, the new national body should establish an office with the responsibility for assessing the standards of medical training in the countries Australia is now drawing its OTDs from. But if a new national body is charged with enhancing supply it could weaken what is left of the existing institutional support for high medical standards, namely the AMC and the specialist colleges.

So far the discussion has only related to an initial screening test for OTDs, which is limited to medical knowledge. A proper assessment system must also include an evaluation of the prospective OTDs' clinical skills. This is obviously vital for specialist areas like surgery. But if OTDs are to be thrown into the deep end of service in

hospital emergency departments or general practice in remote areas their practice skills need to be evaluated as well. This issue is yet to be resolved. There is agreement within the Steering Committee that, at a minimum, OTDs should possess skills similar to Australian graduates who have completed their intern year and one year of practical experience. However, there has been no agreement as to how to assess the relevant skills. The Steering Committee is considering trialling an orientation and assessment program for OTDs before they enter general practice. Whether this could become the basis for a new national program and, if so, whether it would be made mandatory remains to be seen. The bottom line is that there is no immediate prospect for the implementation of a nationally agreed assessment process of clinical skills.

How could this state of affairs have come to pass? The medical profession in Australia has, in the past, been a proud and vigilant custodian of medical standards and its medical turf. Yet, as this review has shown, an increasing number of OTDs are now employed in Australia from countries where Australian authorities know little about medical training standards and without any preliminary systematic testing of their capacity to meet Australian medical service standards. Why is there no outcry from the Australian medical profession? Our engagement with medical authorities indicates that many care deeply about the situation. Their silence partly reflects worries about doctor shortages and partly a reluctance to comment for fear that they will be regarded as feathering their own protected nest. Another factor is the highly fragmented nature of the medical authority structure in Australia. There are literally hundreds of medical groups engaged in the education and regulation of medical services. This makes co-ordination of any response nigh on impossible.

The State Governments are the key players in decision-making regarding OTDs. They set the recruitment priorities, and, for the most part, pay the salary bills. They continue to operate on the basis of what used to be past practice, that is, filling 'temporary' shortages by recruiting UK temporary resident OTDs. The reality is that the scale of the medical shortage in Australia, as well as the limited supply of willing UK doctors, means that there will be increasing dependence on OTDs drawn from non-Western medical settings. It may well be that most of this latter group only require an intensive bridging course before practising in Australia. But some need extensive help before dealing with Australian patients and some (like Dr Patel) are not equipped to practice medicine in Australia at all.

Despite all the public debate about the issue, there is no immediate prospect of the establishment of an assessment system which will determine which of these three categories prospective OTDs fit into. Nor does it seem that the Federal and State Governments are willing to fund a comprehensive system of bridging courses designed to integrate OTDs successfully into Australian medical practice.

References

1. B. Birrell and A. Schwartz, 'The aftermath of Dr Death: has anything changed?', *People and Place*, vol. 13, no. 3, 2005; B. Birrell and L. Hawthorne, 'Medicare plus and overseas-trained medical doctors', *People and Place*, vol. 12, no. 2, 2004
2. The details of this 'catastrophe' are explored in Birrell and Schwartz, ibid., pp. 56–57
3. J. Boutlet, J. Bede, D. McKinley and J. Norcini, 'An overview of the world's medical schools', Paper delivered at the Association for Medical Education in Europe Conference, Amsterdam, September, 2005. Cited in L. Hawthorne, *Labour Market for Migrant Professionals: Canada and Australia Compared*, Statistics Canada, Ottawa, 2006 (forthcoming)
4. Recruitment, recognition and retention of overseas trained doctors for the rural and remote medical workforce in Australia, Policy Position Paper, October 2005, ARRWAG, p. 10
5. ibid., p. 6
6. *Negotiating the maze: review of arrangements for overseas skills recognition, upgrading and licensing*, Joint Standing Committee on Migration, Parliament of the Commonwealth of Australia, September 2005, p. 124
7. ibid.
8. AMC, Submission to the House of Representatives Joint Standing Committee on Migration, 2006, p. 5
9. ibid.
10. ibid., p. 7
11. Ian Frank, Transcript of Evidence 24 May 2006, p. 11, quoted in *Negotiating the Maze*, op cit, p. 124
12. ibid., p. 9
13. *Negotiating the maze*, op. cit., p. 123
14. B. Birrell, L. Hawthorne and V. Rapson, *The Outlook for Surgical Services in Australasia*, Royal Australasian College of Surgeons, Melbourne, 2003
15. It is difficult to provide comparable figures for 2005–06 as DIMA ceased issuing visa subclass 422 visas in that year. Doctors seeking a temporary entry (other than as Occupational Trainees) were required to use the business long stay 457 visa subclass. DIMA has also encouraged OTDs intending to come to Australia to come as Occupational Trainees under the 457 visa subclass. These OTDs were previously visaed under the Occupational Traineed (442 visa subclass). No final figures for these various groups of OTDs visaed under the 457 visa were available at the time of writing.
16. A. Jasper et al., 'The RACGP examination', *Australian Family Physician*, vol. 34, no. 11, November 2005, pp. 967–969
17. Occupational Trainees visaed under the 457 visa subclass in 2005–06 have not been included in this table.
18. Productivity Commission Position Paper, *Australia's health workforce*, Productivity Commission, 2005, p. XLV
19. AMC Media Release, 'New Screening Process for International Medical Graduates', 17 August 2006