Submission No. 134
(Overseas Trained Doctors)
Date: 30/03/2011

The Secretary
Inquiry into Overseas Trained Doctors

A OC.

I have already contributed to the ADTOA submission but I now feel, especially after hearing from some doctors, that I would like to make a separate submission. I have worked on this issue in various capacities for the past 30 years—as an academic researcher, as a NSW public servant at the former Ethnic Affairs Commission and Director of Research at the Human Rights and Equal Opportunity Commission, and on various inquiries and consultancy projects. I have also worked as an informal advocate and supporter for many OTDs who have come to me and as an advisor to the ADTOA.

I have no personal involvement in this issue but have a concern for social justice and human rights. This is what has motivated me over the years.

My comments refer mostly to TOR (3)

1. Australia has a long history of discriminating against many OTDs and I am inserting a section from a paper that I recently published[1], where this is summarised. The purpose of including this section is to show that the pattern of assessment and registration has developed in an ad hoc, uncoordinated and at times discriminatory fashion.

> *Nine overseas-trained doctors (OTDs) arrived with the First Fleet and since the first medical schools were not established till after 1868, most doctors up till the beginning of the twentieth century were overseas-trained (mostly in the UK and Ireland). Some of these early doctors had no or dubious medical training and, according to a former medical practitioner Emeritus Professor Max Kamien, in a talk that he gave to the Australian Medical Association (AMA) in 2006, the traditional established aboriginal doctors (mabangs) 'could well have been critical of the OTDs' clinical practices of blood-letting, purging and restraining, which were often ineffective and sometimes dangerous'.*
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> *During World War 1, 'Widespread anti-German feeling ... affected Australian doctors and fanned their innate xenophobic prejudice and intolerance of medical outsiders, especially if they threatened their medical turf' (Kamien, 2006). The influx of Jewish refugee doctors in the 1930s, from Germany, Austria, Russia and Poland, marked the beginning of OTDs' difficulties in gaining registration. They were denied registration and required to undertake at least three years further training at medical schools in Australia.*
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> *By 1938 there were only four medical schools in Australia and 'public debate about the shortage of medical practitioners was vigorous' (Committee for the Review of Practices for the Employment of Medical Practitioners in the NSW Health System, 1998: 34). One outcome was an amendment in 1955 to the 1938 NSW Medical Practitioners Act to enable selected foreign doctors (mostly from other Commonwealth countries) to gain temporary registration to practise medicine in specified institutions and locations for 12 months in NSW (all states operated separately). After five years of temporary registration they could gain full registration. A further amendment in 1957 gave the NSW Health Minister the authority to enable more doctors to take up temporary registration, as it was felt that the intentions of the Act were being frustrated by the NSW Medical Registration Board and others.*

[1] 'Luring Overseas Trained Doctors to Australia: Issues of Training, Regulating and Trading', *International Migration*, 47(4): 31-65.

The AMA reacted to the amendments with a public campaign to discredit foreign doctors, referring to them as 'quacks' and 'charlatans' and as 'possessed of what may be termed eastern European standards of ethics' (Iredale, 1987: 123). Kamien (2006: 3) states that:

The all powerful, British Medical Association (i.e. the AMA), did not want them. eg. The NSW Branch of the BMA convinced the Premier of NSW, B S Stevens, to write to the PM pointing out that "Alien and Refugee Doctors posed an unacceptable competition to Australian doctors who had the highest standards of medical practice in the world."

In Queensland Sir Raphael Cilento, Director-General of Health and Medical Services in the 1950s, stated:

The Britisher is an individualist... the Jew has two thousand years of servility behind him. If refugee doctors were permitted to go taking jobs along the Queensland coast, they would create the same situation that caused them to be thrown out of Germany and Austria. (Kamien, 2006: 3)

Many foreign doctors entering at this time were Displaced Person (DP) doctors who arrived soon after World War II from Latvia, Estonia, etc. They were mostly specialists and Australian GPs felt threatened by them.

Though labelled incompetent, unethical and dangerous, the DP doctors were allowed to work in areas where work was arduous and financial rewards were meagre. There were no Australian Medical Association objections against a handful of outback appointments. They were also allowed to serve as medical officers in the Australian Antarctic Stations and in Papua New Guinea ... '. (Kunz, 1988: 191)

Discriminatory treatment towards DP doctors applied in a wide range of policies and institutions. Sydney University was notorious. It took 'refugee doctors' for retraining but right up till 1974 it only allowed eight to graduate each year. If more qualified, a ballot was held. In his talk to the AMA, Kamien (2006: 6) stated:

Those of you who are hearing this story for the first time, will probably be incredulous that, in the country which defines itself as giving everyone a "fair go", Australian doctors could treat other doctors in such a mean spirited, unbrotherly and by our PM's [John Howard's] definition, un-Australian way.

Kamien (2006: 9-11) lays the blame squarely at the feet of the AMA, formerly the British Medical Association (BMA).

The BMA/AMA was then even more of a Trade Union than it is now. It was a powerful and influential, pressure group with enough clout to cow and defy governments. Its members were found in government, state health departments, state medical boards and on university senates. Its leaders were, xenophobic, protectionist and isolationist. They were in the words of George Bernard Shaw, "Patriotic in the conviction that their country was superior to all other countries because they were born in it".

... At a time of scarcity of doctors in Hospitals, Health Departments, Medical Faculties and in Rural areas, the AMA was more interested in preserving the turf of its members, than providing greater access to the health care of the Australian public and to 70,000

migrants coming to Australia each year and who craved the security of consulting a culturally attuned doctor in their own language.

The treatment of the pre and post-war medical practitioners was not the AMA's finest hour, nor one of Australia's better immigration achievements. For those two decades the AMA became part of that xenophobic dark heart which periodically rises to the surface of our Australian politic.

Nevertheless, further liberalisations in the handling of OTDs occurred in the 1960s in various states/territories, as there were ongoing shortages (especially in particular geographic areas). The number of medical practitioners arriving in Australia increased. Training places also increased after 1971 but by the mid-1970s fears of an oversupply were emerging. The AMA began to lobby the government to limit both training numbers and the immigration of doctors.

A national examination was instigated in 1978, under the auspices of the Australian Medical Examining Council (AMEC) and then under the Australian Medical Council (AMC), as a means of assessing most OTDs (GPs and specialists). Individual state registration boards continued to waive the examination for people with 'automatically recognisable qualifications' (both undergraduate and specialist qualifications) — which included qualifications from up to 20 countries (the major English speaking countries as well as countries such as Pakistan, Puerto Rico, Lebanon, Uganda and India) (Iredale, 1987: 124). NSW had the longest list of 19 countries whose qualifications were automatically recognisable. In 1981, in a reversion to the restrictions of the 1950s, the NSW 1938 Act was amended again to make the AMEC examinations the sole pathway to registration for permanently resident OTDs without 'automatically registrable qualifications' — only three countries were automatically registrable by then (UK, Ireland and NZ). The only country now is New Zealand.

The AMEC/AMC examination consisted of three parts: an English language test, a multiple choice question (MCQ) test and a clinical test. The chairman of the Examination Committee of the AMC, Emeritus Professor Ralph Blackett, published a Medical Journal of Australia article on the AMC Examination performance of 1,703 foreign medical graduates between 1978-89. Their overall pass rate was 36.8% with the highest pass rate being for graduates from South Africa, Canada and USA. Only 12% of candidates passed all sections of the examination the first time around. This pass rate was about half that of the equivalent examinations held by bodies in the United States and the United Kingdom and about one third of that in Canada (Kamien, 2006: 13).

Numerous criticisms of the AMC exams concerning bias, lack of adequate preparation and bridging courses, cost of the exams, restrictions on the number of attempts, inappropriateness of the exam for specialists, etc were voiced. But 'Blackett explained the poor examination results as due to difficulties with English, the increased age of the candidates, poor undergraduate training in basic sciences and clinical methods and a lack of substantial postgraduate experience' (Kamien, 2006: 13). The NSW Committee for Review of Employment (1998) subsequently found that there were significant differences in the way Australian medical students and AMC candidates were treated and this limited the latter's chances of reaching the required standard and access to employment. The Committee recommended (1998: 158) that 'to ensure procedural fairness and to avoid complaints of discrimination, the Australian Medical Council examinations be based on a clearly articulated curriculum'. This Committee also recommended the adoption of a nationally accredited bridging program for

permanently resident OTDs on the grounds that while the benchmark for AMC candidates was recent Australian graduates, there were few similarities between 'the two groups in terms of the level of assistance they are given to prepare for examinations' (1998: 134).

However, at the time the AMA complained of too many OTDs coming into Australia and the 'Doherty' Report led to a reduction in the medical student intake from 1450 to 1100 per year, and a reduction in the RACGP intake by 33% (Committee of Inquiry into Medical Education and the Medical Workforce, 1988). Fears of competition and over-servicing in metropolitan areas and a Medicare blowout abounded.

The OTDs rejected the Blackett and AMA positions and accused them of racism and stereotyped views leading to a closed-shop mentality. To this they added a charge of muddle headed reasoning through confusing recognition of qualifications with work force need. Other reports, such as those of the Fry Committee (1982), the National Population Council (1988), the NSW Committee of Inquiry (1989) and the Human Rights and Equal Opportunity Commission (1991) echoed many of these sentiments. The Australian Doctors' Trained Overseas Association (ADTOA) also levelled 'a charge of hypocrisy at the licensing bodies for actively recruiting unassessed temporary doctors to fill areas of need positions but not using permanent resident overseas trained doctors from the same countries' (Kamien, 2006: 13).

The stated intention of the examination was to test for standards but the unstated intention was to limit the number of OTDs entering the Australian medical workforce. Thus, a test of standards coincided with concerns about over-supply. This became most explicit in 1992 when the Health Minister's Conference 'voted for the implementation of three strategies to restrict the supply of overseas trained medical practitioners entering the temporary or permanent labour market in Australia' (Iredale and Gluck, 1993: 20). The AMA strongly believed that 'an attempt must be made to deal with the problem [of oversupply] by restricting overseas trained doctors, first, before there is any reduction in medical school numbers' (Iredale and Gluck, 1993: 23).

The first strategy was a quota system to restrict the number of OTDs eligible to proceed to registration each year from the AMC exams, even if they passed the AMC exams. The quota was set at 200 and of this number 100 places were preserved for NZ trained doctors, leaving 100 for the rest. The quota system eventually led to a discrimination complaint in the Human Rights and Equal Opportunity Commission and, though the complainant Dr Siddiqui, was unsuccessful, the quota system was abolished in the mid-1990s.

The second strategy was a review of the points system and subsequently 10 (later 25) points were deducted from the point scores of OTDs applying to migrate to Australia.

The third strategy was the proposed abolition of temporary work visas for OTDs but this was replaced by a 'proposal to phase out temporary overseas recruitment over the next five years' (Iredale and Gluck, 1993: 21). This never eventuated and medical migration increased, especially of temporaries. The nationally accredited bridging program proposed in NSW was never taken up though some states do offer individual programs to some permanent OTDs.

2. In spite of previous inquiries and reviews, the situation has not improved much in the last 20 years. There was a time around 2004-06 when I thought that the provision of temporary registration to large numbers of OTDs was going to provide a breakthrough. It did for a time and I know some permanent resident doctors who had been unemployed for up to 15 years, and they were lucky enough to be able to take advantage of this opportunity to gain temporary or even permanent registration. They were hired in Areas of Need - some were GPs and other were specialists who were in desperate shortage (ENT specialists, psychiatrists, etc).

3. The opportunity existed at this time to move to a situation where doctors who had been temporarily registered for some period (3 years or so) could then move fairly seamlessly to permanent registration. A spokesperson for the NSW MRB told me privately that this was what he thought would happen. It did not, however, and now that the registration process has been nationalised, there is no longer scope for states to use mechanisms that were available to them to offer registration. During this period, some MRBs provided permanent registration to some doctors who had passed no AMC exams — they relied on their own assessment methods.

4. This method advantaged those who were willing to work in AoN positions or where there was a specialist shortage. It relied on a period of 'supervised' (or often unsupervised} practice as means of assessing competence. This method of using supervised practice was used in the 1970s, until the AMEC and AMC examinations came in. It could have been generalised to provide a pathway to permanent registration for all doctors.

5. When examinations were introduced, it was presumed that they would be a more 'objective' mechanism of assessment. They are far from this - as I have described in many publications.[2] In fact, they are an unfair test: they test often-outdated knowledge; no local experience is provided before sitting the test to become familiar with local conditions, terminology, practices, etc; they are a speed test that favours those from ESB; the clinicals have been criticised for being very subjective and so the list goes on. Many complaints over the years have led to some improvements but the failure rate among perfectly competent doctors, such as Dr Galak who has made a submission to this Inquiry, must tell the committee that there is an intrinsic problem with the AMC exams.

6. The AMC exams are an example of systemic discrimination where certain ethnic /linguistic (NESB) groups do not achieve pass rates comparable to ESB groups. In the US, this would require the tester (i.e. AMC) to prove that their examinations are not discriminatory. In Australia, however, differential rates are attributed to the lesser knowledge and skills of certain candidates.

7. The same comment applies to the pass/acceptance rates of the specialist colleges. A number of complaints to the Human Rights and Equal Opportunity Commission in the late 1980s led to the then Race Discrimination Commissioner, Ms Irene Moss, instigating an inquiry into a number of these complaints in the light of the Racial Discrimination Act 1975.[3] The report found evidence of possible discrimination under the Act, mostly in relation to specialist colleges.

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[2] *New Assessment Procedures for Overseas Trained Medical Practitioners in Australia*, 1990 Centre for Multicultural Studies, University of Wollongong, Occasional Paper No. 24.

[3] Human Rights and Equal Opportunity Commission 1991 *The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975*, Sydney: HREOC.

8. The specialist colleges operate more or less independently. I made a submission to the ACCC, on behalf of the ADTOA, in relation to the anti-competitive practices of the RACS. This, 'The struggle for justice for overseas-trained doctors', is still available on the ACCC and other (http://www.bmartin.cc/dissent/documents/Iredale.html) websites. The ACCC Inquiry has had no obvious positive results.

9. I personally know of many cases of highly qualified overseas trained specialists who have not been able to become members of the specialist colleges. I will highlight five but the list is very long.

    Case 1: German orthopedic and emergency specialist in NSW was denied entry, even after appeal, but eventually was offered a two-year 'training position'. She turned it down as she did not want to belong to a 'group that had treated her the way that they did'. Became an alternate therapist.

    Case 2: Another German ENT specialist (Professor in Germany) in Queensland took 20 years to get his qualifications accepted by the college. This was in spite of a lot of professional support from his colleagues at hospitals where he 'volunteered'. A few years after he gained membership, he denied of leukemia.

    Case 3: A Chinese hand surgeon who had worked at an international hospital in the US. He eventually gained specialist college membership after the 1997 NSW Hunger Strike brought his case to the public attention and he underwent supervised practice. He had formerly worked on temporary registration throughout Australia but lost his access to this registration when he married an Australian and became a permanent resident.

    Case 4: An Indian cardiologist who also gained membership after the NSW Hunger Strike. He had been excluded for many years and had appealed, without success. He continued to travel and work overseas in first class hospitals. After media attention he was invited to the College in Melbourne, given a cup of tea and told he could become a member of the Royal College.

    Case 5: A South African woman who had studied and worked in Canada was offered a job at a Sydney University. She was expected to practice part-time and so applied for membership of her college. She was rejected and her appeal failed. The reason given was not to do with content of her training but the 'timing of one of her examinations'. It was apparently held at a different time in Australia. She gave up her job offer and her attempt to migrate.

10. Access to the medical workforce in Australia is still largely in the hands of the medical profession itself. This nexus needs to be broken or at least loosened. I would recommend that:

    (a) 'supervised practice' become an avenue to registration for those GPs who can demonstrate appropriate training and experience;
    (b) assessment of overseas-trained specialists is taken out of the hands of the colleges and some other mechanism be developed. The *NSW Race to Qualify* report proposed that NSW Health departments train specialists to help overcome the artificially-induced shortages. If this were to happen they could also handle assessment, with the involvement of universities.

I would be very happy to appear before the Committee as an Expert Witness and I look forward to this opportunity. I believe that I bring an independent and international perspective as a result of my wide experience. For example, I am currently in Manila on an EU project on the movement of natural persons (MNPs) and mutual recognition arrangements (MRAs).

I am available other than during the following periods: 6-12 April and 1 May to 20 June.

Yours sincerely,

Dr Robyn Iredale,
Adjunct Associate Professor,
Australian Demographic and Social Research Institute
ANU, ACT

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