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Factors in the non-recognition of overseas qualifications: The case of medical practitioners

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**FACTORS IN THE NON-RECOGNITION OF OVERSEAS
QUALIFICATIONS : THE CASE OF MEDICAL PRACTITIONERS**

BY

**Christine V. Farag. Bachelor of Arts. Aboriginal &
Intercultural Studies: Honours student**

**A Thesis Submitted in Partial Fulfilment of the
Requirements for the Award of**

**Bachelor of Arts, Aboriginal & Intercultural Studies (Honours)
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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

ABSTRACT

The overseas qualified doctor is a potential threat to the state-sanctioned control practising doctors have over medical knowledge in Australia. The non-recognition of qualifications of many migrant and refugee doctors, in particular from non-English speaking background (NESB) countries, presses them into a subordinate relationship to that of registered practitioners. The ownership of medical knowledge is limited to state-recognised practitioners, thus allowing them to maintain significant economic and social advantage within the general community.

The relationship between qualified practitioners and the state is indicative of a particular dynamic in which some individuals are able to exclude others by mechanisms of social closure from membership of, or entry to, positions of relative status and economic advantage. Each state in Australia has different restrictions as to who are to be excluded. Currently in Australia, the relationship between registered practitioners and the state from which they receive legitimacy may be described by the 'professional administrative' model in which the medical profession maintain control over entry into their domain. This is in contradistinction to the 'national health' model where medical practice plays an important, but not a dominant role.

The difficulties many migrant doctors face in gaining recognition is indicative of the tension between these two models. The issue is not one of medical practice, but one of control over administration. This thesis examines the tension and the underlying ideological and philosophical bases of these two models, in the light of data related to non-recognition of qualifications of overseas trained practitioners and concludes that the mechanisms of the process outlined must be resisted in the interests of the health and well-being of a multicultural community.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signature

Date

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LIST OF ACRONYMS

AHMC	Australian Health Ministers' Conference
AMA	Australian Medical Association
AMC	Australian Medical Council
AMEC	Australian Medical Examining Council
APFM	Australian Postgraduate Federation in Medicine
CAAIP	Committee to Advise on Australia's Immigration Policies
COPQ	Council for Overseas Professional Qualifications
CPI	Consumer Price Index
DILGEA	Department of Immigration, Local Government and Ethnic Affairs
DP	Displaced Person
ECFMG	Educational Council for Foreign Medical Graduates
ENS	Employer nomination scheme
ESB	English-speaking background
DEET	Department of Education, Employment and Training
FRACGP	Fellow of the Royal Australian College of General Practitioners
IRO	International Refugee Organization
GDP	Gross Domestic Product
GMC	General Medical Council
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCQ	Multiple Choice Questions
MWDRC	Medical Workforce Data Review Committee

NACSR	National Advisory Committee for Skills Recognition
NCHO	National Council of Health Organizations
NESB	Non-English speaking background
NOOSR	National Office of Overseas Skills Recognition
NSQAC	National Specialist Qualification Advisory Committee
OMA	Office of Multicultural Affairs
OCS	Occupations in demand
OTD	Overseas trained doctor
PLAB	Professional and Linguistic Assessment Board
PMP	Patient Management Problems
RACGP	Royal Australian College of General Practitioners
RMO	Resident Medical Officer
ROMAMPAS	Review of Migrant and Multicultural Programs and services

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CHAPTER ONE

INTRODUCTION

Medical knowledge in Australia is controlled by an elite of medical practitioners. Access to medical care, either through public or private health care systems, depends on the concurrence of this elite in the definition of appropriate treatment and the administration of the system. Entry to this elite is restricted by agreement with government and largely determined and controlled by the elite. The monetary rewards gained by this elite are considerable, as are their status rewards.

In this thesis I will argue that the control this elite has over structures of medical care in Australia reflect an implicit pattern of social closure¹ that operates at an informal, personalised and culturally specific level. I will illustrate this process in action by reference to the case of the non-recognition of the medical qualifications of overseas trained doctors (OTDs).

OTDs wishing to migrate to Australia from non-English speaking background (NESB) countries face formidable barriers in achieving recognition of their qualifications. At present, most State Medical Boards accept as registrable the qualifications of those coming from the United Kingdom, Ireland and New Zealand. Tasmania is the only state which also accepts qualifications from South Africa and Canada. Since 1987, New South Wales only accepts Australian and New Zealand qualifications. All other OTDs of both English speaking background (ESB) and non-English speaking backgrounds (NESB) must pass examinations set by the Australian Medical Council (AMC). Many never achieve their goal, but success rates are predominantly better for ESB candidates. For example, for the

42.7% compared to the NESB average of between 27.1% to 15.4%. Especially noteworthy is the fact that those from India and Sri Lanka where English is one of the national languages had an average pass rate of only 29.6% for the same period (Blacket 1990, pp.125-126). Added to this is the fact that there is a disproportionate number of OTDs that never succeed. OTDs that enter Australia under temporary visas, generally from ESB countries, are allowed to apply for temporary registration while those granted permanent resident status are in most cases unable to seek such temporary registration.

These facts taken together suggest the possibility that NESB OTDs are either poorly trained in their country of origin, or unable to practise in Australia due to their lack of command of English. This thesis will examine this and reject this possibility, and further, explore alternative reasons for the non-acceptance of OTDs by the Australian medical profession.

I will argue that NESB migrants experience structures of discrimination that are not subject to legislation since they are structures of informality and cultural bias. I will argue that these structures reflect the cultural inheritance of those who currently dominate the system; that the judgements they make are not objective, but are constrained by a range of subjective factors², among which is the desire to maintain the ethnic orientation of their own comprehensible social reality, to maintain the social status of their elite, and to maintain the high levels of financial rewards achieved through the structure of medical practice in Australia.

The result of recent policies will be that the Australian medical profession will remain an elitist group whose increased period of training will not only cost the community more, but by virtue of their increased status, they will become increasingly able to demand more remuneration for their services and wield more power in the political sphere. This is clearly not in the interest of the Australian community, yet it has been supported by successive Australian governments. The

opposition between the dominant approach to medical practice and community medicine will also be examined in this thesis as it is by the control of the definition of 'good medical practice' that the profession guards itself against NESB OTDs and prevails by subverting government policy on structural reforms.

A more liberal approach to the entry of NESB OTDs threatens a loss of control over the practise of medicine itself. The power medical practitioners have, therefore, lies in the degree to which the consumer accepts the authenticity of their definition of medical knowledge and therefore their control over its methods of delivery. This power also relies on the Australian Medical Association's (AMA) ability to politically represent the interests of groups of practitioners in different market positions, often with diverse ideological and philosophical orientations (Daniel 1990, pp. 90-92). There is also a reliance on informal networks which cut across different spheres of the structural systems, for example, education, media, politics, bureaucracies, business (Australian Medical Association 1991, p.4). The media also helps to construct a social reality maintaining an "ideology of expertise" ... "that the doctor and the doctor alone knows best" (Willis 1989, p. 220).

The freedom of choice in the health sphere is limited to what is paid by Medicare, what is reimbursable by private health insurance and consequently what is defined as "medical" by medical practitioners. Those who define "medical knowledge" also control who should enter its domain. I will argue that at the level of health care financing there are two approaches to medical care :

- 1) The professional administrative model which has its traditional emphasis on diagnosis, treatment and clinical care, but is now being widened to include primary health care.

- 2) The national health model which embodies social as well as biomedical models of health, but does not necessarily place the biomedical paradigm as dominant in the control of administration.

These two models operate at the political level and engulf two different philosophies towards the provision of health and social welfare. One philosophy has its emphasis on treating sick people which is more of a 'blame the victim' orientation and encompasses the entrepreneurial/philanthropic nature of medical practice. The other believes that sickness and degeneration can be prevented by improving environmental and other factors which are beyond the individual's control. Empowerment of the individual is the key to preventing sickness and disease. These approaches are derived respectively from the residual philosophy of Locke and the institutional philosophy of Hobbes.

The residual model operates on the notion that intervention by the state or the public sector should only occur as a last resort, that is when other support systems, such as the family or the market have been ineffectual (Graycar 1977 cited in Gardner 1989a, p.164). Within this model there is a focus on individual responsibility for finding employment and paying health insurance from private funds. Responsibility of the state is for the "residual groups" or disadvantaged sectors, for example pensioner groups, the unemployed, and single parents. This assistance is usually in the form of an indexed income and some other relief, such as rebates on certain services (Gardner 1989a, pp. 164- 165).

The institutional approach recognises that inequality is structural and permanent, therefore provision must be institutionalised. As individuals are influenced by their environment, change is focussed at community level rather than on the individual. Socially effective means of health delivery and funding are the responsibility of the community (ibid, pp. 164 - 165).

While these philosophies are polarised and various stances would be taken across the political spectrum, their reflection in policy objectives and ideology can be discerned from statements on health care. For example, the Labor party platform parallels ill-health with "occupational and physical environment and socioeconomic circumstances" (Australian Labor Party 1986 cited in Gardner 1989a, p.161). The Australian Medical Association (AMA) is more aligned with Liberal party philosophy of individual enterprise (Gardner 1989a, p.152). However, other medical practitioners, such as the Doctors' Reform Society, who are mainly employed in the public sector, may be more aligned with governments in their philosophy on health care (Daniel 1990, p. 87).

Although there are conflicting philosophies about the delivery of health care, there is overwhelming consensus about which Australian citizens will be allowed to practise medicine in this country. Economic efficiency, reorganization and curtailment of health care expenditure is at the expense of socially progressive reforms for access and equity for all. It is argued that these actions must be measured against Rawls' (1978) principles of justice and fairness :

- * Each person is to have an equal right to the greatest liberty, compatible with a similar liberty for others.
- * Social and economic inequalities should be arranged so that they are (i) reasonably expected to be to everyone's advantage and (ii) attached to positions and offices open to all (cited in Sax 1990, pp.146-147).

In 1987, medical practitioners in Australia earned seven times the average industrial wage. This compares with their counterparts in the United Kingdom and Sweden whose earnings were three times greater (Iredale 1987, p.116). In the six-year period 1984 to 1990, benefits paid by Medicare for general practitioner services rose by 90% per head of population, whereas the Gross Domestic Product (GDP) rose by only 73% per capita for the same period (Douglas et al. 1992,

pp.29-30). Yet, as this thesis will show, the medical profession has managed to negotiate a package of beneficial measures as well as quotas on OTDs on the basis of a perceived 'oversupply' of medical practitioners.

Despite a decade of reports and enquiries, the position in 1992 is that there is now considered to be an oversupply of doctors in Australia and a quota system will be instituted to commence from 1 January 1993 to limit the number of new doctors to 200 a year and end reciprocal arrangements, except with New Zealand. While there are varying opinions of the accuracies of projections, there is general agreement that a geographic maldistribution and shortage especially in rural areas exists, while there is an over-abundance of medical practitioners in the more densely populated urban areas. At the same time, some OTDs have finally been assisted by State initiatives with improved access to bridging courses, with resultant increased pass rates in Australian Medical Council (AMC) exams.

This thesis will show that the rationale behind imposing a quota on OTDs is not in keeping with principles of social justice and equity to all Australian residents in this country. The government is concerned primarily with Medicare expenditure and medical practitioners are concerned with infringement on private practice, but most OTDs initially spend two or three years in the public sector. In addition, despite claims to the contrary, many are prepared to work in areas of need. It is irrational to bring in numbers of temporary doctors, while OTDs in Australia are relegated to the ranks of the unemployed. Arguments that these doctors are "mismatched" to the major national immigrant groups will be refuted.

New requirements for general practitioner practice will place restrictions on both local graduates and OTDs preventing them immediately entering private practice. In any case, research shows that most new OTD doctors spend two or

three years in the hospital system acquainting themselves with Australian medical practices. At the same time, current policy initiatives for changes in general practitioner workforce distribution will not have immediate results. It will be argued that OTDs have not been shown the same considerations as Australian medical practitioners in concerns about deskilling, but have been victims of discrimination.

It will be further argued that ethnicity is a public construct and that Australia has an obligation to those medical practitioners who were recruited from overseas on a non-discriminatory basis as professionals and were accepted for resident status on that basis. The NESB proportion of OTDs constitutes 9% of the general practitioner population and 7.6% of psychiatrists (Committee of Inquiry 1988, p.533). Therefore, Australia is not sufficiently represented by adult medical practitioners who have the experience, cultural sensitivity and knowledge to not only service their own national groups but those of other cultures, as some OTDs are also multilingual. In addition, they will enrich Australian medical practice by making it an international instead of a monocultural community if their expertise is acknowledged. It will be emphasised that bilingual does not necessarily mean bicultural. While Australian students of different cultural backgrounds may choose to service their own communities, they will not necessarily have the same "ethnic" consciousness as their parents. Socialisation is a life-long process and education, especially the intensiveness of a six-year medical course, will generally instil many of the norms, values and behaviour of many in the Australian medical community and wider society which place individual achievement and success before community-consciousness.

The control practitioners have over the definition of "medical" and access to medical knowledge is an explicit act of closure that is indicative of implicit

structures of discrimination against overseas trained practitioners (OTDs). These structures are informal, individualised and based on personality, yet rendered 'natural' by ideology.

Until such time as dominant societal values change so that the value of non Anglo-Celtic cultural groups is not discounted by culturally-biased measures of quality, the principle of equity will remain at the level of rhetoric. It is not government policies that can change the structures, it is individuals, personalities and informal networks who silently help to maintain the status quo. The non-recognition of overseas qualifications of medical practitioners is a case in point.

Methodology

The questions being investigated are, therefore : do the medical elite in Australia maintain a social and economic advantage over overseas trained doctors (OTDs), especially those from NESB countries and, if so, for what reasons? Essentially, this lends itself to qualitative research, the term "qualitative" being used

to describe the nature of the answers in terms of their descriptive nature: the who, which, what, when, where and why - in contrast to quantitative answers addressing the "how many" (Wadsworth 1987, p. 85).

Table 1 may serve as a guide to understanding the paradigm, method, methodology and expected result underlying the process of data collection and analysis for this thesis. As Miles & Huberman (1984) and others point out, sometimes there appears to be confusion in attaching stereotyped associations to qualitative research as being an epistemological stance, rather than an approach. In this instance, the approach and the ontological stance are one and the same. As depicted in Table 1 below, the paradigm is naturalistic (or qualitative-phenomenological). The axiomatic base is relativistic and holistic. The method is a case-study approach; it is expansionist at the outset and does not place any

priori constraints on either antecedent conditions or outcome. Inductive logic is applied: facts are used to build theory.

Table 1

Conceptualisation of Data Collection and Analysis

<u>Paradigm</u>	<u>Method</u>	<u>Methodology</u>	<u>Description</u>
Naturalistic (qualitative phenomonological) - Relativistic - Holistic	Case Study - group study - cultural and descriptive - inductive logic - No <i>a priori</i> constraints on antecedent conditions or outcome - Facts used to build theory - Expansionist	- Data collection academic texts, reports, inquiries - Focussed interviews - Key informant interviews - Observation - Verbal and non- behaviour - Peer reviews	Emphasis on in-depth analysis - "thick" description. - Latent content addressed, ideological and philosophical bases. - Final analysis reductionist: draws conclusions.

In the final analysis, worthwhile research is credible (Giarellie 1988, Le Comte & Goetz 1984). Giarellie (1988, pp. 25-26) states :

All of the formal epistemological distinctions between quantitative and qualitative inquiry are dissolved in the search for ways of explaining, understanding and promoting those activities which will advance our most basic social and moral aims and the standards of excellence that are appropriate to these activities.

Research for this thesis has been conducted in the following areas in order to triangulate the information collected :

- * Library-based research;
- * Survey of relevant organizations;
- * Interviews and key informant interviews.

Library-based research generated the following secondary documents. These consisted of academic texts, reports, government inquiries and articles from medical journals. There were a number of areas researched. The first of these was regarding the non-recognition of qualifications directly relating to overseas trained doctors (OTDs). For example, the most comprehensive Commonwealth government inquiry, was conducted by the Fry Committee (1983). Medical workforce documentation, which included reference to OTDs was also examined, the main Commonwealth inquiry in this area being conducted by the Doherty Committee (1988). More generally, literature on the non-recognition of overseas qualifications was reviewed. This included historical documents, such as the Immigration Advisory Council (1973), Inquiry into the Departure of Settlers. The contemporary reform processes for new directions in assessing the competency of overseas-trained persons began with a documented speech by Dawkins (1989), the Federal Minister for Employment Education and Training. Since then, a progress report has been published detailing achievements.

Literature regarding health care administration, the politics of health and statutory regulation of licensing bodies were also examined. Dewdney (1972) served as a historical text, while Carter (1987), Crichton (1990), Gardner (1989) and Sax (1990) were core texts in these areas.

It was necessary to review the Australian literature on immigration, ethnicity and multiculturalism. Two main inquiries were conducted in the 1980's, one being the Committee of Review of Migrant and Multicultural Programs and Services

(ROMAMPAS), (Jupp 1986). The other was the Committee to Advise on Australia's Immigration Programs (CAAIP), (Fitzgerald 1988). This then led to material regarding the economics of migration. The Centre for Economic Studies has produced conference proceedings held in 1987 on this subject. Other papers, also emanating from this source, were discussion papers of labour market analyses of comparisons between ESB and NESB groups.

More general and theoretical reading included sociological texts relating to medical power and professional dominance, social closure, class, power and status, health and social welfare, gender issues in the division of labour of health and bureaucratic administration. Finally, international literature regarding medical competency and primary health care programs was examined. These were documents published by the World Health Organization, Geneva.

Primary documents were generated from the survey of organizations and through one of my key informants. The survey consisted of a letter to the Australian Medical Association, the Australian Medical Council, the Centre for Multicultural Studies, the Centre for Economic Studies, the Human Rights Commission and the Federal Minister for Health, Housing and Community Services. The resulting documentation from these inquiries included a Human Rights Commission Report (1991), a Medical Workforce Data Review Committee (MWDRC) report (1992), the Australian Health Ministers' Conference (AHMC) (1992) extract of minutes and a statement by the AMA and the Deans of Medical Colleges regarding OTDs. Also received was personal correspondence on behalf of Howe, the Federal Minister for Health, Housing and Community Services giving the government's reasons behind new policies on medical migration and a submission prepared by the Centre of Multicultural studies, Wollongong, on behalf of the Women's Advisory Council to the New South Wales Fry Committee (1989).

People have been responsive and I was more than pleased at the replies received to my requests. The AMC was the only organization which did not respond. Most of the primary data was in the form of unpublished raw data not available through the library system.

It was not my intention at the outset to conduct many interviews because the research had been planned to be primarily library-based. However, the one interview conducted, as well as the key informants, were considered essential. Both a telephone and personal interview were held with Ms. Lisa Throssell, the Course-Coordinator for the bridging course program for OTDs at Edith Cowan, and these were most informative.

In addition, I had two key informants. One was Mr Mike Jones, of the Department of Education, Employment and Training, Overseas Qualifications Unit in Perth. I had met Mr Jones at the beginning of this year when planning my research proposal for this thesis. During that time and throughout the time of this research, he has been more than helpful in supplying me with news releases and information to which I would otherwise not have had access. There have been several meetings and telephone communications throughout this year.

The other key informant was Dr G. Gates, who was a former President of the Royal Australian College of General Practitioners (RACGP). I only interviewed Dr Gates on two occasions, as the interviews conducted were quite focussed. Dr Gates' knowledge and experience in medical politics was most valuable in trying to gain an emic perspective of the position and plight of general practitioners in the health care system and their battle for status, a subject that would be worthwhile further research.

In summary, data collection for this research has been qualitatively focussed, and has utilised both documentary material and primary research data. Although there is not a great deal of academic work directly dealing with the

subject matter, the difficulties associated with data-collection were minimised by using a wide range of literature and the three methods outlined.

The following is an outline of the content of the chapters in the remainder of this thesis. Chapter two discusses the theoretical perspectives underpinning this thesis. Chapter three outlines immigration policy and demographics of Australian society and discusses the concepts of multiculturalism and ethnicity. Chapter four is a historical summary of Australian medical practice and experiences of overseas trained doctors (OTDs). Chapter five describes the mechanisms of regulation by giving an account of the role and function of the statutory bodies involved in credentialism. This chapter also outlines the components and effects of medical migration. Chapter six discusses the nature and extent of discrimination towards OTDs. The conclusion summarises the arguments put forward in this thesis and states that the mechanisms of the process outlined must be resisted in the interests of the health and well-being of a multicultural community.

Footnotes : Chapter One

1 This is a Weberian concept and is the basis of the theoretical framework of the thesis which will be fully outlined in Chapter two.

2 Eagleton (1983) argues that subjectivity cannot be recognised by those in the same class background because value judgements that reflect prejudices and beliefs are part of the same socially constructed view of reality which have their roots in deeper levels of consciousness (p.16).

CHAPTER TWO

THEORETICAL PERSPECTIVES

The theoretical perspective of this thesis is that the stratification system is multifaceted, and the stratification of human populations can be analysed in various ways. In society, class, status and power are independent of one another (Lenski 1966, p.74, Waters 1989, p.144). Class, in this sense can best be defined as a group of people who share a common position in society which gives them some form of "power, privilege and prestige". For example, in an industrial society such as Australia an individual may have a considerable amount of property which would place her in a middle class according to property ownership, while she may make her living as an employee in a factory, which would place her in a working class. At the same time she may also be of an ethnic origin which would place her in a minority group class membership. Therefore, the multiple group membership influences her life chances - each placing her in a different class, but at the same time one can not locate her in any one specific class (Lenski 1966, pp. 74-75).

It may be useful here to first of all consider the Marxist perspective on class before outlining the fundamental difference of the Weberian phenomenon of status. Marxist historical materialism uses the dialectical interpretation of change or the struggle of opposing forces around the means of production by the bourgeoisie and the proletariat, or the owners of capital and the working class (Giddens 1989, p. 611). Marxism as a philosophy used class struggle and the means of production as tools in analysis of history and human motivation, that is interaction with the material environment (Giddens 1989, p.437, Leach 1988, pp.123-124).

According to Marx, economics and class were the "hub" (infrastructure) of the "wheel of life", the "spokes" (superstructure) for example, religion, politics, cultural institutions all function in relation to the "hub" (Leach 1988, pp.123-124). The wheel of history was driven forward by class struggle, sometimes in confusion, but always there was "incremental progress to socialism". The original Communist Manifesto predicted the demise of bourgeois society and a replacement by a proletariat dictatorship. However, the concept of "revolution" was revised in 1870 by Marx himself when he conceded that the existence of worker franchise (such as in the United States and the United Kingdom) may lead to a peaceful solution to state socialism (ibid).

Many sociologists/historians who do not view themselves as Marxists generally accept Marxist interpretations of the demise of feudalism and the beginnings of modern capitalism (Giddens 1989, pp. 637-638). Weber, however, believed that while economic factors were important, there could be no unitary theory adequately able to interpret the diversity of human society. Factors other than economic class struggle can be equally important in the analysis of interpretations of historical change. While, as Marx states, the class structure is formed and maintained around economic differences or the means of production, Weber introduced four types of strata, castes, estates, status and elites, to distinguish them from class.

Firstly, castes, in contrast to classes have no upward mobility. Generally, these are viewed in terms of Hindu castes, but the term could well be applied to members of a group or segment of society that may be designated an underclass; secondly, estates are prestigious groups or collectivities which have certain rights or privileges sanctioned by laws; thirdly, some status groups are occupational groups which have estate-like phenomena; other status groups are based on family heredity, ethnic origin or even some Indian castes. Social honour and prestige are

characteristics that underpin membership of these groups. Status groups differ from classes which, according to Weber, are based on economic power because they normally develop distinctive subcultures. That is some status groups could be prestige classes, based on family heredity; others could be power classes setting them apart from other classes, for example, if they had an "endogamous, hereditary and communal character". Lastly, there is the elite group which, unlike the other three, could not be viewed as a special kind of class, as it can occupy contradictory places, that is it may be recognised as the most powerful, privileged sector of a class or can be referred to as a class of political elite (Lenski 1966, pp.77-78).

If we view ethnocentrism, competition and power as essential ingredients of any general theory of race and ethnic relations, then the central issue is how power is distributed among different groups on the basis of ethnic, linguistic or religious differences (Stone 1985, p.8). As should be evident, ethnicity *per se* cannot be collapsed into class, but may be used as a reason for denying status, prestige or honour on the basis of credentialism. (Giddens 1989, p.212. Parkin 1974, p.19).

Those in the upper echelons of the occupational hierarchy, by virtue of group association with other members, have certain means at their disposal for restricting access to credentials. This is generally state sanctioned by licensing or registration. Restricting market access means that members usually enjoy both monetary rewards and special privilege, prestige and status which not only assists them to accumulate wealth, but also gain political strength.

The approach which interprets the restriction of access by Australian medical practitioners to OTDs is essentially that of Weber's concept of social closure. This is defined as "any process by which groups try to maintain exclusive control over resources limiting access to them" (Giddens 1989, p.214). Weber suggests that "virtually any group attribute", ethnicity, language, social

origin, descent, may be seized upon provided it can be used for "the monopolisation of specific usually economic opportunities.... this monopolisation is directed against competitors who share some positive or negative characteristics: its purpose is always the closure of social and economic opportunities to outsiders" (Weber 1968 cited in Parkin 1974, p.3). Parkin (1974) further states that justification for exclusionary practices based on religion, ethnicity or language is fundamentally the same as those glorified by credentialism and rights to property. In essence they are representative of social control in its most exploitative form (p.14).

Traditional cleavages in the Marxist tradition are viewed as having a dichotomous nature, of conflict between have's and have not's, whether based on property ownership, division of labour or authority relations. These are basically those of inter-class relations which are basic features of any social system (Parkin 1974, p.1). Intra-class relations are based on linguistic, ethnic or religious differences, by virtue of which status attainment is denied or severely restricted to others by the dominant group. However, while inequality between and within groups is accepted by pluralist perspectives, it is argued that there is always countervailing power. Change, therefore, is a "succession of compromises" - it is gradual, not radical (Gardner 1989b, p.200). Results therefore do not always mean that the dominant group is completely successful in restricting membership to other groups. The advantage of drawing on Weber's concept of closure is that it accommodates another way of approaching class analysis by retaining "the necessary and traditional focus on dichotomy without its constrictive zero-sum accompaniments" (Parkin 1974, p.3).

This approach to power is useful as it provides a way of explaining closure on the basis of qualifications and/or the basis of ethnicity both of which are necessary to this thesis. Encel (1984) reiterates this liberal-pluralist viewpoint

when he states that in Australia the maintenance of structures of inequality, privilege and power is perpetuated by the effectiveness of different groups in being able to restrict entrance through mechanisms of closure available to them. He points out that this type of argument proved an alternate to the "melting pot" theories of assimilation - the other aspect of closure being a strategy used by some minority groups who remain culturally distinct from the majority in order to maintain their integrity against victimisation or discrimination (pp. 6-7).

Strategies of medical control over the division of labour in the health sphere have been analysed by Turner (1987) and Willis (1989), both referring to three historically significant characteristics of closure mechanisms. These are: 1) subordination of other health workers, for example nurses and midwives; 2) limitation - as represented by dentistry, optometry and pharmacy. These limitations involve various forms of control of a specific part of the body (dentist) or special therapeutic method (pharmacy). Forms of limitation and restriction are maintained by medical practitioners playing a dominant role on official registration bodies; and 3) exclusion - whereby legitimation is denied alternate and competing practitioners, for example, chiropractors or homeopaths (Turner 1987, p.141, Willis 1989, p.91).

It does seem that researchers of both Marxist (Johnson 1972, Larson 1977, Willis 1989) and Weberian (Bates and Linder-Pelz 1987, Dingwall and Lewis 1985, Freidson 1970) traditions all emphasise the phenomenon of medical dominance regardless of country-specific focus. Turner (1987) is of the opinion that eventually sociological analysis of medical power lies in between Marxist and Weberian theories. Miller (1967) emphasises that the "individual rules of exclusion reach their apogee in that complex of social practices ... called "credentialism", that is the imposition of examinations as a means of entry control. Miller asserts that attempts by the elite establishment to maintain professional reproduction by their

own children has only a fifty percent success rate, which shows that their own children have no guaranteed place in the upper echelons. The most effective way of transmitting priority to their own sector is to centre exclusionary practices on a group, or collectively defined quality of persons, rather than individuals (cited in Parkin 1974, pp.6-7). Doctors and lawyers maintain these practices to restrict new entrants. Scarcity value is sustained by keeping control on numbers (ibid, p.21).

So far, Marxist and Weberian perspectives have been discussed to differentiate between class and status groups. The concept of "closure" has been introduced as a means of understanding how power is wielded by dominant cultural groups over others, ethnocentrism, competition and power being viewed as essential ingredients to any general theory of migrant and ethnic relations. Now we will turn to the concept of profession, how it can best be understood and, in turn, how knowledge is reproduced and sustained as a particular social construction of reality.

It is argued that the institutional concept of profession, as a distinct form of organized occupation, is far more relevant to analysis as part of the social and economic relations of wider society. The division of labour is viewed as a division of knowledge - knowledge being "a social product, reproducing and constituting a particular order" (Dingwall and Lewis 1985, pp.1-3).

The problem of definition of "profession" or "professionalisation" in functionalist or post-modern theories of "ideal" types has been in treating professions as a universal concept rather than a dynamic historical reproduction, with particular roots in industrial nations strongly influenced by Anglo-Celtic institutions (Freidson 1985, pp. 19-22). Atkinson (1985) supports the notion that production and reproduction of knowledge, whether it be legal, medical, educational, or other, is coded in a manner that is to some degree arbitrary. Curriculum is a mechanism by which knowledge is a culturally imposed. He

states "there is no ideal 'law' - 'medicine' - 'theology' or whatever out there to which curriculum responds as a reflection or copy" (pp. 234-235). Similar views are shared by international studies on medical competency - asserting that there is no such thing as an "ideal physician" (McGaghie et al. 1978, pp.35-43)¹. Larson (1977) asserts that knowledge produced in education to sustain an occupational hierarchy is by its structure "inegalitarian, antidemocratic and alienating" (p. 241). Freidson (1985) argues that in the American context life chances are largely characterised by the prestige/status of the institution from where a person graduates. He also points out that occupational identity is much more defined as an educational elite than in Europe (pp.19-23). This does also seem to apply to the Australian context .

While the above points to the historical and reproductive role of knowledge, it is important for the subject of this thesis to consider how this knowledge is maintained, legitimated and used as a means of power. Turner (1987, p.132) renounces

... the normative function of the profession and questions its ethical character by emphasising the role of power and market control over the legitimising field of knowledge.

He states that in Foucault's historical treatment of the "archetypal" professions - the police and the medical men replaced priests as guardians of social reality. Foucault used the expression "knowledge/power" to emphasise this unity and attempted to define associations between power relations in society and medical discourse, that is, the interrelationship between professional groups, discourse and medical practice (Turner 1987, pp.10-11). He coined the notion of "panopticism", or the development of a form of social surveillance through the clinic, the asylum and the prison. He sought to find the very real relationship between power and knowledge, where at the end of the 19th century the rise of

"scientific knowledge" gave medical practitioners "social power in defining reality and hence defining deviance and social disorder" (ibid).

Supporting the Foucaultian analysis there are some who have suggested science to be the contemporary replacement for religion in the Durkheimian sense of the sacred and the profane (Freidson 1985, Turner 1987). If this perspective is linked with the social institution from which it is derived, the dominant views and beliefs pertaining to medicine in Australia may very well lie in the realm of the sacred, while other views and beliefs may be treated as lying in the domain of the profane. In this sense Merton's (1957) criticisms may be well heeded. He questions the degree of capability that professionals have to fulfil sociological functions for the entire social or cultural systems (cited in Rueschemeyer 1985, p.43). Merton - a structuralist/functionalist - is sceptical about the claims of scientific knowledge and believes it to have latent functions. He asks "in what ways is the scientific enterprise influenced by the fact that people may create organizations in order to carry out scientific work? (cited in Cuzzort and King 1980, p.186). Therefore, the latent function behind the closure mechanisms which are used as a guise for protecting the quality of this scientific knowledge must be brought into question.

This thesis can also benefit from the philosophy of Jacques Derrida, a French philosopher of the deconstructionist school. Derrida himself is an anti-positivist and rejects philosophical thought with its traditions from Plato to Levi-Strauss. Western philosophy in Derrida's eyes is logocentric, that is, it is committed to a belief that all forms of thought or knowledge have some ultimate foundation on which to base themselves, such as notions of truth or reality. Derrida coined the term "différance", which is purposefully ambiguous and not-translatable, to demonstrate "that there are no inviolate entities - everything is part of a play of differences" (Eagleton 1983, pp.147-148).

The ideas of Derrida, Foucault and Weber have one striking thing in common - that the notion of truth or knowledge is not absolute - and it therefore must be viewed as a relative concept. Although we live in a world of differences, those maintaining control over "esoteric" knowledge cannot be easily challenged until their knowledge base becomes demystified.² There are also questions to be clarified when their power and influence allows them to widen their definitions to include value judgements about the worth of people and their knowledge, whether they be of the same culture or of different cultures.

In this chapter, it has been argued that the dual focus of status and power must be used to analyse conflict in intra-class relations over the control of knowledge. This conflict is one centred around ethnicity, where the dominant cultural group excludes the alien "other" from group membership using whatever means available to it. Historically, in theories of race relations there have been two types of exclusionary practices which have been traditionally perpetuated: the sociological one of structural control and the other psychological (or cognitive restructuring). If individuals or groups come to believe they are inferior and less competitive than the dominant group, they will in time accept their subordinate position (Baker 1983, pp. 199-200). The prime example of this in Australia is the treatment of its Aboriginal people. Baker (1983, p.200) states:

the belief in one's incompetence effectively erodes or destroys
an individual's or group's incentive for motivation for bringing
about change, confront an oppressor, or build power resistance ...
the necessary [resistance being] an act of self-affirmation or self
assertion of competence, for example "Black Power".

The empirical information can also be assessed by referring to Weber's thesis on bureaucratic control and administration, which means exercise of control on the basis of knowledge. Knowledge in this case, is just as much an instrument of power, as is property - a feature that makes it specifically rational.

In the case of medical practitioners, they have the advantage of maintaining the base of "esoteric" knowledge which cannot be easily challenged (Freidson 1985, Horobin 1985, Turner 1987). Not only does this knowledge enable them to increase their power, but they have other knowledge arising out of their own peculiar history which relates to their "special knowledge of facts" regarding their own profession. In the need for rationalisation, that is organization of social and economic life to principles of efficiency, the state becomes forced to maintain bureaucratic administration of health care through medical practitioners in the interests of capital (Giddens 1989, p.708, Weber 1922, pp.370-371).

The discussion in this chapter has emphasised power as a built-in attribute of social closure and demonstrated the usefulness of social closure as an analytical concept. It has also been pointed out that the institutional concept of profession is considered useful because it enlightens our understanding of the historical emergence of this social institution. The works of French philosophers, Michel Foucault and Jacques Derrida are also concerned with the historical emergence of the particular contemporary relationship of knowledge to social relations. Theories of medical power and social knowledge have also been put forward identifying traditional closure mechanisms that have been used to maintain power and control over other health professions.

The point to be made is that until recently legitimization has been maintained by control of AMC examination pass rates in justification of the fact that OTD skills are inferior. However, this legitimization has been threatened because pass rates since 1988 have become public and observable. This and other factors has resulted in an increase in numbers sitting and passing the AMC exams, particularly some NESB groups. This has now caused a new argument, that these NESB groups are "mismatched" to the major national groups of the immigrant population and, therefore, Australia does not need these doctors. The introduction of a

quota and the increased rigidity of the examination criteria will not make it possible for any further comparisons to be made. Assessment procedures have become confused with labour market considerations clearly making OTDs victims of discrimination.

Footnotes - Chapter Two

¹ The authors have produced a Public Health Paper for the World Health Organization entitled Competency based curriculum development in Medical Education. They argue that countries producing graduates in order to meet an external criteria of quality, such as the Educational Council for Foreign Medical Graduates (ECFMG) often meet an "ill-defined international standard of excellence" at the expense of meeting the social and economic needs of the country it serves" (pp.41-42).

² Research by Bates and Lapsley (1987) and Bates and Linder-Pelz (1987) both point to a need for the demystification of medicine.

CHAPTER THREE

IMMIGRATION, MULTICULTURALISM AND ETHNICITY

The non-recognition of overseas qualifications in Australia has been considered by the Federal government to have been an issue of prime social and economic concern for a number of years. However, it was also realised that it was an issue about which very little positive action had been taken (Dawkins 1989, p. 1). Although the issue of non-recognition of overseas qualifications is sometimes seen to have arisen in the past twenty years or so, its nature is more deeply rooted in the history of general protectionism in Australia which began in the early 20th century with the Immigration Restriction Act of 1901 - more commonly known as the "White Australia Policy". The underlying cause was primarily established in the depression years of the 1890's - the belief that "migrants took jobs from locals" (Jupp 1984, p. 8). However, later justification drew on racist ideology. For example, Jupp (1984, p. 8) states:

For the next sixty years [following the introduction of the Immigration Restriction Act of 1901] it became almost impossible for anyone not of 'substantial European descent and appearance' to be admitted to Australia for permanent residence. In its administration the White Australia Policy¹ (which was never officially called that) became increasingly based on race discrimination rather than on fears of economic competition.

This chapter will firstly outline immigration policy and demographic characteristics of Australian society; secondly, the concept of multiculturalism and "ethnicity" will be discussed. This will essentially provide a backdrop to any discussion on ethnic relations in the Australian context.

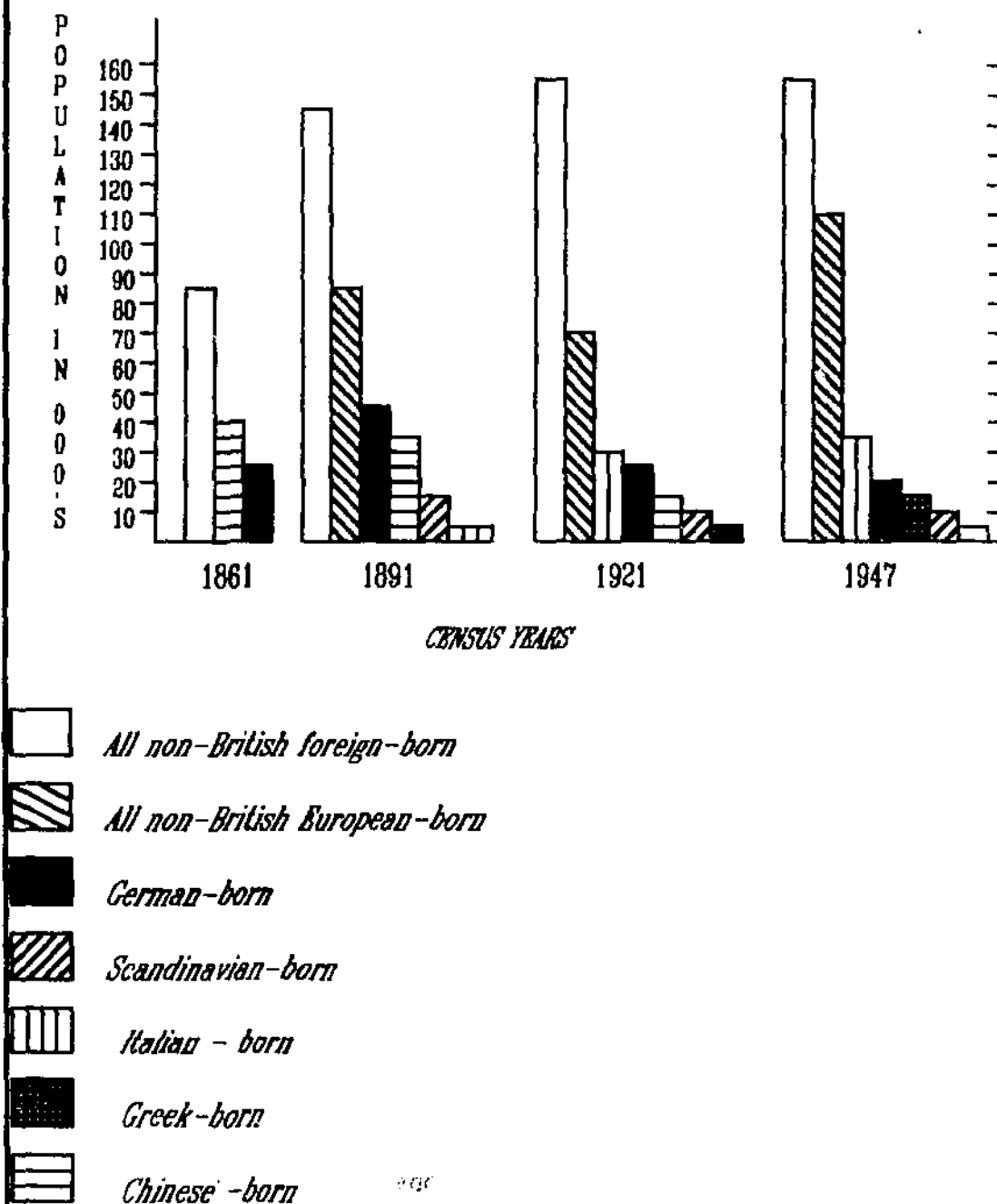
Although general restrictions on immigration from traditional source countries were lifted progressively during the 1950's and 1960's, it was more for reasons of population building and the need for labour, than any desire for a more culturally diverse society. Government policies and practices emphasised that migrant labour would be mainly concentrated in industrial and manufacturing occupations, regardless of educational background or experience (Castles, Mitchell, Morrissey and Alcorso 1989, Collins 1988). There was little opportunity for migrants to learn English. Trade unions and professional groups actively pursued restrictive registration and licensing practices to "protect" Australian jobs. The policy of assimilation, that migrants should learn English and adopt "Australian" ways, did very little to encourage a more egalitarian ethos towards migrant groups.

The nature of mass-migration in the post war period has suggested that the population of Australia was largely of Anglo-Australian birth or origin and was 'transformed' to a multicultural society. This does not take into account that also among the first migrants to Australia were groups from non-English speaking backgrounds (NESB). People of Italian, Greek, German, Jewish, French and Swiss origin, as well as Aboriginal, Pacific Islanders, Kanakas and Chinese, contributed to the development of colonial Australia ²(Jupp 1984, pp. 1-7). Figure 1 on page 28 shows proportionate representation of Non-British minority group settlement for the census years 1861 to 1947 inclusive.

Even in the 1990s in some sectors "migrants" are equated with being either "Greeks" or "Italians" - two groups, among others, who have had a historical presence in Australia almost as long as the British colonials (Immigration Advisory 1973, p. 3).³

Figure 1

NON-BRITISH MINORITIES IN AUSTRALIA 1861 - 1947



(Borrie 1954, p. 41)

Nevertheless, the post-war period saw the face of Australia changed from a predominantly Anglo-Australian population of 7.5 million in 1947 to a population in 1973 of 13.5 million where one in four persons were either post-war migrants or children of migrants of diverse origins. However, it was not until the late 1960s in the wake of Civil Rights movements in the United States of America, that minority rights became a major issue in Australia with Aboriginal rights⁴ high on the agenda.

From the late 1960s onwards many migrants began to return home and the causes of this became the subject of a number of government enquiries. An inquiry by the Minister for Immigration on settler departures was conducted in 1966/1967. In 1969, the Henderson Poverty Enquiry emphasised victimization, exploitation and "official and community neglect" (Curthoys 1988, p. 52). A further inquiry between 1971/1973 was asked to report on the pattern, rate and cause of return migration due to an identified settler loss at the rate of 21% to 24% for the previous six-year period (Immigration Advisory Council 1973, p. 3). Although the findings indicated that there were more "pull" factors in return migration, this then may have been a debatable point⁵.

The point to be made is that the government did not identify the non-utilisation of skills as being a "problem" at that time. Although the Council for Professional Qualifications (COPQ) was established in 1969, its terms of reference were mainly to streamline functions at the pre-migration level to make Australia attractive to skilled migrants. As the COPQ was an advisory body only, it had no legislative power and was constrained by its narrow terms of reference.

In the 1980s, further government enquiries began to emerge. Both the Fry Committee of inquiry into recognition of overseas qualifications (Report of Committee 1983) and the Jupp review into migrant services and programmes (Committee of Review (ROMAMP/S) 1986) addressed the inequity evident in the

restrictive nature of various bodies to the recognition of overseas-qualified persons and called for reforms. The medical profession was one to which Fry (1983) gave his attention. The Fitzgerald committee (1988) set up to advise on Australia's immigration policies also highlighted the fact that the system was discriminatory in outcome. The committee stated that over 90% of immigrants from ESB countries are successful in having their qualifications recognised, while only about 50% of those from NESB countries achieved recognition (Committee to Advise (CAAIP) 1988, pp. 54-55).

For the period 1983-1986 the net migration gain of workers was 69.1%. However, the data shows clearly that for every two professional or skilled tradesman entering Australia, one emigrates again. In other words permanent arrivals for professional and skilled trades-persons were 55% and 49% of the total intake in these categories, compared to 87% for unskilled and semi-skilled workers (Hugo 1988, p. 15). The Fitzgerald Committee (CAAIP 1988, p. 54) asserts :

Reform has been caught in the rivalry between State and Federal jurisdictions, in protracted tripartite negotiations and in the acquiescence of government agencies to the restrictive practices of some professional associations.

The government drew its attention to the issue of non-recognition of overseas qualifications when the economic and social effects could not be ignored. It has been estimated by the Office for Multicultural Affairs (OMA) that during the past forty years there has been approximately 645,000 underemployed or unemployed migrants whose skills have not been utilised. The survey, conducted by McNair in 1988, estimated that the rate was in the vicinity of about 15,000 per year (Chapman and Iredale 1990, p. 1).

The traditional patterns of a general social acceptance of persons from ESB backgrounds in preference to those of NESB backgrounds has persisted in spite of

the fact that Australia's migration policy for the past twenty years has been non-discriminatory in theory. Before this is further discussed, the demographic character of various waves of migration is presented below as Table 2. This reflects the official dismantling of the "White Australia Policy" in the 1970s when a non-discriminatory selection process was introduced for intending migrants.

Table 2

**Settler Groups of Australia's "Top Ten" Source Countries
by Country of Origin 1962-63 to 1986-87**

Country of Origin	Number	Percentage
1962/1963 - 1971/1972		
UK and Ireland	667773	46.1%
Yugoslavia	114398	7.9%
Greece	114291	7.9%
Italy	112835	7.8%
New Zealand	38414	2.4%
Germany	34596	2.4%
USA	29381	2.0%
Malta	26592	1.8%
Netherlands	21775	1.5%
India	20838	1.4%
1972/73-1981/1982		
UK and Ireland	342393	38.6%
New Zealand	79019	8.9%
Vietnam	54805	6.2%
Yugoslavia	29008	3.3%
Lebanon	27727	3.1%
South Africa	20446	2.3%
USA	19748	2.2%
Italy	18340	2.1%
Greece	17554	2.0%
Philippines	15604	2.8%

(cont.)

Table 2 (cont.)

Country of Origin	Number	Percentage
1982/1983		
UK and Ireland	27586	29.7%
Vietnam	8690	9.3%
New Zealand	6867	7.4%
Germany	4129	4.4%
Poland	4095	4.4%
Kampuchea	4074	4.4%
South Africa	2758	3.0%
Philippines	2735	2.9%
Malaysia	1937	2.1%
USA	1803	1.9%
1986/1987		
UK & Ireland	22580	19.9%
New Zealand	13580	12.0%
Vietnam	6640	5.9%
Philippines	6410	5.7%
South Africa	4670	4.1%
Malaysia	3950	3.5%
China	3480	3.1%
Hong Kong	3400	3.0%
Lebanon	2800	2.5%
Sri Lanka	2800	2.5%

(DILGEA "Statistical Monthly" cited in McConnochie 1988, p.174 and Jayasuriya 1989, p. 11)

The overall pattern is a decline in immigration intake from the United Kingdom and Ireland, from 46.1% in 1962/63 to 19% in 1986/87. Also intake from Greece and Italy and Yugoslavia has declined significantly, not exhibited in the figures for 1982/83 and 1986/87. However, although the table shows changes in the mix of waves of migration, even these figures do not give a true picture of settled populations of migrants in Australia, because they only show the top ten source countries in each period. While UK and Ireland, New Zealand, Italy, Greece and Yugoslavia remain the major immigrant groups, there are people of 140

different ethnic backgrounds which make up 40% of the Australian population (McConnochie 1988, p. 175). Table 3 below depicts immigrant populations by country of origin that in 1988 have more than 20,000 residents in Australia.

Table 3

Major immigrant groups with more than 20,000 resident in Australia

Country of Origin	June 1988 - Population ('000)
UK and Eire	1197.3
Italy	269.7
New Zealand	250.2
Yugoslavia	163.3
Greece	148.7
Germany	122.0
Vietnam	100.3
Netherlands	99.9
Poland	72.2
Lebanon	67.8
Malaysia	61.3
Malta	59.5
India	54.8
Philippines	51.2
South Africa	47.2
USSR	46.8
USA	45.9
China	45.4
Hong Kong and Macao	38.8
Egypt	34.6
Hungary	29.3
Sri Lanka	29.1
Turkey	28.5
Indonesia	28.0
Cyprus	25.7
Austria	23.9
Canada	23.8
Papua New Guinea	22.9
Chile	22.5
Singapore	21.2
Fiji	20.3

(Hugo 1990, p.806)

Having given a brief outline of immigration and demographic characteristics of Australian society, I will now turn to defining multiculturalism and the beginning of an era when "migrants" became "ethnics". Multiculturalism, the recognition of pluralism and the right of cultural groups to retain their language, religion and cultural identity, replaced the earlier assimilationist philosophy. It was introduced by the Labor government in 1973. However, multiculturalism as a concept and ideology is not confined to Australia. It emerged in the 1970s in Australia and western Europe where "it has been the political recognition of multi-ethnic societies ... which prioritises culture over power as the main policy agenda (Husband 1988, p. 1).

Although Grassby, the Federal Minister for Immigration and Ethnic Affairs, during the Whitlam Labour government era, among others, had a particular vision of a multicultural Australia - one that frowned on prejudice and ethnocentrism and saw an Australia of the future as an ethnically heterogeneous and culturally diverse society - this in fact has not yet been achieved (Curthoys 1988, p. 52). Research into Australian society identifies ambiguities around policies which espouse equality and social justice for all Australians (Foster & Stockley 1988, p. 3). It shows the reasons for the shift to multiculturalism from the previous assimilationist practices and policies. First and foremost multiculturalism arose because of the recognition that the assimilationist policies had failed dismally. This was emphasised by the Henderson Poverty enquiry and in the high rates of return migration outlined earlier.

However, rather than perceive the "problem" as social - it was defined as belonging to the migrants. "Ethnicity" was created and therefore associated only with migrants. The term "ethnicity" is usually used to :

define group membership in a 'shared culture' such as language, customs and institutions ... [it] may become a basis for national separatism or political subordination ... [the] ambiguity of ... definition of ethnic group reflects political struggles of a society around inclusive or exclusive group membership (Abercrombie, Hill and Turner 1984, p. 90).

Migrants then became categorised as the "other". Because of their cultural diversity which was foreign to the Australian "norm", it was their disadvantaged nature that prevented them learning English and assimilating successfully into the Australian lifestyle (Curthoys 1988, p. 52, Husband 1988, pp. 2-7).

By creating a superficial ethnic homogeneity, policy makers camouflage the existing power, status and class structure of society. As power is mainly in the hands of the ethnic majority, the maintenance of existing exclusionary and discriminatory practices can be easily carried on. In fact this is one of the major criticisms of the "multicultural society" conceptualization. Encel (1981, p.15) states:

It is also clear that ethnicity can be exploited as a manipulative device if it is used as a high-falutin' label for minor forms of cultural diversity, cut off from the world of class conflict, divergent interests and power struggles.

In addition, Curthoys (1988, p. 53) asserts:

The multicultural position has served to convert the self-perception of many Australians of British descent from unselfconsciously 'Australian' to aggressively 'Anglo-Australian', as members of a distinct ... majority.

Multiculturalism, as a perspective has created an image of a 'public ethnicity' attached to minority groups. By associating members of these groups with country of origin it has imposed a homogeneity on individuals who are much more likely to be heterogeneous. It has created a conflict and tension which places

'ethnicity' in the category of the 'other'. At the same time, it has glorified the image of 'national need' which has served to construct an 'imagined community' where Australian homogeneity and unity is aligned with Anglo-Australian identity (Beckett 1988, p.191, Curthoys 1988, p.58)

The Hawke Labor government launched its National Agenda for a Multicultural Australia in 1989 espousing three policy principles: cultural identity, social justice and economic efficiency (Office of Multicultural Affairs (OMA) 1989, p.vii). At the same time policy-making responsibilities were shifted and new structures established. Some of these were :

- * The Office for Multicultural Affairs (OMA) was relocated from the Department of Immigration and Ethnic Affairs (DILGEA) to the Department of Prime Minister and Cabinet.
- * The National Office of Overseas Skills Recognition (NOOSR) replaced the Council on Overseas Professional Qualifications (COPQ) and was placed under the portfolio of Employment Education and Training.
- * Under the portfolio of Community Services and Health, the Australian Institute of Health was to conduct research into the needs and status of NESB people. Other priorities were improvement of access to health services of Aboriginal and migrant groups, consumer education programmes in languages other than English, and the total involvement of local and state governments in addressing community needs (OMA 1989, pp. 24 -35) .

At the same time, the Minister for Employment Education and Training announced a Migrant Skills Reform Strategy (Dawkins 1989). The National Advisory Committee for Skills Recognition (NACSR) under the chairmanship of former R.S.L. President, Sir William Keyes, was established to examine legislation and advise on effective ways of establishing national accreditation of skills across all trade and professional groups and to monitor progress to achieve this aim (NACSR 1991, pp. 25-31). Also, Overseas Qualification Units now established in most states now offers a "one-stop" service for clients. Progress is reported to be occurring. Particular success has been with programmes established for migrant nurses. It has been said that industry, trade and professional groups are acting in the spirit of the reform processes (M. Jones - personal communication - August 5, 1992). The pace of this action will not be known until a future time.

It has been found that the most disadvantaged in the workforce generally are those with higher levels of educational achievement coming from Non-English speaking background (NESB) countries. Although, people of English-speaking background (ESB) achieve a higher level of attainment, it is still somewhat lower than native Australians. The gap between ESB and NESB groups wage rates and degree of acceptance amongst employer groups, professional bodies and trade union groups is significant⁷. In addition, arguments that the "quality" of migrants' skills is inferior to that of the Australian-born are increasingly being refuted by researchers.⁸ Chapman and Iredale (1990, p. 41) however, point out that:

Immigrants with no formal Australian training are treated very similarly to each other in the Australian labour market. It doesn't seem to matter if an immigrant from a Non-English Speaking Background (NESB) country has a Ph.D. or has dropped out of high school, the wage outcomes are close to identical, a result implied indirectly by the other Australian literature.

This is not to say that English-speaking background (ESB) migrants do as well as native Australians, but that there has been a stronger tendency to treat NESB migrants, as being of a somewhat "inferior quality". Some studies still suggest migrants and "developing" countries are not culturally attuned to "advanced industrial societies" like Australia (McAllister & Kelley 1984, pp. 65-66). However, there is now considerable consensus that the "problem" lies not with the migrant, but with the means of assessment.⁹ It is also significant that this has been supported by current government policy (NACSR, 1991).

In summary, it has been shown that during approximately the first half of the 20th century, general protectionism was maintained under the Immigration Restriction Act of 1901. The post-war years saw a mass-migration programme change Australia from a nation of predominantly Anglo-Celtic origin, to a multicultural society. Concern began in the 1960s when large numbers started returning home. However, it was not until 1989 that positive action in the form of structural reform processes was taken. The success of this cannot yet be judged.

With the benefit of hindsight, a pattern can be identified. Multiculturalism in the 1970s emerged after concerns that assimilationist policies had not worked. Although, it has existed as policy for almost twenty years, it is necessary to ask what happened prior to 1989 producing the need for the National Agenda announced by Prime Minister Hawke? Did the National Agenda really arise out of concern for migrants' social and economic benefits in Australia or was it more about the need for an economically focussed migration programme? Is the prime reason again the high return migration rates of professional and skilled trades-persons? When governments begin to legitimate actions on the basis of culture, there is a need to have some degree of scepticism.

The late 1980s and early 1990s brought an end to a bipartisan approach to immigration policy and multiculturalism and a new element of "New Right" sentiment has been expressed both in the political arena and in business circles. Also, there have been reductions in family reunion applications and an increase in application fees for intending immigrants. In addition, processes applied for weighting of intending migrants have become more selective, operating on a points system, except for close Family Reunion or Humanitarian categories, with increased emphasis on the need for English skills.¹⁰ In the Federal Budget statement announced in August 1992, future migrants will be expected to support themselves during the first six months of arrival in Australia.

Despite these contradictions, there has been one major achievement. There has been a realisation that the "problem" does not lie with the migrant, but with historically-rooted protectionist practices, and moves have been made to change these practices. However, it appears that the medical elite are set to sail in the opposite direction and politicians have acquiesced. Medical migration can be seen as an instance of overall migration patterns, but the involvement of the medical profession in policy formation gives it a particular characteristic that sets it apart from other professions.

Footnotes - Chapter Three

¹ This was the term given to various statutes in the 19th century, beginning in the 1860s when Victoria enacted restrictive legislation for official control of migration, after which other colonies imposed similar sanctions. In 1901, the Immigration Restriction Act enacted by the Commonwealth Parliament consolidated these various laws (Allbrook 1985, p.76).

² Accounts of early migration and settlement are also to be found in Sherrington (1990).

³ Kunz (1975) pointed this out and, surprisingly, there is evidence that this view is still held in some quarters - particularly by the medical profession. This point will be taken up further when discussing the medical practitioners.

⁴ For an historical account of the Aboriginal experience in Australia, see Broome (1982), especially pp. 143-159, which demonstrates how Aboriginals were thrust into a "caste-like" strata of society and denied any basic form of human rights.

⁵ Although returning migrants were from five major countries: Britain, Yugoslavia, Italy, Greece and Germany, interviews were only conducted with three groups returning home, Yugoslavian people who were mainly unskilled workers, and British and Italian of unskilled and skilled backgrounds. Professional groups interviewed were in the main British and Italian in origin. The former related reasons for return migration to be the non-recognition of skills, and the latter complained of receiving lower salaries and loss of social status. Additionally, those with health problems expressed a general lack of confidence in Australian medical services. Mainly those from Italy believed their doctors had more ability to treat illnesses said in Australia to be untreatable. There was also a great concern for the urgent need for interpreters with medical knowledge in hospitals and private practice (Immigration Advisory 1973, pp. 38-39).

⁶ Hugo (1990) presents a full discussion on the various demographic and spatial aspects of immigration, together with a review of major research undertaken in this area.

7 For an analysis of labour market outcomes, see Chapman and Iredale (1990) and on experiences of trade and professional groups, see Castles et al. (1989) and Mitchell, Tait and Castles (1990) respectively.

8 See DILGEA (1987), Chapman & Iredale (1990), Iredale (1987), Iredale (1988).

9 See DILGEA (1987) Economics of Migration, Proceedings of a Conference at the Australian National University, 22-23 April 1987. Various papers based on econometric studies have put forward a view that migrant skills have been significantly undervalued. Jones (1987, p. 159) expressed the belief "that regression models of returns to education and overseas labour force experience make no allowance for differential measurement error, yielding lower estimates for ethnic groups educated in cultures more distant from the culture of Australian institutions".

10 Those allocated bonus points for skills in short supply enter under Occupations in demand category (OCS). At present there are only four occupations in demand. Others enter under the Independent & Concessional categories where points are given both to English language skills and educational qualifications. Other means of entry are (1) through the Employer Nomination Scheme (ENS) where contracted employment is prearranged and the job vacancy is unable to be filled in Australia; (2) through the Family Reunion (B) category, sisters and brothers enter, but who are subjected to the same selection criteria as are other migrants; (3) through the Business Migration category where a large amount of capital (approximately \$500,000) is required. More recently, increased weight has been given to English Language Skills as a preferred prerequisite.

CHAPTER FOUR

AUSTRALIAN MEDICAL PRACTICE AND THE EXPERIENCES OF OVERSEAS TRAINED DOCTORS : 1860 - 1978

Early 19th century medical practice in Australia was carried out by medically qualified doctors from the United Kingdom and Ireland and a minority entering from other countries. "Unqualified", according to the 1861 Census, were Chinese and Aboriginal practitioners and homeopaths. Chemists also operated individually in dispensing medicines (Willis 1989, pp. 41-44). This chapter firstly describes the historical development of the medical profession and secondly, puts it into the context of immigration policy relating experiences of refugee and migrant OTDs.

British doctors in Australia were not the prestigious graduates of Oxford or Cambridge, but males who were in their early and mid-careers and had found it difficult to compete with an elitist profession in England. Very few were general physicians, the majority being surgeons or surgeon-apothecaries (ibid, p. 41). Medical practice in the first half of the 19th century was not always lucrative. Bankruptcy was not uncommon. Competition not only between "qualified" and "unqualified", but also between "qualified" practitioners sometimes erupted in physical violence (especially in the Gold Fields in the 1850's in Victoria). Consequently, medical expertise lacked public confidence (ibid, pp. 36-41).

On the other hand, Willis (1989, pp. 39-41) states that some doctors, for example, Lindeman and Penfold, undertook wine-making or some such "hobby", as well as continuing to practise medicine. Others left medical practice altogether and became squatters (or a landed aristocracy).

The Medical Registration Act was enacted in 1835, although it was not immediately effective in stopping the practice of "unqualified" practitioners. The N.S.W. Medical Board was established as its administrator. The Act (after an English Act) set out to define the "legally qualified" as being graduates of certain universities in the United Kingdom or Ireland. The Act was passed more for reasons of maintenance of state legitimacy for coroner's inquests, rather than aimed at helping medical practitioners secure economic advantages. However, by 1858 it was further amended to become legally obligatory for medical practitioners to become licensed (Allen 1989, pp.255-256, Sax 1990, p.270, Willis 1989, p.47). Nineteen bodies - with only some being of a high standard - began operation to control licensing (Allen 1989, pp. 255-256).

Willis (1989, p. 46) points out that from the very beginning there were ideologically opposed groups to the question of registration. He states:

the most important of these was the ideology of 'laissez faire' individualism which ran counter to the notion of restricting economic activity in the health arena to those who were 'duly qualified' (ibid).

Crichton (1990, p. 17) also refers to entrepreneurial medical practice as intent from the beginning on keeping out "quacks and foreigners". Collins (1985 cited in Crichton 1990, p. 17) states that the underlying Australian ideology is "Benthamite", Bentham being an anti-collectivist who preached utilitarianism, legalisation and positivism. This entrepreneurial/philanthropic nature of medical practice was fuelled by an underlying Protestant ethic which could justify defining some groups as "inferior beings"¹. The emergence of Social Darwinism during the 1850s helped to give this belief its "scientific" base.

The main point to be made about this era is that not all medical practitioners shared the same ideology. However, by 1880 a medical elite emerged which drew on British institutions and traditions, linking itself to education and politics.

This medical elite became the "militant vanguard", reflecting a higher class and status group. Other medical practitioners were largely drawn along behind them, with or without their full consent. The medical profession today still retains this duality (Willis 1989, pp. 46-60).

By 1886, a demonstrated knowledge of surgery, medicine and pharmacy was required as a requisite for medical practice. The British Medical Association (BMA) since its inception drew on the prestige of its association with royalty and wealth. From its commencement, the association was intent on granting political power to a selected group of practitioners and withholding this from others: thus forming an exclusive membership (Allen 1989, p. 256-257).

Medical knowledge also became historically linked to British traditions following the biomedical model in which knowledge was acquired through scientific research. Despite the fact that Australia lacked initial resources, the arrangement of knowledge, organization and distribution were similar to British modes of practice: "teaching hospitals/university based medical schools at the top, specialists without research commitments next and general practitioners last" (Crichton 1990, pp. 204-205). A Royal Commission on Health in 1926 recommended that the government's responsibility should be for the provision of the less wealthy, while medical practitioners should control the private sector. The traditional mode of payment was established as "fee for service", the ideological lynch-pin of contemporary debates. Complete professional autonomy was established by further legislation enacted during the 1930s (Daniel 1990, p.21, Willis 1989, pp. 79-81).

The structure of the health system which operated since 1950 was dictated by the Australian Medical Association (AMA) working through the Minister of Health, Sir Earle Page, who was later succeeded by another medical practitioner. During this time private medical and hospital insurance organizations played a

major role in most boards' membership constituting medical practitioners. Also, until 1963 biomedical research opinion represented that of the Australian Medical Association (AMA) and not of the medical researchers (ibid, p.123).

Until the 1970's, therefore, both government and medical practitioners shared a common "laissez faire" ideology with medical practitioners in control of the private sector and research. However, since the 1940s in light of British medical practitioners' experience, a resistance to any form of "nationalism" and fear of socialist policies remained a threat in the minds of Australian medical practitioners.

This has produced a particular socio-economic profile for doctors. Encel (1976, p. 113) states that since 1923 there have been at least thirty state and federal politicians who were medical practitioners, ten of whom held various portfolios. He points out that medical practitioners start earning a maximum rate over the age of forty, and retain this status for at least a further fifteen years. In the 1970s, the salaries of orthopaedic specialists were about five times more than the average general practitioner operating privately. In contrast, dentists and architects have their peak at over fifty, while lawyers peak between the ages of fifty and fifty-nine. Encel (1976, pp. 122-123) states :

Australia is almost unique ... the social position of medicine is highest of any - extends to the realm of political decision making particularly in regard to health and welfare.

Although "medical dominance" grew in other countries, it was never stronger than in Australia:

Doctors were able to get the Constitution changed to protect their position and hold off accountability for public moneys until 1968 - and have been fairly effective since then (Crichton 1990, pp. 204-205).

Survival of the entrepreneurial/philanthropic nature of the medical profession is also seen by some not to have altered much since convict days when

Australians were particularly parochial towards minority groups, lacking consideration for Aboriginal people, the poor and ethnic minorities (Crichton 1990, p.13). The way to independence, high social status and success was via entrepreneurialism, while there were limitations placed on what philanthropists were willing to do to provide aid and care for the disadvantaged (ibid., pp. 12-13). Evans (1979 cited in Crichton 1990, p. 13) describes the convict legacy thus :

... the indigent and indigenous fell foul of those doctrines of work, success, progress and puritanism which nurtured colonial society and which in turn, were enshrined by it. Such colonial deviants formed a definable 'group of despised inferior beings' ... a 'caste' apart. Despite substantial alterations in the political and economic structure between convict days and world war years, the survival of such moral rationalisations and scapegoating of the vulnerable, which was thereby engendered, ensured that punitive patterns, emerging originally from a convict background, altered surprisingly little.
Instead of such patterns being reformed along medical therapeutic and humanitarian lines, they emphasised a concern for morality, discipline and physical constraint.

The duality of the medical profession became institutionalised when in 1969, an agreement was made between the Gorton Liberal government and the Australian Medical Association (AMA). The establishment of a "common fee" began a division of interests between specialists and general practitioners, which effectively meant that a higher and lower rate was paid for exactly the same clinical procedure. This was further reinforced when a national body was established to maintain accreditation for specialists under the National Health Act 1970.

From the 1970's onwards there have been continual cleavages within the medical profession itself, with specialists viewing general practice as not a true academic discipline and general practitioners as "failed specialists" (Gates - personal communication - September 15, 1992). Also, divisions of interests began

to emerge between medical practitioners and governments. Whitlam's introduction of Medibank was seen as a threat to doctor's incomes. Fraser, intent on refining and making the health care system more efficient, discovered fraudulent practices. Current government policy does not offer any incentive to private health insurance and thus threatens specialists' incomes. Also, events of a New South Wales strike of medical practitioners and, particularly procedural specialists in 1985, caused further rifts with the AMA, the government, and other doctors' associations. This strike, together with charges made of fraudulent practices, has undermined medical practitioners' credibility and status, as well as what they see to be their basic economic right (Daniel 1990, pp.83-100).² One of the reasons may be due to the fact that in this later part of this century governments have abandoned the residualist model to health care and adopted a new philosophy of universal rights (ibid, p. 17). However, while there may be a philosophy of "universal rights" to health care, universal rights may not take such a prominent stance when related to medical practice. The following relates some of the experiences of migrant and refugee OTDs.

The Immigration Restriction Act (1901) was effective in restricting entry of non-British migrants to Australia. From 1908, however, reciprocal arrangements existed for medical practitioners from the United Kingdom, Canada, New Zealand and Italy³ (Willis 1989, p. 79). At the beginning of the 20th century, Australian medical practitioners acted similarly to other countries belonging to the British Empire: to control the international movement of professional labour in order to protect the domestic market (Salter 1971, p. 67-75).

With the rise of Hitler's regime in Germany, during the late 1930s and early 1940s political and religious refugees were reluctantly allowed into Australia. Among these were OTDs who, under the Medical Registration Act 1858, were not permitted to practise medicine in Australia. Because of shortages of doctors in

rural areas, public and media attention gave rise to the New South Wales Medical Practitioners Act (1938) being enacted. This Act allowed these OTDs to practise in rural districts, with a proviso that deregistration would occur if they did not remain in their locations. Shortages in rural areas were so critical that the government offered doctors a guaranteed income of one thousand pounds per year⁴. The following extract from a letter to the Medical Journal of Australia in 1939 was indicative of attitudes which Kunz (1975) states were to persist throughout the post-war years:

Sir: In a time of national crisis we as a profession are engaged in attempting to safeguard the welfare of those of us who will make sacrifices to serve. The object is worthy, and is one pursued otherwise by certain reputable private firms. But at this very time there arises a clamour that refugee aliens be registered ostensibly to serve outback centres where after paying living and professional expenses the incumbent will find himself in the affluence of a less than basic wage. Firstly, Sir, are these refugees trained to our standards in general medical work? Also, will they stay in these unattractive locations? I am sure not. And, will the administration of the machinery devised to keep them there succeed or not suffer from being tampered with? Again, I am sure not. The present agitation will again raise its head to grant further licence, or else the newcomers themselves will deliberately circumvent the restrictions in some other way. Indeed, I would ask, how many cases have already arisen in which these aliens have flouted the law by surreptitious practice?.....
(Maxwell 1939, p. 919).

This letter questions quality of care and demonstrates the high moral overtones of a view held by one of the medical profession at that time. Although it might be said that one person's viewpoint cannot be generalised, the style of the argument, for example, misrepresentation of some facts, assertions of suspicion, distrust, and of unsafe medical practice, as Kunz (1975) asserts, are historically

repetitive at the time of his study. In 1991, arguments against OTDs may have changed in some form, but not in substance. It will become more evident later that these, plus other factors such as medical workforce issues and oversupply, are part of strategies embedded in these early 20th century practices, when medical elites reinforced their status by establishing their links with medical colleges.

The first Australian medical school established in Melbourne in 1863 had at its helm a medical practitioner/ zoologist, a Professor Halford, who instituted "a new direction in medical training". The 5-year course consisted of one half biology and basic science, while the second half was more clinically oriented. This decision predated the model being adopted in the United Kingdom where in 1894 they changed direction and replaced "the traditional" medical school. Iredale (1987, p. 122) asserts after Barrett (1940) that a "myopic" approach to Australian medical training compared to overseas training models stems from the "momentous decision to include biology". This would seem to indicate that historically, Australian medical training has set itself apart from other countries as being a leader in its field.

In 1938, only Adelaide, Melbourne, Sydney and Queensland had medical colleges. The requirement to take university training was legislated under the New South Wales Medical Practitioners Act (1938) with the proviso that only eight alien doctors per year could be registered on completion of the course. When in one year 13 were able to complete the course, there had to be a ballot to decide who could be registered. The Act was amended in 1950 to omit the clause (Iredale 1987, p. 121). However, one doctor it seems was advised 23 years after the completion of his course that he could in fact become registered (Kunz 1975, p. 48).

On the other hand, there appeared to also be certain loopholes which allowed Medical Boards to waive requirements for those deemed acceptable.

These powers were used to a limited extent. However, during the 1940's, the most usual means of obtaining registration was by undertaking a minimum of three years university training (Iredale 1987, p.121). In the post-war years, there were over three hundred doctors among refugees from Displaced Persons' (DP's) Camps. Some of these OTDs had post-graduate qualifications and many had worked through the war and later in the European refugee camps. Personal files and a professional medical register was prepared by the International Refugee Organization (IRO) and given to Immigration authorities. These files were never handed over to Department of Labor and National Service officials, who were responsible for arranging employment, because they were deemed of little value. Personal files of other professional groups also met with a similar fate (Kunz 1975, pp. 20-27). It was impressed upon new arrivals by a District Controller at Bonegilla that:

... all newcomers are labourers and all European professional degrees are in Australia of no value as such documents can be bought on the black market in Europe. Therefore there are no doctors among the newcomers (cited in Kunz 1975, p. 27).

Kunz (1975) refers to the AMA's deliberate public campaign which set out to discredit the OTDs, who were required by the Commonwealth to work out their "contract" of two years in unskilled occupations. The "contract" was like a two-years' indenture so that migrants and refugees could make their economic contribution to Australia. (p. 27, pp. 112-115). Although this practice has long been discontinued, one wonders whether in some quarters the belief still exists that migrants have to pay a duty to Australia. If such a belief exists, then it would follow suit that migrants would be expected to go through an initiation ceremony by undergoing a ritualistic rite of passage, such as working in low-skilled jobs and retraining to Australian standards before they become 'accepted'. This may be one element of the AMA/AMC's ideology influencing the examination procedures.

One of the avenues for practising medicine afforded to DPs was five-year contracts in New Guinea, after which they could seek registration. Others took up contracts in Antarctica, but after return could only be registered in Australia by undertaking at least three years' university training. (Kunz 1975, p. 27, Gordon 1990, p. 5). Out of approximately 300 of these doctors, one-third were never able to work in their profession while others spent a third of their working life studying and working at menial tasks before they were eventually registered. Martin (1978, p. 173) refers to the AMA as "definers of reality" who were rigid and inflexible towards overseas doctors and to migrant health needs. She states that a consequence of the AMA's actions was the growth of a system of illegal unqualified persons who exploited their own country-people. Statistics at that time indicated that there were 13 doctors, 44 nurses and 4 social and welfare workers to the total immigrant population. She points out that there was

no obvious way in which interests of the profession would have been advanced had it assumed any active interest in migrant health care and at least on the question of recognition of overseas trained doctors, it is clear that doctors believe their interests would have been actually damaged by any concession to migrant interests (ibid, p. 179).

It becomes evident that during this time there were some differences across states in regard to acceptance of OTDs. Salter's (1971) research concentrated on Victoria between 1850 to 1966. Salter found that the most unfairly treated were refugees and displaced persons (DPs). She pointed out that during the period studied, thirty-one percent of OTDs were a "migratory elite". Although she states that discrimination was unquestionable, she also states that there appeared to be no prejudice against the overseas qualified when there was a shortage of doctors, but feels that it may have "crept in" later. This she cites as a fact which may therefore weaken the charge of "protectionism" (Salter 1971, pp. 67-75). However, this is also indicative of the degrees of variation in practices which occurred within

different States and the ambivalence in attitudes and rules about whether or not qualifications would be accepted. One of the main reasons that the DPs in particular found it so difficult was that Australian medical practitioners at that time were mainly general practitioners, while many DPs had postgraduate degrees and were specialists. Kunz states that the status of Australian doctors was threatened, as they were required to go overseas for further training (Kunz 1975, p. 39).

Several arguments and counter-arguments about the registration of DPs are almost identical with those put forward in the 1990s. For example, one raised questions about standards, contending that those being denied registration in Australia would not be likely to obtain registration in other countries. However, although other countries had mechanisms in place to restrict competition, barriers in Australia against refugee doctors were more restrictive. In the United Kingdom, Europe and the United States of America, foreign doctors and refugees could find positions in hospitals and institutions. It was more difficult to obtain registration for private practice, but this was achievable. The argument that conditions of registration in Australia were the same as other developed countries could not therefore be sustained. A second argument was the assertion that all OTDs must have a good command of English. However, the language argument could be applied in reverse on the basis that an immigrant has a basic human right to be treated by a doctor who can communicate with him/her. The final argument was that OTDs congregated in the cities, but DPs were forced to begin medical practice in Australia in remote locations and many stayed there after their contracts expired proving that they were more willing to remain in country locations than some Australian practitioners (ibid, pp. 65-67).

Public campaigns in the 1950s about rural shortages brought two results: 1) the expansion of the list of automatically acceptable qualifications, and 2) the introduction of legislation to provide qualifying exams for those whose

qualifications were not acceptable. A Bill was inserted in the Medical Practitioners Act of New South Wales to ensure that after five years licensed practice in rural areas suitable practitioners could be assessed for registration by a selection panel of Medical Board representatives and Sydney University examiners. Others sat examinations, but during 1955/1956 only twenty out of sixty passed (Iredale 1987, p.122). The medical professions at the time was controlled by the AMA, the Medical Boards and the Medical Colleges (Kunz 1975, pp. 45-46). A political debate ensued. Mr Sheahan, the State Health Minister was frustrated with the Medical Board's uncooperative stance. He passed another Bill through parliament to allow the Ministry of Health to overturn Medical Board decisions. In 1963, the Medical Act was again amended to allow three years supervised hospital practice, following satisfactory completion of an oral test, for those with qualifications not automatically accepted. The Exam Committee consisted of Dean, Faculty of Medicine, Medical Board representation, and a registered person nominated by the Minister (Iredale 1987, p. 123). Iredale states that this test was "subjective and not open to public scrutiny" (ibid). Barrett (cited in Dewdney 1972, p. 270) stated in 1940:

While registration laws have the important function of safeguarding the public from incompetent practitioners, and some State Boards quite justifiably require holders of certain overseas qualifications to complete a period of supervised hospital practice before granting full registration the use of registration laws as a means of securing the services of overseas qualified practitioners for general practice in remote areas where Australian graduates are unwilling to work appears to be open to question.

Since the early 1960s there had been prediction that from 1963 to 1975 Australia would not produce sufficient graduates to meet national demands and that 17 per cent of the medical workforce should be obtained from overseas (Last 1964

cited in Iredale 1987, pp. 118-119). During the years 1963 to 1975 migration was used to meet workforce needs. Restrictions were lifted somewhat, as reciprocal arrangements were extended to those countries recognised by the General Medical Council (GMC) and between the years 1971 and 1978 migration remained at a high level. With the cost of training of a medical practitioner then at \$50,000 per annum, this represented a considerable intake of "human capital" (Iredale 1987, p.119). However, reciprocal arrangements began to be dismantled when, by the mid-1970s, the AMA began to express fears of oversupply and started to pressure the government to not only reduce migration intake, but also to reduce local graduate intakes (ibid. p.120). Table 4 on page 56 shows the automatically registrable qualifications that existed in 1970 and which were progressively dismantled before the decade's end, even though at that time there was a move to non-discriminatory selection process in general immigration policy.

From the early 1970's qualifications from the Indian subcontinent were the first to be removed. Later remaining Commonwealth countries were removed and then the remainder (Human Rights Commission 1991, p. 44, Iredale 1987, p. 124). The states moved at independent rates and the outcome was an increased dependence on hospital practice means of assessment (Iredale 1987, p. 125). However, by 1978, the only avenue open for recognition was through Australian Medical Examination Council exam (AMEC), which in 1985 changed to Australian Medical Council (AMC), and which had then established itself as a national body for accreditation of OTDs.

Although, the medical profession was the first to establish an examination procedure for OTDs which would be recognised by all State Medical

Table 4

**Overseas Medical Qualifications Automatically Registrable
by State or Territory 1970 and 1989**

Country of Qualification	State or Territory							
	NSW	ACT	NT	QLD	SA	TAS	VIC	WA
United Kingdom	r	R	R	R	R	R	R	R
New Zealand	R	R	R	R	R	R	R	R
Ireland	r	R	R	R	r	R	R	R
Canada	r	r	r	r	r	R		r
South Africa	r	r	r	r	r	R	r	r
Malta	r	r		r	r	r	r	r
Hong Kong	r	r	r		r	r	r	r
Malaysia	r		r		r	r	r	
Singapore	r	r	r		r	r	r	r
Uganda	r		r		r	r		
Sri Lanka	r	r	r		r	r	r	
India	r		r		r	r	r	
Pakistan	r		r		r	r		
Burma	r		r		r	r		
West Indies			r		r	r		
U.S.A.	r							
Puerto Rico	r							
Israel	r							
Lebanon	r							
Sweden	r							

R = registrable in 1970 and 1989

r = registrable in 1970 but not in 1989

(Human Rights Commission 1991, p.44, Iredale 1987, p. 124 (updated))⁵

Boards, this did nothing to alleviate differences in accreditation criteria for postgraduate qualifications or problems of geographic mobility between states. Allsop (1970, p. 284), a doctor from the United Kingdom, in a letter to the Medical Journal of Australia describes the situation at that time :

As one who has practised in South Africa, as well as in England, and enjoyed the convenience of a medical registration which enables one to practise in any area

of the country, I, too, am at a loss to understand the confused and old-fashioned systems which obtain here, and which are a relic of a bygone era.

Being interested in the possibility of practice in Queensland at one point, I had the expense (not tax-deductible) of flying to Brisbane, to attend, in person, one of the infrequent meetings of the Board, although I was already registered in South Australia and New South Wales. With all the paraphernalia of photographs and fingerprints, one felt more like a convict than a doctor!

One cannot, as in other countries, register before arrival in several states; where one has, in addition to appear personally, one may have to wait a month before being allowed to practise - leading to considerable inconvenience and a loss of earnings to immigrant doctors.

It is high time that the States got together, and that a new registration body at Commonwealth level, on the lines of overseas bodies, was formed. This would also eliminate the anomaly of certain postgraduate qualifications being registrable in one State, but not in another, as well as solving the dilemma of those doctors who live near the border and who must needs register in two States and practise under different laws! Broken Hill is one example, where an area linked in practice with S.A. is geographically in N.S.W. As doctors from South Australia go to Broken Hill to do a few weeks' locums, they have all the inconvenience, delay and expense of re-registering.

I would add a strong plea to that of Dr Cooke for a Federal licence to practice medicine, in this space-age Australia.

If these were indicative of the problems of those who were automatically registrable, they were nothing compared to what others not automatically registrable had to face in the decades to come. While State Medical Boards until the late 1970s had their own licensing laws and examination procedures for recognising overseas qualified skills, the setting up of the Australian Medical Examining Council (AMEC) in 1978 was in effect to be a much more indirect

means of regulating the influx of OTDs and also limiting the avenues open to practise. Except for those under reciprocal agreements, other OTDs no longer had the benefit of entering directly into the hospital system, but were faced with an more expensive and rigid system of examination without the prior advantage of interaction and gaining local knowledge of medical practice. This had the effect of limiting entry into medical practice of OTDs not under reciprocal arrangements. It also led to a huge influx of short-term visa entries being granted to supply the hospital system with medical practitioners, while Australian resident OTDs, mainly from NESB countries, were either unemployed or underemployed.

In summary, this chapter has described the historical emergence of the medical profession with the medical elite dominating in education, the political sphere and accreditation of OTDs. The particular experiences of refugee and migrant OTDs have shown that where the medical profession could not directly influence limitations to entry of OTDs, as in the case of the rural doctors, on the other hand they have several means at their disposal, through the State Medical Boards, Medical Colleges and the Australian Medical Association, to successfully influence entrance into their domain. Instead of the medical profession of modern Australia becoming more flexible and outward-looking, as time passes the rigidity and restrictiveness is increasing. This is the subject matter which will be discussed in the following chapter.

Footnotes - Chapter Four

- 1 Dickey (1987) amply illustrates this point. Dickey traces medical relief for the poor from 1890 and discusses tensions and struggles between the medical profession and the state around selectivity and universalism from 1916 to 1950, debates about which he states were to reverberate time and time again (pp. 102-108). Women's studies - such as Summers (1975), especially pp. 244-247, and Roe (1988, pp. 1-19) emphasise the vulnerability of women and women's health, even though some women became doctors.
- 2 It is not possible to present a full discussion on health care issues. A historical account of health care administration between professional interests and governments is to be found in Crichton (1990). Daniel (1990) also presents a comprehensive account of divergent situational and material interests within the medical profession, centred around the New South Wales strike in 1985. Willis (1989) also relates a social history of medical dominance in Victoria in relation to medical practitioners and other 'allied' health professions.
- 3 These were countries which at that time allowed reciprocal registration to Australian graduates. Iredale (1987, p. 121) states that in 1939 in New South Wales, countries under reciprocal arrangements were New Zealand, United Kingdom, South Africa and Italy. However, N.S.W. legislation provided for the registration of other OTDs provided they worked in rural areas.
- 4 Exact figures for professional wages during this period is not known. However, since 1907 the basic wage was established through the Arbitration Court at Two pounds two shillings per week (or approximately 110 pounds per year). After 1937 the Court changed its perception of what was viewed as "basic" according to the state of the economy. By 1953, there had been a 50 per cent rise in the basic wage since 1911, and the minimum basic wage was over twelve pounds per week or about 624 pounds per year (Shaw 1955, p. 284). It probably could be estimated that professionals would be paid around five times the basic wage which would give a figure of around 600 to 800 pounds per year.

5 As from 1 January 1993, only qualifications from New Zealand will be automatically registrable. At the time of writing the Western Australian Medical Board cannot confirm this as the announcement by the Australian Medical Council was made before legislation was amended.

CHAPTER FIVE

STATUTORY REGULATION AND EFFECTS OF MEDICAL MIGRATION

Growing concerns about the non-recognition of overseas qualifications generally, and also the issue of medical workforce projections and requirements have led to several government enquiries. These are :

- * The Committee of Inquiry into the Recognition of Overseas Qualifications - 1983 (Fry Committee, Commonwealth)
- * The Committee of Inquiry into Medical Education and Medical Workforce - 1988 (Doherty Committee, Commonwealth)
- * New South Wales Committee of Inquiry into Recognition of Overseas Qualifications - 1989 (Fry Committee, New South Wales)

The first two inquiries were commissioned by the Federal government, the first by the Minister for Immigration and Ethnic Affairs and the other by the Minister for Health. The third was commissioned by the New South Wales government in response to a proposal put forward by the Ethnic Affairs Commission of New South Wales (Iredale 1988, p. 6). However, despite these inquiries, the situation in Australia for OTDs has not improved.

This chapter will outline the role and function of statutory bodies involved in the accreditation of OTDs, discuss the components and impact of medical

migration, and describe how the Doherty Committee has confused the problem of medical assessment with medical manpower requirements. This chapter will also describe that the processes involved in accreditation of OTDs impose mechanisms of social closure, as they constitute unfair and discriminatory practices which create social and financial barriers to effectively deny many NESB OTDs the right to practise medicine in Australia.

The delay of almost a decade while these inquiries were in progress caused a backlog of about 1,000 OTDs¹ who had been unable to gain accreditation in the early 1990s. This was the subject of a Human Rights Commission report and a Bureau of Immigration Research study of OTDs in Victoria, produced in 1991 and 1992 respectively. The Human Rights Commission (1991, p. 9) states :

... despite the considerable resources spent on the major reviews, some of the key matters identified by the first of these (the 1983 Fry Committee), such as the provision of bridging courses for all overseas trained doctors, have still not been adequately addressed. Indeed, the apparent preoccupation with reviews has diverted attention away from the difficult issues and avoided the need for hard decisions to be taken on the vexed question of relative priorities of resources.

Issues can be more easily understood when discussed in the context of the various registration bodies involved in the assessment and accreditation of OTDs. Although AMEC/AMC has been set up to examine OTDs and all State Medical Boards recognise the AMC exams, no national uniform system for accreditation of medical practitioners exists in Australia. State Medical Boards have always had different rules and procedures for granting conditional, provisional or temporary registration (Carter 1987, p. 62. Report of Committee 1983, pp. 128-129)². State Medical Boards also differ as regards their degree of autonomy. The extent of direct state control over election of board members differs greatly because of the different provisions of legislation under which boards have been established

(Dewdney 1972, pp. 92-112, Report of Committee 1983, p. 128). For example, New South Wales and Victoria have a more centralised system of state administration and the Medical Board, especially in New South Wales, is made up of representatives of public interests outside of the profession, as well as medical practitioners (Dewdney 1972, p. 108). In contrast, in other states, State Medical Boards are given complete autonomy and control in determining terms of reference for entry (Carter 1987, p. 61-63). Carter (1987, p. 63) states:

From time to time, exercise of such functions
are a basis for charges of elitism and
discrimination levelled against Boards.

All Boards recognise the AMC exams and these are in effect a mechanism devised for delegation of authority by State Medical Boards. A national exam process is conducted on their behalf to examine OTDs³ except those from countries under reciprocal arrangements before AMEC was established, although these OTDs have no portability of qualifications. A move to another State would mean either retiring from practice or sitting for the AMC exams⁴. The role and function of State Medical Boards are to advise the public which practitioners have achieved a certain standard to use a registered title. It is not a "guarantee of actual competency" (Carter 1987, p. 61). For example, a new graduate would not demonstrate the same clinical judgement and expertise that only develops with years of experience. On the other hand, annual renewal of registration does not depend on the development of skills or any test of "competency", the only requirement is continued payment of fee in absence of any evidence of malpractice. In the event of a change of regulation, such as is occurring under the present Vocational Guidance Scheme for medical practitioners⁵, there is what is called a "grandfather" clause which allows a time-frame for meeting new requirements. (Carter 1987, pp. 61-66, Howe 1992, pp. 1-2).

In contrast, since the 1930s, OTDs have been principally assessed on their primary qualifications, that is the regionally based institution from which they have attained their basic medical degree, Bachelor of Medicine and Bachelor of Surgery (MBBS) (Iredale 1987, p.121). In other words, neither experience nor post-graduate qualifications whether in the United Kingdom, United States or any other country are taken into account. For example, in Australia, specialists become accredited when they become a Fellow of the particular specialist College from which they graduate, while general practitioners are now officially recognised by the government as more highly qualified when they become a Fellow of the Royal Australian College of General Practitioners (FRACGP). However, Kidd and Braun (1992, p. 10) state that even those OTDs who had undertaken a course of specialisation in an Australian medical college and graduated by becoming Fellows of the Royal Australian College of Surgeons and Ophthalmologist have been forced to sit for the AMC exams, because their primary qualifications are not from British-based institutions.

State Medical Boards are able to register OTDs without temporary resident visas or without residence qualification. However since 1985 only those persons with permanent resident status are eligible to sit the AMC exams (Committee of Inquiry 1988, p. 422). State Medical Boards of Queensland, South Australia, and Western Australia have legislation for registration of specialists, which enables them to scrutinise experience and qualifications (Committee of Inquiry 1988, p. 344, Commonwealth Department of Health 1987, p.38).

It can be seen that the discretionary powers of the State Medical Boards allow them to register some OTDs to practise in Australia where the need arises, while others are forced to wait until they pass the AMC exams. Although experience of Australian doctors is recognised, there is little or no acknowledgement of experience or specialist qualifications. The fact that an

OTD's primary degree has been accepted by a Specialist College in order to gain specialist accreditation and then rejected by the National Specialist Qualification Advisory Committee (NSQAC) is one of the many anomalies that arise.

NSQAC is a national body set up to meet requirements under health insurance legislation. All states work under the criteria established by the NSQAC for accreditation of specialist qualifications. NSQAC recommend which fields should be registered as specialties and which postgraduate qualifications should be recognised. A recognised specialist (i) is able to claim a higher rate of scheduled fee under Medicare, (ii) may satisfy certain legal requirements under State legislation; (iii) is able to gain accessibility to various facilities (Committee of Inquiry 1988, pp. 292-293, Commonwealth Department of Health 1987, p. 38).

However, as with State Medical Boards, no nationally uniform system is in existence for accreditation of specialties. The Doherty Committee (Committee of Inquiry 1988, p. 344), Recommendation 9 (i), recommended :

that NSQAC, AMC and State Medical Boards consult to develop a national policy on accreditation and collection of statistics, about specialties, specialty qualifications and specialists.

Nevertheless, unless OTD qualifications are acceptable to NSQAC, specialists must sit the AMC exams (ibid, p. 447). The National Council of Health Organizations (NCHO), in its submission to the Doherty Committee, was critical of NSQAC. The NCHO stated that the membership of NSQAC reflected the "industrial and economic power it wields" (cited in Committee of Inquiry 1988, p. 330). It recommended that the membership be broadened to reflect the public interest and bring specialist accreditation more in accord with community needs. It was of the opinion that there were deficiencies in services in public health fields, such as epidemiology (non-FRAGP), accident and emergency medicine, geriatrics, palliative care and infectious diseases. It asked the Inquiry to reflect why

"very specialised" expertise was not considered such as in the areas of occupational health, community health, women's health (holistic) and ethnic health (including Aboriginal health) (ibid. pp. 340-342).

In short, although NSW has established special conditions for registration of specialists (Human Rights Commission 1991, p. 46, Iredale 1987, p. 125.), in the main specialist practitioners whose primary qualifications are not recognized by the National Specialist Qualification Advisory Committee (NSOAC) are unable to gain automatic registration and are required to sit the Australian Medical Council (AMC) exams. However, as from 1 January 1993, legislation is to be amended to allow specialists whose primary qualifications are not recognised to be assessed by the relevant Specialist Medical Colleges, in order to gain registration to practise only in the specialty trained. The exact details of this are at present being finalised (Australian Medical Council 1992, p. 6). It is assumed that there may be practical difficulties because of the limited range of specialties at present acknowledged.

It was mentioned in chapter three that the Council for Professional Qualifications (COPQ) was established in 1969 in response to a need to investigate accreditation procedures for overseas professional and trade qualifications. The inconsistencies which existed in procedures for medical registration and accreditation caused COPQ to firstly direct its attention to medicine. In 1974, a COPQ Expert Panel in Medicine was established to consider :

the compilation of a uniform list of qualifications considered suitable for immediate registration; the introduction of exam procedures for holders of other qualifications; methods for accepting eminent medical practitioners from overseas without further examination, and methods for considering practitioners from the United States who did not possess the Educational Commission for Foreign Medical Graduates (ECFMG) certificate (Iredale 1987, pp. 125-126).

In 1977, a Conference of Presidents of Medical Boards agreed to the establishment of the Australian Medical Examining Council (AMEC) which came into being in June 1978. Legislation in Queensland, the ACT and Western Australia was not amended until 1980 to acknowledge recognition of the AMEC certificate (ibid, p. 126). In 1985, AMEC became the Australian Medical Council (AMC). The AMC is independent of State and Commonwealth Governments. It is now the national standards and examining authority for basic medical education in Australia. The AMC's membership consists of representatives of State and Territory Medical Boards, the Australian (University) Vice-Chancellors Committee and the National Office of Overseas Skills Recognition (NOOSR) which replaced COPQ (Australian Medical Council 1991b, pp. 1-2).

The AMC examination contains two components : (a) a multiple-choice question (MCQ) written examination, and (b) a clinical examination. Before sitting the AMC exam, candidates must have passed the Occupational English test administered by the National Languages Institute of Australia, unless exempted. Before proceeding to the clinical component of the AMC exam, candidates must pass the MCQ component. It is possible to sit for the MCQ overseas, but the clinicals must be undertaken in Australia (ibid, p. 2).

Since 1985, to qualify to sit for the AMC exam, an OTD must (i) be an Australian resident, or in the case of overseas applicants they must possess proof of impending status, (ii) have completed a basic medical degree of 5-6 years duration with one year internship and (iii) have successfully completed the Occupational English Test conducted by the National Languages Institute. As from July 1989, documentary requirements of intern training is no longer required by the AMC. However, the AMC now states that the State Medical Boards require this proof and "may require evidence of current registration or good character before granting registration to candidates" after passing the AMC exam (Australian

Medical Council 1991b, p. 2). This latter factor is not stipulated in the compendium of Professional and Technical Skills Recognition in Australia published by the National Office of Overseas Skills Recognition (NOOSR) (Department of Employment 1990 (p. 62). The AMC also has the function of determining and recommending which qualifications could be acceptable without exams. The Medical Act has not been amended to acknowledge this (Carter 1987, p. 66). These anomalies only add to confusion for, when criteria are not clear-cut, there is room for various interpretations.

The Fry Committee in 1983 was critical of the AMEC mainly for the following reasons. That it :

- * ignores competency based on specialist training, and language and cultural skills;
- * ignores responsibility for problems encountered by overseas doctors in gaining clinical practice before exams;
- * defines own terms of reference as its only responsibility being for examinations;
- * ignores associate organization's recommendations for review of basic educational criteria by which standards are gauged;
- * ignores and does not itself monitor changes in overseas educational systems (Report of Committee 1983, pp. 137-141).

The Deans of the Medical Schools at that time had endeavoured to assist refugee doctors to gain clinical experience, or access to postgraduate activities, libraries and museums. A joint evaluation submitted to the Fry Committee in 1980 found results disappointing because of the following barriers :

- * Inadequate preparation in English;
- * Lack of participant training in clinical refresher courses;
- * Inadequate financial support to allow full-time commitment;
- * Lack of recognition by the AMEC of social circumstances and difficulties of overseas-trained doctors (ibid, pp. 142-143).

The main criticism of AMEC during its initial establishment was that it had been effective in setting itself up as a licensing body without being responsive to government policy. As stated above, the AMC still retains this independence. The original body was made up of representatives of the eight state and territory Medical Boards are members of the Executive Council of the AMC, as well as two educational representatives from COPQ (now NOOSR), and a representative from the Australian Medical Association (AMA). In 1992, the AMC - although largely retaining the composition of its Executive Council - has a much larger representation of membership because of its increased function in overseeing accreditation processes for Australian graduates, as well as that of OTDs (Australian Medical Council 1991a, Report of Committee 1983).

COPQ was severely restricted in its terms of reference because of ministerial direction that its services be directed to overseas professional and skilled migrants rather than to assisting the resident population (Report of Committee 1983, pp. 18-19). There are claims that the AMEC was effectively able to set itself up autonomously, taking over a function which COPQ should have been given in the first place. Stutchbury (1988, p. 14), a journalist for the Australian Financial Review, states :

While the English language test for migrant doctors is now being reformed, the medical profession still guards against overseas competition. When the Wran Government threatened to import doctors to fill NSW hospital positions in 1985, specialist leader, Dr Bruce Shepherd, warned that only "the dregs" would come. A key factor here is how

professional bodies such as those for doctors have managed to capture the Federal Government's Council on Overseas Professional Qualifications. The capture has been largely by default, due to COPQ's deficiency of resources, insufficient Commonwealth authority and a rigorous lack of intellectual purpose.

Iredale (1988, p. 16) also states that when criticisms were raised that the AMC exam processes were not equitable, the AMC consented to a review being conducted. However, a medical academic, instead of an independent agency, was commissioned to conduct the review.

The initial procedures for examining OTDs had an English test as an initial component of the AMEC exams, besides the MCQ and the clinicals. Originally, failure in any section of the exams would require the candidate to re-sit the whole exam (Report of Committee 1983, pp. 128-135). Since its inception, rules have been changed from time to time and so has the cost of the exams.⁶ In 1983, English language was separated from the MCQs. It is now tested by NOOSR (formerly COPQ) and costs \$120 per attempt. The cost of the MCQ component and the clinical exams are \$591 each per attempt, with a limit of three attempts (Human Rights Commission 1991, pp. 70-71).

Until 1988, passmarks were adjusted periodically at the discretion of the AMC Board. Marks of 67% have at times been considered a fail mark (ibid, p.22). This has been the subject of much dissatisfaction from OTDs until in 1988 an official pass-mark of 50%, was set with computerised results being mailed to examinees (Australian Medical Council 1990). The expense of repeating exams which, since 1985, have been at the minimum of \$500 an attempt has resulted not only in lost time and increased financial burden, but also a loss of self-esteem and sometimes severe personal stress (Iredale 1987, p. 133-137, Kidd and Braun 1992, pp. 30-31). This has been compounded by the fact that until recently AMC exams were only conducted in Sydney and Melbourne (Iredale 1987, p. 134-135).⁷

As announced in July this year by the Australian Medical Council, from 1 January 1993, the examination criteria will change. The MCQ exams will consist of five parts. Although the passmark remains at 50% a candidate is required to achieve a minimum of 40% in each section before a pass-mark of 50% or over will be recognised. There will be no limitations placed on the number of attempts for the MCQs, but after three attempts, the candidate will receive counselling. At the same time, a quota of 200 places a year will be set on access to the clinical component. The limit to the clinicals will remain at three attempts, but special counselling will be provided after two attempts. Reciprocal arrangements will cease except for New Zealand. Those OTDs proceeding to the clinicals will be taken from the MCQ candidates, based on merit of performance (Australian Medical Council 1992, pp. 1-6). In effect this will mean that only the high-range of achievers will be able to compete⁸.

Candidates for the MCQ since 1988 were only required to have an overall pass mark of 50%. Since the main criticism of the exam is that the time factor disadvantages those from a NESB background in completing the MCQs, it will be very probable that those persons of ESB background will be more likely to achieve a higher pass-rate.

The Human Rights Commission (1991, p. 19), Recommendation No. 11 stated:

The AMC should have its examinations independently evaluated to ensure that the format of the examinations, and the wording of the questions, does not unduly disadvantage those overseas trained doctors from non-English speaking backgrounds. An independent assessment has already been undertaken in respect to the appropriateness of the multiple-choice format, but that does not appear to have been specifically directed at the difficulties the questions may pose for those of a non-English speaking background.

The fact that the examinations might be positively skewed towards ESB migrants was realised at a Medical Workforce Data Review Committee (MWDRC) (1992) which was established at the recommendation of the Doherty Committee to monitor and evaluate national medical workforce needs. The discussion revolved around introducing a selection system to "match" ethnic doctors to ethnic communities of similar origin in need of their services (MWDRC 1992, pp. 1-14). This suggestion was not eventually adopted by the Health Ministers, as the practicalities of trying to institute such a system would render it unfeasible. However, as will be shown the issue of "matching" did not disappear. In addition, although Australian students and OTDs will be restricted by quota, there has been no restriction on numbers of New Zealand doctors entering the country. The only winners are hopefully the OTD specialists, who will no longer have to sit AMC exams. However, it is envisaged that probably those practising in specialties in short supply will be the most successful in achieving recognition.

In contrast, the National Accreditation Council for Skills Recognition (NACSR) (1991), a federal body established to oversee the Migrant Skills Reform Strategy, announced that a Special Premier's Conference in 1990 recognised the need to establish a framework for mutually recognising professional, para-professional and trade skills throughout Australia. The goals are to increase labour mobility, progress towards creating a national market for the professions and trades involved, increase competitiveness and result in meaningful benefits for the community. Nursing is the first profession to adopt national competency-based standards which will be applicable across Australia for all new registrations of qualified nurses - whether their education has been in Australia or overseas. Nine other professions are following suit. These are architecture, dietetics, engineering, occupational therapy, optometry, physiotherapy, psychology, social welfare and veterinary science (NACSR 1991, pp. 8-9).

NACSR has been monitoring progress of the review of the AMC in relation to its examination procedures towards competency-based standards in light of the Human Rights Commission Report (1991) (ibid. p. 9).

Dawkins (1990 cited in NACSR, p. 9) stated :

To compete successfully in the global marketplace of trade in professional services, Australia must follow this course of action [using a person's ability to perform tasks and duties as the main mode of skills recognition], already taken by the European community. For many professionals, it is now easier to move between countries in Europe than between States in Australia.

In summary, it appears that the medical profession over time has moved towards increasing regulation and restrictions for OTDs to practise medicine in Australia. The Fry Committee (1989) and the Human Rights Commission (1991) both called for an increase to discretionary powers of State and Territory Boards, increased access to bridging courses. The Human Rights Commission (1991, p. 13), Recommendation 3, also recommended that :

if appropriate steps to amend these statutes are not taken by the various State Governments, then the Federal Government should consider introducing Federal legislation in respect of the accreditation and recognition of the qualifications, training, experience and skills of overseas trained doctors, and their registration to practise medicine in Australia.

However, although there have been reviews for competency-based assessment criteria by the AMC, the quota arrangements have been state-sanctioned and based on recommendations made by the medical profession themselves, without any outside consultation. The remaining section of this chapter demonstrates that medical migration accounts for an insignificant portion of those entering Australia under long-term migration programmes compared to other categories. The effects of medical migration must take into account three factors :

- * Impact of numbers of OTDs who obtain permanent resident status through family migration, independent and concessional categories, Employer nomination scheme, and Trans-Tasman agreements;
- * Resultant net gain based on arrivals and departures of medical practitioners already registered.
- * Impact of OTDs who enter under temporary-resident categories on short-term visas (Douglas, Dickinson, Rosenman and Milne 1992, p. 15).

The focus of medical migration has been predominantly on those seeking permanent resident status through the AMC exams (AMA 1992, Committee of Enquiry 1988, Kidd & Braun 1992, New South Wales Committee 1989, Report of Committee 1983). The Overseas Doctors Association, the Commonwealth Committee of Inquiry into Non-Recognition of Overseas Qualifications (Fry Committee, 1983) and the New South Wales Committee of Inquiry into Non-Recognition of Overseas Qualifications (Fry Committee, 1989) have argued that 1) entry through the AMC exams has resulted in very insignificant numbers of OTDs becoming registered and 2) the low-success rates plus reciprocal arrangements were discriminatory. Douglas et al. (1992, p. 20) estimate that for the 11-year period 1978-88, a total of 627 persons have passed the AMC exams and subsequently have sought registration. This means an average of approximately 54 per annum gained accreditation. My own summation of performance is based on the AMC results for 1978 to 1991 as outlined in Table 5 below.

Table 5

**Australian Medical Council: Summary of Results of Examinations
conducted for Overseas Trained Doctors
for Financial Years 1977/78 - 1990/91**

YEAR	MCQ			CLINICAL		
	Number Candidates Newly Presenting	Number Sitting Per Session	Number Passing	Number Candidates Newly Presenting	Number Sitting Per Session	Number Completing All Sections
78/79	174	198	117	96	103	35
79/80	125	170	104	73	100	28
80/81	93	155	91	51	86	26
81/82	90	146	75	47	78	30
82/83	118	191	76	59	107	55
83/84	111	191	74	73	150	68
84/85	122	219	85	82	149	75
85/86	143	264	111	111	214	79
86/87	253	447	69	65	190	83
87/88	193	424	88	64	137	64
88/89	282	501	122	93	168	85
89/90	394	655	326	187	281	131
90/91	537	915	455	278	391	194
TOTAL	2635	4476	1793	1279	2154	953

(Australian Medical Council 1991a, p.12)

It can be seen that for the above thirteen-year period, from a total of 4,476 attempting the Multiple Choice Question (MCQ) exams, 953 have eventually passed the second component of the exam which is the Clinicals and therefore have been able to gain registration to practise in Australia. That is, less than 20% of those originally attempting the exams have eventually passed. The average annual contribution of OTDs according to these figures is approximately 73 persons per year.

The increase in the number sitting may be due to an accumulation of repeated attempts rather than increased migration. For example, for the years

1986/87 to 1988/89 more than 75% failed the MCQ component of the exams. In contrast, the clinicals have remained virtually the same in outcome, showing a consistency of an average pass rate of 45% (except for the years 1978/81 and 1985/86 when there was a 33% pass rate). The problem has been trying to pass the MCQ component in the first place. Although there has been an increase in pass rates of those sitting for the MCQ component of the exams for the period 1989-91 to approximately 45%, the pass rate of the clinical component has remained constant, despite the fact that during this period Overseas Qualifications Units have been set up in most states and increased access to bridging courses have become available. In addition, the AMC has also run additional examinations to try and clear up the backlog. Douglas et al. (1992) point out the numbers sitting the AMC exam cannot be solely attributed to increased migration.

Table 6 on page 77 shows migration intakes from 1986 to 1990. These figures include persons from the United Kingdom, New Zealand, and Ireland who have not been required to sit the AMC exams. The Special eligibility category and the Employer Nomination Scheme (ENS) also should not be taken into account as these persons enter under special contractual arrangements.. Those sitting the AMC exams would be generally in the Family, Independent and Concessional and the Humanitarian categories. It is therefore difficult to match AMC figures to medical migration figures because of the above factors. Also there may be spouses of principal applicants that are OTDs, but would not show in the migration figures.

Table 6

**Permanent entrants of overseas-trained doctors to Australia
1984-1985 to 1988-1989 (specialists/medical practitioners)**

CATEGORY	1984-85	1985-86	1986-87	1987-88	1988-89
Employer Nomination Scheme (or equivalent)	34	66	66	73	82
Business Migration Program	-	1	-	19	17
Family Migration	93	89	42	69	66
Independent/Concessional ('points system')	-	1	66	156	136
Refugee & Special/Humanitarian (no points required)	8	10	10	10	10
Special Eligibility ('super specialists')	1	1	6	3	3
New Zealand citizens	36	43	20	25	27
Other (not included in above)	3	1	-	-	1
TOTALS	175	212	232	355	352

(Gordon 1990, p. 16)

The number of repeated attempts is particularly relevant and this is tabled in Appendix (ii) and (iii) showing the MCQ component and the clinicals. With a charge of over \$500 per attempt per component since 1986, a 20% to 25% pass rate until 1989/90 and a 45% pass rate since then in the MCQs and the clinicals, the closure mechanisms in place are clearly discernible. This clearly refutes the Federal government's argument that 60% of OTDs would be expected to pass if a quota was not set in place (S. Northcott - personal communication - October 6,

1992). At a cost now of \$591 per attempt, the AMC must be showing a healthy balance sheet.

Correspondingly, for the 7-year period 1979-1986, a total of 336 OTDs of UK/Eire origin entered Australia for permanent residency status (Commonwealth Department of Health 1987, p. 34). This means that on average, about 47 per annum were given automatic right to practice without any accreditation process. Similarly, for the 5-year period 1984-1989, a total of 151 New Zealand medical practitioners - an average of 30 per annum - also entered Australia and also were entitled to automatic registration (ibid, p. 30).

Table 7 below shows net results of arrivals and departures for the period 1987-1990. While there has been an increase in net immigration of OTDs, at the same time there has in effect been a net loss of Australian medical practitioners for the past three years. Iredale (1987, p. 119) states that permanent departure has historically been a constant and significant factor in migration patterns.

Table 7

**Net permanent or long-term gain from migration of
Australian resident doctors and overseas trained doctors**

Year	Australian resident Doctors	Overseas trained Doctors
1984/5	122	46
1985/6	105	153
1986/7	46	128
1987/8	-34	252
1988/9	-78	340
1989/90	-83	360

(Department of Immigration, Local Government and Ethnic Affairs, January 1992 cited in Douglas et al. 1992, p. 18)

Although the above figures show the permanent-long term gain from all sources, they only give an indication of doctors entering Australia, not those which have been registered to practise.

Finally, the third means of entry into Australia of OTDs is through short-term visas. Table 8 below shows the almost one-thousand fold increase between numbers entering if 1987/88 figures are compared to 1989/90 and 1990/91. The figures of 1,255 and 1,226 for those respective periods each surpass the total number of the annual local medical graduate output. A person entering under temporary visas can be granted permanent resident status should they prove that there is no local person adequately trained to fill their position. However, estimates of those entering through this means are said to be relatively few (Douglas et al. 1992, p. 19, National Health Issues 1992, p. 63).

Table 8				
<u>Overseas medical practitioners granted temporary visas</u>				
<u>by length of stay</u>				
	6 months	6-12 months	12 months	Total
1986-87	-	74	42	116
1987-88	-	66	56	122
1988-89	192	321	76	589
1989-90	752	434	69	1255
1990-91	447	669	110	1266
(Department of Immigration, Local Government and Ethnic Affairs 1992, cited in Douglas et al. 1992, p. 19) ⁹				

Table 9 below shows the number of medical practitioners who were allocated Medicare Stem provider numbers for the period 1989/90 and 1990/91. Of the total of 3,388 medical practitioners, 1,944 were local graduates. Sixty-six percent (953) of the OTDs were trained in UK/Eire out of a proportion of 42%

(1,444) of the total OTD component (Douglas et al. 1992, pp. 21-22). However, although these figures may not necessarily reflect permanent additions to the workforce, they do reflect that a significant number of visa-entry doctors are given Medicare provider numbers to enable them to write prescriptions (National Health 1992, p. 63). The numbers of OTDs not from UK/Eire source countries adequately reflect the pass rates in the AMC exams.

Table 9

Medical practitioners allocated a stem provider number for the first time in the two years 1989-90 and 1990-91 (by country of initial medical qualification)

Country of initial medical qualification	Number of medical practitioners allocated a stem provider no.
New South Wales	621
Victoria	578
Queensland	355
South Australia	243
Western Australia	72
Tasmania	75
Australia (total)	1944
New Zealand & Pacific	29
United Kingdom/Ireland	953
Europe/USSR	47
Southeast Asia	60
Northeast Asia	30
South Asia	83
USA/Canada	22
South & Central America, Caribbean	11
Other Africa (not further defined)	8
Total others	1444
Total	3338

(Douglas et al. 1992, p. 22)

The data presented in this chapter establishes the fact that most OTDS have come from ESB countries either through long-term migration or under temporary visa arrangements. However, those OTDs who have migrated to Australia and have been accepted by the Federal government for professional and/or non-economic reasons as Australian residents face formidable barriers to gaining recognition. The Human Rights Commission's Report concluded:

Many overseas trained doctors have been the unwilling and undeserving victims of Australia's rigid medical registration system. No doubt the system operates to ensure the maintenance of high medical standards in Australia but it also deprives permanent Australian residents of proper recognition of their hard-earned qualifications and experience and it deprives the rest of the Australian community of their skills and expertise. There can be no doubt that it is in effect a restrictive trade practice that preserves medical practice as a virtual 'closed shop' for local graduates. There is compelling evidence that it is also discriminatory within the terms of s.9 of the Federal Racial Discrimination Act 1975 and therefore unlawful (Human Rights Commission 1991, p. 20).

The report received condemnation from the Australian Medical Association and other medical practitioners who strongly denied that there was ever discrimination based on race (Eather 1991, p. 4, Gerber 1992, pp. 502-504, O'Brien 1991, pp. 2-3). The nature and extent of these allegations of discrimination will be explored in the following chapter.

Footnotes - Chapter Five

- 1 The Fry Committee in 1983 estimated a backlog of approximately 270 medical practitioners. The AMC gives estimates of there being over 2,000 resident in Australia at some stage of the accreditation process in 1992. They also estimate that there are an additional 2,000 overseas who are awaiting entry to Australia (MWDRC 1992).
- 2 The Human Rights Commission (1991) outlines details of statutes and comparisons between states (pp. 39 - 41).
- 3 As shown in Table 4, under present reciprocal arrangements, N.S.W. only automatically accepts Australian and New Zealand qualifications. All other states, excepting Tasmania, accept qualifications from the United Kingdom/Eire and New Zealand. In addition to these countries, Tasmania accepts qualifications from Canada and South Africa. However, from 1 January 1993, reciprocal arrangements will cease to exist for all countries, except New Zealand.
- 4 However, both the Northern Territory and New South Wales have made amendments to their Acts to allow registration to OTDs whose primary qualifications were accepted before 1974 and who have practised continuously for five years in one state (Human Rights Commission 1991, p. 39).
- 5 For details, see National Health Strategy Issues Paper No. 3 (1992).
- 6 See Appendix I. This shows the changes in rules and fee structure for the period 1969 to 1990 (Human Rights Commission 1991, pp. 70-71).
- 7 Appendix II shows attempts made at MCQs and Clinicals for the period 1979 - 1990. (Human Rights Commission 1991, pp. 50-53). . It is interesting that since NSW has ceased accepting UK/Eire qualifications, that not all from these countries have successfully been able to complete the AMC exams. Blacket (1990) has also reproduced results of AMC exams by regional groupings for the period 1983-1989 and which shows percentage pass rates averaged per group (pp. 140-152).

8 Appendix III shows the new regulations, as reproduced from the AMC information leaflet sent to OTDs (Australian Medical Council 1992).

9 This data may represent some movement of medical practitioners who have entered on multiple-entry visas.

CHAPTER SIX

THE NATURE AND EXTENT OF DISCRIMINATION

There are significant differences in socio-economic status amongst various sections of the medical profession and between them and the broader population. First of all this chapter will look at the most recent stated incomes of medical practitioners. Their current socioeconomic status will then be compared to overseas trained general practitioners and specialists who are permanent residents of Australia, but have as yet been unable to pass the AMC exams, nor gain a temporary licence to practise. This will be compared to other research of migrant status and earnings. This chapter will then go on to show that neither lack of English language skills nor lack of medical competence are prime causes for exclusionary practices. Exclusion is sanctioned by the ethnocentric values and attitudes of an elitist group that has little regard for other cultures, nor concern for the social and economic well-being of their OTD counterparts. It will be shown that present policy is discriminatory, especially to NESB migrant and refugee OTDs not entering under the points system. Finally, it will be shown that there has been a convergence of forces dictating these moves which are contradictory to socially progressive reforms.

The education system has produced a medical elite of specialists who have limited access to specialties through strict control of numbers, while general practitioners have had no such limitations placed on their numbers. The pattern has also been reproduced in controlling accreditation of OTDs, pushing specialist OTDs into the general practitioner workforce. The disparity between specialist and general practitioner incomes was sanctioned by the Gorton government's

agreement with the AMA and subsequent decision to pay specialists more than general practitioners for the same clinical procedure. It is evident that specialists have more or less dictated their terms of employment. Medical incomes are hard to assess for private practitioners as they contain three components: a) surgery-based practice (paid by Medicare); b) private/public hospital practice (sessional payments); and 3) teaching/administration (paid by the Medical Colleges) (National Health Strategy 1992, p. 48). The following figures are only based on Medicare and compare the rise in general practitioner and specialist incomes between the periods 1984/85 and 1989/90 and relate these to the rise in the Consumer Price Index (CPI) and average weekly earnings for the general population :

- * Incomes for general practitioners rose during that period by 42% to \$138,900 (Deeble 1991 cited in National Health Strategy 1992, p. 49)
- * For the same period, surgeons have had an increase of 60.9% to \$230,100 per annum and obstetrician/gynaecologists incomes rose by 57.1% to a figure of \$259,900 (ibid.)
- * In the corresponding period, the CPI rose by 47.4%, while average weekly earnings increased by 39.9% and award pay rates by 29.9% (ibid).

However, as medical incomes are not gross figures, some further explanations need to be made. It is estimated that approximately one-half of general practitioner earnings go to practice costs. Hospital access has been increasingly restricted to specialists and it is rare that general practitioners are paid by the colleges for their teaching contribution¹. In contrast specialists are paid for their teaching roles in hospitals and universities, where budgets ensure adequate cover. At the same time procedural specialists are able to maintain lower

overheads, that is the hospital pays for the running costs of their private medical practice, such as equipment, reception, nursing staff and billing facilities. The increase in their incomes has been attributed to their tendency to charge more than the Medicare scheduled fee (*ibid*, Sax 1990, p. 72). Specialists, therefore, earn more, have some of their expenses subsidised, and have lower overheads.

The above profile indicates that although general practitioners and specialists are highly paid, general practitioners' incomes have not only been unable to keep pace with the CPI, but also they have greater overheads which diminishes the extent of their real income. In contrast increase in specialists' incomes not only exceeded the CPI by a considerable margin, but also they do not outlay the same overheads as general practitioners for practice costs. This is one aspect of the specialists' control over the health industry.

In contrast to both of these categories, it is estimated that at least 1,000 and maybe up to 2,000 medical practitioners trained in overseas countries are either unemployed or underemployed (Human Rights Commission 1991, Kidd and Braun 1992). It is also highly probable that the majority are from NESB countries.² Kidd and Braun (1992, p. 49) assert that many OTDs due to a multitude of personal and financial reasons will be unable to pass the AMC exams and thus become registered to practise. Many have given up being able to work as medical practitioners, moved to other employment or remained unemployed. Social security benefits for single unemployed persons currently pay a rate of approximately \$6,600 per annum, while award rates for non-skilled labour are in the vicinity of around \$19,000 to \$25,000 per annum at the very maximum. Comparison of Australian doctors' earnings to OTDs, therefore, is in line with patterns indicated by labour market analyses and other research which show that earnings and status of immigrants relative to natives systematically deteriorates as years of education increases (Beggs and Chapman 1988, p. 21, McAllister and

Kelley 1984, p. 53). Figure 2 on page 88 illustrates hourly rates of pay between native, ESB, and NESB groups based on an average of 14 years of schooling. This also shows that incomes remain at a peak between the ages of 44 to 54 after which they begin to decline. Age here is considered to be an added dimension to closure against adult immigrant groups, especially when, as has been previously been noted by Encel (1976, pp. 112-113), doctors' incomes start to peak from over the age of 40.

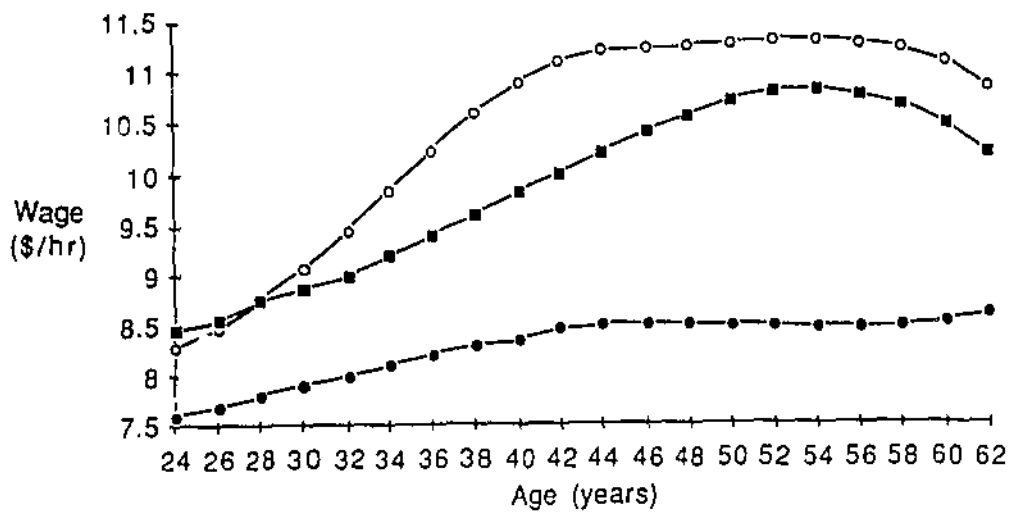
The only method by which high incomes are retained is through limiting entry to the profession. As already outlined, State Medical Boards and the NSQAC each play a significant role in pushing OTDs into the AMC examination process. Specialists preserve higher incomes by pushing OTD specialists into the general practitioner sector by insisting that they pass the AMC exams. From a neo-Marxist perspective, Collins (1988) would state that a reserve army of labour is maintained through those entering under the Employer Nomination Scheme or the temporary-visa arrangements, therefore protecting the private-sector market. However, although specialists have been successful in limiting numbers, general practitioners have imposed no such limitations (National Health Strategy 1992, p. 57).

Having established the economic disparities between specialists, general practitioners and OTDs, this chapter will demonstrate that OTDs are not poor performers through lack of skill, but are the victims of "collegiate control" which operates when

the producer defines the needs of the consumer and the fashion by which its needs are satisfied. Self-regulation and surveillance are mechanisms by which it controls itself (Johnson 1972 cited in Turner 1987, p. 136).)

Figure 2

Non - parametric Regression Estimates of Average Hourly Wage Rate
14 Years of Schooling



(Beggs and Chapman 1988, p. 5)

● NESB
○ NATIVES
■ ESB

As Collins (1988, p. 112) states, the most common reason put forward for high rates of unemployment is lack of English skills. However, the Fry Committee's (Report of Committee 1983, pp. 137-149) assessment of the AMEC exams pointed to the inappropriateness of the English test, as well as:

- * low pass rates;
- * lack of any clear definition of goals of examination;
- * widespread unease about exams by candidates and also by people of educational standing within the profession;
- * inappropriateness of the English test.

The English test is now administered by the National Language Institute. However, the Multiple Choice Question (MCQ) component has the highest failure rate, which also requires a particularly restrictive form of English competency (ibid, p.127). Iredale (1987, p. 136) asserts that English competency, although sometimes a major problem, was not as insurmountable as obtaining clinical experience. She also identifies that in New South Wales there is a general pattern of acceptance into the professions: those of British tradition first, then European second and thirdly more recent immigrant groups (ibid, p. 187), which indicates simple possession of English language is not the determining factor. Cooke & Western (1987), who surveyed Queensland, came to similar conclusions. Kidd and Braun (1992), whose study concentrated on Victoria, found that while lack of English poses considerable disadvantage, over 50% (113 out of 206) of their study sample had a good command of English. In addition, 178 were able to pass the English proficiency examination, but those without a very strong command of English faced difficulties in passing the Multiple Choice Question (MCQ) component. As Kidd and Braun (1992, p. 14) point out, there are "degrees of fluency". They state that only 27 OTD respondents who had a good command of English passed the AMC exams, while only five of the 84 who were not fluent on

arrival were able to pass, even though some had undertaken their primary medical training in English.

One of the main criticisms put forward about the MCQs is that there is inadequate time in this component to make allowances for those sitting the exam whose mother-tongue is not English. Kidd and Braun (1992, p. 14) state:

It seems that it is much more difficult for those who do not speak English fluently on arrival in Australia to pass the AMC examinations, at least in the first five years after migration.

There can be a great difference in the written word when built into academic texts and the written and spoken word used in every-day life and literature.

The AMC examinations limit acceptance of OTDs in ways other than the control of language. While the Human Rights Commission (1991, p. 5) agrees that examination procedures conducted by the AMC caused difficulties in particular for those trained in third- world and NESB countries because of the MCQ component, other criticisms were about the structure of examinations and that clinical knowledge places particular emphasis on Australian practice of medicine. Difficulties experienced by OTDs, according to Kidd and Braun (1992), are reproduced in Table 10 on page 91.

It does not seem from the following that English language difficulties are the primary concern. The income and status differentials imposed by the AMC examination barrier to OTDs are starkly illustrated by examining Kidd and Braun's sample. Out of the 206 OTDs surveyed, only 57 entered under the general immigration points system. This number included 14 women doctors, who had entered Australia as dependent family members. Of the others, 61 were sponsored by family members (either spouse, fiancé, parent or sibling); 35 were refugees

Table 10

Difficulties experienced by OTDs in preparing for AMC examinations

<u>Problem</u>	<u>Number of Respondents</u>
Lack of suitable retraining positions or courses	36
Difficulty of the AMC examinations themselves	34
Lack of exposure to Australian-style medicine	19
Poor information about AMC examinations	17
English language difficulties	12
Having to care for young children	12
Having to relearn basic medicine	11
Having to work full-time	9
Cost of self-education	8
Lack of time to study properly	6
Getting motivated to study	5
Lack of adequate counselling service	5
Difficulty in finding past multiple-choice questions	4
Lack of patient contact	4
Stress	4
Isolation from medical colleagues	2
Isolation from other family members or friends	1

(Kidd and Braun 1992, p. 20)

from 13 different countries; 28 had married an Australian; and the remaining 16 either entered originally under tourist visas, were overseas students, came in under a humanitarian programme, business migration or became naturalised Australian citizens, one having entered Australia originally as a research officer sponsored by a Medical college (Kidd and Braun 1992, p. 12). Only 54% of the sample had ever been employed in any form of work since arrival in Australia. While some had worked as nursing aides, medical researchers, hospital orderlies and other medical related employment, others worked as taxi drivers, gardeners, process workers, journalists, mail sorters, milk bar assistants, newspaper distributors,

baker's assistants, bank tellers, cleaners, forklift drivers, singers, tram conductors or waiters (ibid, p.13). It costs the Federal government \$90,000 to \$100,000 to train a medical graduate and this is therefore a considerable loss of human resources.

From the above, another dimension to closure must be added and that is gender. One cannot ignore the fact that closure is maintained to Australian women in specialties that are considered a male domain, such as orthopaedics. A submission prepared by the Centre for Multicultural Studies to the New South Wales Fry Committee (1989) stated :

To the extent that non-recognition results in complete denial of paid employment, the personal consequences are severe; loss of self-esteem, increased dependency and atrophy of skills amongst them. For a woman of non-English speaking background there are additional, equally damaging consequences. The most serious of these is that a woman denied employment outside the home tends to be denied the opportunity to develop English language skills, with the cycle of dependency thus becoming self-reinforcing (Castles, Mitchell & Morrissey 1989, p. 23).

Despite the consequences of sometimes insurmountable barriers caused by stipulations imposed on OTDs, the Human Rights Commission report was strongly condemned by the Australian Medical Association (AMA). Dr Passmore, Secretary-General of the Association states:

The Commission's report attempts to identify ways in which complaints of racial discrimination can be sustained and is unsuccessful in this attempt However, whether the current system of accreditation, assessment and registration is the best, most efficient, most practical, or even the most fair method of determining the qualifications of overseas trained doctors is an entirely separate, albeit important question (cited in O'Brien 1991, p. 3).

This is a belated recognition of the main criticism about the AMC exam process that has been under debate for the past ten years. According to economic theory, discrimination exists if "human capital", that is level of skills and education,

are not accorded equal value. The discussion above demonstrates this is the case. The AMA, however, distinguishes between process and outcome. O'Brien (1991, p. 3), writing a cover story in Australian Medicine, maintains that a "process may be reasonable, but lead to inequitable outcome."

In this instance the disparity between income and status of the Australian and the majority of NESB OTDs is so great, to say that the outcome is inequitable would be under-stating the issue. Australian specialist incomes (minimum of \$250,000 per annum) to that of a specialist OTD awaiting accreditation (range of approximately \$25,000 to \$6,600 per annum) is incomparable. As one OTD representing the committee of the Overseas Trained Doctors' Association states:

It is a death sentence coming to this country - we live in limbo - on the peripheral. The irony is we came to Australia to contribute - many of us are now social security burdens" (cited in Gordon 1990, p.16).

O'Brien (1991, p. 3) believes that

if a person earns an annual income of \$250,000, it would be admirable if a substantial donation (my emphasis) were made to aid Aboriginal health. However, failure to make such a donation would not be unreasonable even though it would perpetuate the maldistribution of economic resources among the races.

Therefore, if the safeguarding of professional standards leads to inequitable outcome, this does not point to racial discrimination (ibid). This depends on whether the medical profession's right to a *carte blanche* about who and how many are to be allowed to practise medicine in Australia is upheld. Although standards should be maintained, these standards appear to fluctuate in defence of what the medical profession believe is their individual right. Evidence points to the fact that the safeguarding of professional standards are in effect the safeguarding of financial and status rewards, rather than medical knowledge, a point that has been made by other researchers (Kunz 1975, Iredale 1987).

This is particularly evident in Kidd and Braun's (1992) study of restricting entry to specialist occupations. While out of 206 of the OTD respondents, 103 (50%) had no postgraduate qualifications, 58 (28%) did have one, 13 (6%) had two, six doctors had three and one doctor had four postgraduate degrees. Five who were not registered to practise had previously obtained Australian qualifications :

- * Two were Fellows of the Royal Australian College of Surgeons (Faculty of Anaesthetists).
- * One was a Fellow of the Royal Australian College of Ophthalmologists.
- * One had a Diploma in Reproductive Sciences; and
- * One had a Diploma in Nutrition and Dietetics.

These doctors still have to pass the AMC exams, although their primary qualifications were assessed and accredited by the Medical Colleges before being allowed to undertake further medical training. It is this type of incongruity that has caused much perplexity and animosity among OTDs in Australia (Kidd and Braun 1992, p. 7, p. 32). Out of others that still have to pass the AMC exams, five had postgraduate qualifications obtained in the United Kingdom and three, in France. The range of experience was between 0 - 30 years, with a mean of eight years. Kidd and Braun (1992, p. 10) also point out that in spite of some respondents having inadequate 'paper' qualifications, there was a significant number who seem to be well qualified to become registered as specialists in Australia, but who would be forced into general practice. It is also a paradox that Australian Universities recognise overseas medical qualifications and in fact these Universities employ OTDs in teaching positions as professors or lecturers, whilst at the same time these OTDs would be unable to gain registration to practise medicine in Australia under the Medical Registration Acts (Overseas Trained

Doctors Association 1990 cited in Human Rights Commission 1991, p. 21). Because of this and the information provided in the previous chapter, there is a need to view proposed changes in accreditation for specialists with some degree of scepticism.

On the basis of figures supplied by the Australian Medical Council as at 20 May 1992, there are 2,434 OTDs resident in Australia who are in various stages of the examination process. In addition, there are 2,048 candidates resident overseas also at various stages. The figures are reproduced in Table 11 on page 96.

As AMC results have usually been presented in an accumulative manner, it is assumed that these numbers would be an accumulation of candidates³ over the years since AMEC/AMC was incorporated. This would come close to the estimate that there are at least 1,000 and maybe close to 2,000 OTDs in Australia unable to gain registration (Human Rights Commission 1991, Kidd and Braun 1992). Should only the OTDs resident in Australia choose to attempt the AMC exams, it will take ten years for them to be absorbed, without additional migration.

The overseas component of these figures is far above the yearly average migration figures of OTDs presented in Chapter Five, where it was shown that during the past three years long-term migration was in the vicinity of approximately 250 to 350 per year, including those recruited under the Employer Nomination Scheme. This adds more support to the assumption that the figures have been presented in such a manner as to create perceptions of an impending mass-migration of OTDs. It does seem that such maximum projections would give more support for a case against medical migration. The fact that the Federal government has translated these numbers into a liability, rather than an asset, is but one of the effects.

Table 11

Australian Medical Council
Overseas Trained Doctors and AMC Candidates at each stage
of the Examination Process

A.	OTDs who have lodged applications but not yet sat the MCQ examination	-	<u>2,384</u>
-	Number already resident in Australia	-	936
-	Number resident overseas	-	1,448
B.	OTDs who have commenced the MCQ examination but have not yet passed	-	<u>1,248</u>
-	Number already resident in Australia	-	860
-	Number resident overseas	-	388
C.	OTDs who have passed the MCQ examination but who have not yet commenced the clinical examination	-	<u>231</u>
-	Number already resident in Australia	-	142
-	Number resident overseas	-	89
D.	OTDs who have been listed for or have commenced clinical examination but have not yet passed	-	<u>609</u>
-	Number already resident in Australia	-	496
-	Number resident overseas	-	113

Notes: All data as at 20 May 1992. Figures include results of the Series A (April) MCQ examination and the clinical examinations conducted up to 20 May 1992.

All candidates who have passed the MCQ examination and have lodged applications to sit the clinical examination have been listed as clinical candidates under D.

(Medical Workforce Data Review Committee 1992, Appendix C)

These summations are made because, while the most recent AMC Annual Reports reflect considerations for micro-economic reform processes and establishment of working parties to discuss implementation of more competency-based assessments (Australian Medical Council 1990, 1991a), an information leaflet⁴ to overseas candidates is worded in language clearly designed to deter NESB OTDs. It is clear greater social benefit in an improved medical profession is not to be provided by increased numbers of immigrant doctors. It paints a picture of dismal failures, lack of competency in medical training of candidates, lack of financial support, and general need for most to undertake further training, access to which is severely limited. In addition, it states that success in the AMC exam does not automatically confer the right to register in Australia as a medical practitioner (Australian Medical Council 1991b), even though all State and Territory boards recognise that the successful completion of the theoretical and clinical components satisfies requirements for registration (National Office of Overseas Skills Recognition 1992, p. 62).

The figures for outstanding AMC exam candidates were made the focus of an AMA Executive Council Report, entitled "Since when are 4,472 doctors not a flood" (Arnold 1992, p. 9). The report stated that OTDs threatened the livelihood of general practitioner private practice, their "ethnicity" was not compatible with ethnic origins of communities in Australia; few Arabic-speaking doctors are female and therefore would not care for Moslem women and in fact there were adequate supplies of Australian female doctors; those specialists referred to specialist colleges "aggravate intense competition for training posts for Australian graduates"; and therefore most probably will eventually have to pass the AMC. Also, it was a debatable point whether training of OTDs would adequately equip them for rural medicine; and anyway Australia has enough local graduates reflecting the ethnic backgrounds of the Australian population, therefore:

Quite simply, the tap should be turned off now. No new OTDs should be allowed to sit the MCQ for the next five years. Those OTDs who are resident in Australia and have passed the MCQ should be allowed, at a controlled annual rate, to attempt the AMC clinical exams (ibid).

These arguments entirely ignore the non-economic aspects of migration, such as family reunion and humanitarian categories. Statements about "ethnicity" are not valid as, although OTDs can make a valuable input in helping to service the NESB population, they are firstly Australian residents and professionals, not at all "ethnic" doctors for "ethnic" communities. The migrant communities in Australia do have the right to services of medical practitioners who are more socially and culturally attuned to their needs, but NESB OTDs should not be assumed to limit their practice to these communities. Gender discrimination is also apparent, as women enter as wives of professional immigrants or again, under family reunion or humanitarian categories. It is obvious that the social consequences of loss of skills, self-esteem and financial strain of such restrictions placed on OTDs already here in Australia has not been a matter taken into consideration. Labour market considerations have become confused with the rights of any immigrant to be fairly assessed and be given the chance to become productive members of the Australian community in their own profession.

Another indication that the AMC exams artificially restrict the supply of doctors is stressed by Iredale (1988, p. 16) who states :

Dr I Butfield of the South Australia Health Commission attests that South East Asian doctors who have been given up to five years training in the South Australian hospital system and who are very competent cannot pass the AMC clinical exams.

Also some who applied have not even been given the opportunity of sitting the exams, as they are not deemed to have a suitable undergraduate degree

(ibid), yet they are competent to provide medical treatment in a hospital. Iredale (1988) does not stipulate how these doctors have entered the hospital system in the first place. However, because "training" is mentioned, it is assumed that they have entered as part of the Commonwealth Government's programme under the Australian Postgraduate Federation in Medicine (APFM) scheme. This is a training programme which has operated since the early 1980s for placing non-resident overseas medical graduates in over 91 institutions throughout Australia, mainly in public hospitals and public research institutes. Also a few private hospitals have cooperated. "Training programs have involved 67 specialties from almost the complete spectrum of medical practice" (Thompson, Thomson and Andrew 1992, p. 437).

This is a case where neither arguments of ethnicity nor deficiencies in basic medical training can be sustained. There have been 764 graduates from 61 countries who have entered Australia since 1985-86 and completed their programs by 1990-1991. At present there are 866 undertaking their training. Of these medical graduates (a total of 1630), 39% come from the Western Pacific Region; 17% from South-East Asia and 29% from Europe. Others come from the United Kingdom (20%), China (17%); India (10%) and the United States (7%). Applications for training posts have doubled in the past two years (ibid). Results have been that these

foreign medical graduates have been accepted socially and academically, and have often provided a welcome 'pair of hands'. Competence in English has proved a problem in a few cases (while) progress and performance of 92% of the trainees were rated as "excellent" or "satisfactory" (ibid).

It is clear when OTDs help to service a need and there is no threat to the status quo, questions about English language skills, social and academic status, ethnicity or country of origin are not considered.

Although since 1982, the necessity for bridging courses for OTDs has been stressed, limited resources have ensured that places, especially in New South Wales, have been insufficient in meeting demands. The Overseas Doctors' Association has even suggested that a graduate tax could be imposed to cover costs of bridging courses. The OTD committee state:

We need exams, we need assessment, we need orientation, training courses, clinical exposure. We have deficiencies, but these are being magnified, while no tangible solutions are sought. Too many doctors are failing the MCQ too many times (cited in Gordon 1990, p. 16).

In Western Australia, the numbers are not large, and bridging courses have been funded by DEET and conducted by Edith Cowan University. To date there have been two bridging courses. A third is to start in the near future. In an interview for this thesis the Course Coordinator stated that many of the OTDs are considered highly skilled and are welcomed by the hospitals once they have passed the AMC exams. However, difficulties seem to occur in finding places at hospitals for the clinical training component, as OTDs' needs sometimes clash with that of local graduates. Criteria for selection of candidates by the Course Coordinator appeared at times to be subjectively based. She appeared ambivalent in her attitudes towards migrants and demonstrated a distinct lack of awareness about intercultural issues. Doctors sometimes "wouldn't cooperate" in attending tutorials, those whom she "knew" had funds were taking advantage of "taxpayer's money". Whether she was too enthusiastically embracing the reversed role situation of community nurse to doctor could not be determined. However, it may give an indication that power is not always maintained at the top level and of any migrant's subordinate position in such situations, and the possibility of bridging courses themselves being used as a secondary means of controlling supply of OTDs.

traditional hierarchy of society in terms of class, gender and ethnicity. This appears evident in the following statement made by the Department of Health, Housing and Community Services :

A failure to check the growth of OTDs would ultimately mean reduced opportunities for Australian students to study medicine at a time when medical schools acted voluntarily to reduce their intakes. Health Ministers agreed that the historical (my emphasis) ratio of Australian graduates to OTDs (1200:200 or 6:1) should be preserved and used as the basis for any future changes to the intake of OTDs... (S. Northcott - personal communication - October 6, 1992).

The problem has implications far wider than its effect on a relatively small number of OTDs. The nature and limits of modern democracy are demonstrated when decision-making is highly influenced by the medical elite without adequate representation from other individuals or groups. The consequences of these actions will be felt by the community at large and this is a matter for concern. According to Weber, bureaucratic administration is the main characteristic of all contemporary forms of social life. His fears were that bureaucratic rationalisation could have the effect of taking away power from sources of democratic authority that were centred in the political process. Weber refers to the threat of technocratic or plutocratic structures, where lengthy training may mean that recruitment may be possibly afforded by a few. He was chiefly concerned that bureaucracy encourages "excessive formalism". Decisions are made without reflection and focus is centred on the most pressing demands (Waters 1989, pp. 328-329).

Daniel (1990, p. 164) states :

Values of government at both a political and administrative level were utilitarian and pragmatic. The late 20th century renditions of these philosophies resounds with calls for efficiency, economy, efficacy and, ambivalently, equity. The difficulty of adopting the appropriate perspective for determining whose equity is to be redressed is easily recognised.

An indication of the advance of the forces Weber was concerned about can be found in the Commonwealth Department of Health's (1987) submission to the Doherty Committee. It was apologetic about its failure on an earlier occasion to adequately consult, not only with the States, but also with the AMA and other professional medical associations. It was convinced there were too many doctors and wanted to see medical practice "more effective, more efficient and more productive" (Commonwealth 1987, pp. 2-3, p. 59). It was not concerned about reducing migration again as it had done in the 1970s. It indulged in 'crystal-ball gazing' to support the need for less doctors due to the march of technology as, according to the Department of Health, it was inevitable that our society was going to become an "increasingly computer oriented public". Private homes, medical practices and clinics would have greater use of computer information systems and the "public" will be

able to use these systems to diagnose their health problems, take corrective action, select appropriate professional health care, make medical appointments and even interact with medical practitioners in giving their medical histories and paying for services by electronic funds transfer (ibid, p.38).

It is necessary to question which "public" the Department was referring to. Certainly not those on low-incomes and definitely not those who were unemployed, were aged, were very young, were not computer-literate, or could not speak English. These opinions reflect middle-class as well as bureaucratic values and do not consider the more disadvantaged sections of society.¹¹

The AMA has rejected the Human Rights Commission charge of racism, while accepting there may be a deficiency in procedures. The discussion now turns to this question and demonstrates a continuing theme of racist or ethnocentric attitudes, in the face of the evidence, over at least the previous few decades. Attitudes reflected in the Doherty Committee report towards OTDs and

submissions made by professional associations against medical migration is demonstrated in Appendix VI (Committee of Inquiry 1988, pp. 470-476).

Kunz (1975, p. 60) states that in the 1950's "lengthy bitter activity relied largely on dogmatic repetition of certain statements and accusations over issues of oversupply". Some of these themes will be recognised from what has already been mentioned, and some will become more evident in what will follow. They are :

- * Australia's absorptive capacity is stretched.
- * Australia does not need specialists (nowadays, general practitioners are not needed).
- * Medical qualifications of Non-British graduates are low in standard.
- * Ethics of Non-British doctors are different and not proper.
- * Acceptance of foreign graduates will lead to lowering of standards in Australia which are the best in the world.
- * Australia's registration practice is in line with other developed countries.
- * Poor standard of English and imperfect knowledge makes them "dangerous".
- * OTDs congregate in cities and would not practise in country areas.

This "dogmatic repetition" can be seen in many contemporary debates. For example, Wilkins (1992) has reiterated most of these arguments in Australian Medicine, reproducing a statement endorsed by the AMA, The Committee of Deans of Australian Medical Schools and the Committee of Presidents of Medical Colleges (see Appendix V). It is interesting to compare contemporary documents with Kunz's summary of arguments from the 1950s. The main

arguments which run through the Doherty Report, the minutes of the MWDRC meeting and are supported by the Health Ministers are summarised as follows :

- * that excessive rate of growth of doctors resulted entirely from immigration of overseas doctors.
- * that there was a mismatch between major national groups and the majority of medically qualified immigrants - national groups meaning Italian, Greek and Yugoslav ; medically qualified immigrants were those who had high success rates in recent AMC exams: South Africa¹², India, Egypt and Sri Lanka.
- * the Australian community "will not tolerate" a reduction in medical school numbers denying "our own children" opportunities.
- * High quality of Australian standards and "super-specialist" units jeopardised "world class" service to community.
- * Overseas doctors are unlikely to practise in rural areas (stated as statistically significant - that is 23% want to practise in urban and 20% prepared to work in rural).
- * Overseas training is unsuitable - needs expensive retraining.¹³
- * Differences in cultural backgrounds and poor grasp of colloquial and professional English - makes it difficult for overseas doctors adapt to norms of Australian clinical practice.(Committee of Inquiry 1988, pp. 470-476, MWDRC 1992, pp. 1-12 , Wilkins 1992, pp 4 -5).

Another example comes from Blacket (1990), formerly chairman of the AMC accreditation committee who, in an article in the Medical Journal of Australia, has gone to great lengths to statistically demonstrate that OTDs who graduated from medical schools in South Africa, Canada and the United States were much more competent than those graduating from other countries. He considered that there were risks of "unsafe" practices of those not educated in the British tradition. He questioned the ability of persons over 35 to be re-educated in "middle age". and he seemed to have something personal against Egyptians - who in his opinion are "less competent at the bedside than they were in written exams" (p. 128) and at another stage, suggests comparative data from the Educational Commission for Foreign Medical Graduates (ECFMG) in the United States show that the Vietnamese did as well as Indians and much better than Egyptians¹⁴. He mentioned that most AMC examiners would agree that many candidates required extensive retraining and it was "safe" to say that only 5% had postgraduate qualifications. His clear intention at the outset was to argue against medical migration from "developing" countries which he considered socially and culturally "backward" (ibid, p. 130). At a later date he was much more specific when he stated: "professional competencies depend on the wealth of a nation - poorer countries cannot afford teaching hospitals or post-graduate training" (cited in Eather 1991, p.4). In contrast, Kidd and Braun (1992), who are from the Department of Community Medicine at Monash University, found that overseas-trained specialists well qualified to practise in Australia constituted fifty percent of those surveyed. Yet, according to Blacket (cited in Eather 1991, p. 4), "they have a disability which stems from their education and the poverty of the society that spawned them".

This is clearly in conflict with the evidence presented previously in this chapter on the foreign medical graduate program where it has been demonstrated

that these graduates from over 61 different countries have been highly successful in programs undertaken in Australian hospitals and have been well-received.

As far as standards of teaching institutions are concerned, Australia can be proud that the World Health Organization, in surveying primary health care strategies around the world, has commended the work of the Royal South Melbourne Hospital. At the same time, it has also commended work by other large teaching institutions, such as the Soroka Medical Centre at Beer Sheva, Israel; the Aga Khan Medical College and Hospital in Karachi; the Nangina Hospital in Kenya, the Lady Hardinge Medical College and associated hospitals in New Delhi; the Wad Medani Civil Hospital in Medani, Sudan, the Ramathibodi Hospital in Bangkok, Thailand, to name but a few of the institutions mentioned in various "developing" countries. It is also stated that similar activities could be cited from many other countries. In addition it is stated that recruitment of medical graduates in Israel is "refreshingly linked to the health - and human - needs of people" (Paine and Siem Tjam 1988, p. 85). A prime example of democratic participation in processes is exemplified in that :

Fifty students are admitted annually to the first year class.
Before admission the student is interviewed by a committee that includes ten physicians and ten laymen from the community. Community orientation is looked for in attitude, behaviour and experience of the applicant. Empathy is valued along with the ability to communicate with people from various social backgrounds. (Paine and Siem Tjam 1988, pp. 80 - 84).

This is in direct contrast to the approach taken in Australia and indicates viable alternatives exist. In Australia closure strategies are on the increase. One of the patterns that cause this is when local graduate intakes start to become more heterogeneous. The fear that the profession will be unable to maintain its class and status structure therefore leads to exclusion of outsiders. In this case OTDs from

NESB countries are targeted, as it is envisaged that ESB countries will have a higher pass rate. Professor Richard Larkins, who represents the Federal Minister on the MWDRG, is also currently on the AMC Examining Committee. Although Professor Larkins did not believe it was "fair" to ask a specialist to sit the AMC exams, he did believe, like Blacket, that there was reverse discrimination against Australian children by allowing OTDs to enter Australia (Larkins 1992?). However, exclusionary practices in general are becoming more rigidly enforced and OTDs from ESB countries (except for New Zealand) will now be required to sit the AMC exams. This satisfies the ethnic bias of the medical profession previously noted in that those from ESB countries will not face many problems in the AMC exams and at the same time will take up a significant part of the quota allowed. However, with the exception of the New South Wales Department of Health and the Australian Institute of Health, who both felt OTDs would be a valuable addition to the public hospital system and DEET who were against instituting a quota system, there appears an overwhelming consensus of opinion that OTDs should not be part of the Australian scene and that they are of an "inferior" quality.

It has been pointed out that historically there were sociological and psychological aspects of discrimination towards minority groups. These concerns have led to recent anti-closure measures. In the light of increased research into the difficulties of OTDs, claims to inferior skills are becoming increasingly difficult to defend. Therefore, a new argument has emerged of "matching" overseas doctors to their own ethnic groups. It also appears that it is becoming increasingly difficult for the AMC to continually resist outside forces - and that there will eventually be a change in the AMC examination processes, though not in 1991 and 1992 (Australian Medical Council 1992, p.4). In addition, an appeals mechanism has finally been introduced (Australian Medical Council 1991), a factor which, like

adequate pre-examination material, feedback and access to bridging courses, had been part of criticisms by the Fry Report (1983) and repeated by the Human Rights Commission (1991). Also, the Trade Practices Commission is conducting an enquiry into the profession this year, a matter which the AMA considers may take up considerable resources (Australian Medical Association 1991, p. 3).

It is argued here that quota arrangements, once enforced, become a permanent part of the structures. These actions ignore social aspects of migration, the special difficulties of women and refugees. Rights of migrants, who become Australian residents on arrival, to be promptly assessed for their competency are being confused with labour market considerations. This is not in keeping with socially progressive reforms and ignores the difficulties faced by migrant and refugee OTDs currently living in Australia, who have been forced into financial and social disadvantage under the present structures. In the Introduction it was pointed out that actions should be judged on Rawls' (1978) principles of justice and fairness :

- * Each person is to have an equal right to the greatest liberty compatible with a similar liberty to others;
- * Social and economic inequalities should be arranged so that they are (i) reasonably expected to be to everyone's advantage and (ii) attached to positions and offices open to all (cited in Sax 1990, pp. 146 -147).

Article 1 of the International Labour Convention concerning Discrimination in respect of Employment and Occupation which came into force in 1960 defines "discrimination" as including:

any distinction, exclusion or preference made on the base of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation (cited in Victorian Task Force 1990, appendix III).

Both of these international standards are clearly breached in Australia. The medical profession has been able to wield enormous power to politically influence and dictate its own terms about migration policy, while at the same time allowing others to be recruited as a reserve army of labour. These actions are not in keeping with principles of justice and fairness and they are exclusionary and discriminatory. It is clearly not in the interests of a multicultural community to be denied experienced doctors with a multicultural background. It is also clearly not in the interests of the Australian community that the medical profession should enjoy increased rewards and privileges, while services are not socially and culturally attuned to the needs of the whole community. While it is realised standards should be maintained, there is overwhelming evidence that these standards are not being abused by other foreign medical graduates in Australia under 'temporary arrangements'.

Migrants will keep coming and ethnocentrism will become increasingly more expensive. Governments will have to start seriously thinking of distributing health resources more equitably. It is irrational on the government's part to state that gainful employment of OTDs in Australia will increase health costs, because of the Medicare system. Structures are now in place that will protect an excessive increase in the general practitioner population and introduce quality control and accountability. There should be no resistance to integrating OTDs into areas where their experience can be most utilised. If the Federal government, under its migration programme, is responsible for bringing migrant groups to Australia, there should be no special privileges or considerations given to any professional group, medical or otherwise, that help to serve the profession's interests while disadvantaging their OTD counterparts living in Australia, regardless of any pretext. The denial of social and economic rewards to OTDs resident in Australia is the denial of entry into a collegiate culture of elite medical professionals who are

able to wield considerable influence and power in the political processes. Justification for these practices is not based on knowledge but on ethnicity and is state-sanctioned. This is social control in its most exploitative form.

Footnotes - Chapter Six

¹ In 1990, the Royal Colleges have had 2,800 general practitioner preceptors (that is general practitioners who act as role models by teaching medical students in their practices) who received little or no remuneration or status recognition for their time and efforts in tutoring medical students. It is estimated that the Colleges save \$850,000 a year from this (National Health Strategy 1992, pp. 70-72).

² None of the research indicates that ESB migrants have difficulties. Data for 1983-1989, based on AMC results lists the percentage of candidates by country passing the clinicals for the first time: 79% South Africa, Canada, America; 65% West Germany; 61% Chinese from Hong Kong, Singapore and Malaysia; 41% India & Sri Lanka; 34% Poland; 32% Vietnam; 26% Egypt (Blacket 1990, p.128).

³ At the time of submitting this thesis, no reply has been received to a letter written to the AMC requesting a more detailed explanation of these figures.

⁴ This document an information leaflet produced by the Australian Medical Council - is attached as Appendix IV.

⁵ Iredale (1987) found that the United States nor Canada do not have reciprocal arrangements, the latter being seen to have a more equitable system. The Medical Council of Canada's exam for OTDs is an evaluative one and consists of 320 Multiple Choice Questions (MCQs). Examination results based on four exams conducted between 1980 and 1981 showed a pass rate of 52.4%. The United States and the United Kingdom both have such a preliminary exam for licence to practise in the public sector. In Canada, there are three prerequisites for registration. Two are the adequate completion of exams consisting of MCQs and Patient Management Problems (PMPs). These are computer-scored type exams. The third prerequisite is uniform for both the overseas qualified and local graduate. After registration all doctors have to complete a one-year internship in a public hospital (pp. 137-140).

⁶ See Health for All Australians: Report of the Health Targets & Implementation (Health for All) Committee to Australian Health Ministers (1988). New directions for health administration place increased emphasis on primary health care and the setting of goals and targets to reduce inequalities in health. This thesis does not enter into a discussion on this subject.

7 The history of the Vocational Guidance scheme goes back to 1989 when a Senate Select Committee on Health Insurance approved new conditions of remuneration for the original Vocational Guidance Register.

8 The National Health Issues Strategy Paper No. 3 (1992) gives a detailed explanation of implications for general practitioners and governments in coordinated policy implementation and planning for primary health care. It is important to note that the Community Medicine model is one based on a multi-disciplinary team work approach. The model is based on the North Richmond Family Care Centre which has (i) community nurses, (ii) ethnic health/welfare workers; (iii) interpreters; (iv) social workers; (v) community development workers (Committee of Inquiry 1988, p. 246).

9 New announcements include a package of incentive to increase rewards to general practitioners, enhancing their role beyond individual patient care and creating divisions of general practice controlled and administered by general practitioners. Weightings which have not been finalised will be developed for additional payments to be made to accredited practices depending on size and location which may include isolate or rural practices because of their more difficult role (Howe 1992).

10 Funding for general practitioners will cost \$8 million in 1992-93 and \$15 million thereafter to provide incentives for urban GPs who are trained appropriately to rural practice standards to relocate in country areas. However, the government is of the opinion that 3,600 OTDs who have applied to sit the AMC exams would cost the government an additional \$300 million per annum in health expenditure. The government defends its stance that the quota is unavoidable because no other profession enjoys automatic access to open ended government funded payment system (Medicare) upon registration (S. Northcott - personal communication - October 6, 1992).

11 Connell (1987) has used the class distinction to highlight the unequal distribution of health resources, where health services are designed to suit the more affluent, with consequent inequality in health outcomes, a state of affairs which has been well documented in other Australian and international literature. Particularly evident in Australia is a seeming disregard for the health of Aboriginal people by leaders of the medical profession. The University of Newcastle is the only institution in Australia that has designed a course structure to cater for the needs of Aboriginal medical students.

12 South Africa was dropped from later repetitions of these statements by the government and figures of success rates were inflated, for example, it was stated that 805 Sri Lankan's passed the AMC's (S. Northcott - personal communication - October 6, 1992. This is impossible when until 1991 only 957 OTDs have passed the AMC exams over a 13-year period.

13 DEET in Western Australia has found that bridging courses for nurses and medical practitioners are cost-effective and save the government considerable funds (Western Australian 1990).

14 Differences in interpretations as to performance of OTDs can be demonstrated by referring to Fry (Report of Committee, 1983) who describes pass rates between AMEC, Professional and Linguistic Assessment Board (PLAB) examination in the United Kingdom, and the EFCMG in the United States (pp. 146-147). The EFCMG figures for 1981 showed that 9.2% Vietnamese had passed, 9.08% Egyptians and 29.68% Indians. At the same time South Africa and Sweden both had a pass rate of 94% while the United Kingdom rated 81% and Ireland 72% (ibid, pp. 147-148, Iredale 1987, pp. 16-18). This comparison shows the deficiencies in Blacket's interpretations, because here instead of having Vietnamese OTDs doing as well as those from India, the Vietnamese doctors are almost on a par with the pass rates of Egyptian doctors. In addition, those from countries in the "British" tradition have varying percentages of pass rates and Sweden has equalled South Africa and outperformed graduates from the United Kingdom and Ireland.

The results of Fry's comparisons were that the pass rates for the whole AMEC exam were lower than for PLAB and EFCMG, but not a great deal lower than the latter (Report of Committee 1983, p. 146). However, he asserts that comparisons are "indicative only, since different candidates are involved in the three sets of figures and no allowances can be made for factors such as differences in individual ability, variations in the quality of medical school represented by the candidates, the candidates' experience, or the time lapse of their graduation, their preparation for exams, and so forth (ibid, p. 146).

CHAPTER SEVEN

CONCLUSION

In this thesis I have argued that NESB migrant OTDs experience structures of discrimination that are not subject to mitigating legislation, since they are structures of informality and cultural bias. I have argued that these structures reflect the cultural inheritance of those who currently dominate the system, that the judgements they make are not objective, but are constrained by a range of subjective factors, among which are the desire to maintain the ethnic orientation of their own comprehensible social reality, to maintain the social status of their elite, and to maintain the high levels of financial rewards achieved through the structure of medical practice in Australia.

I have demonstrated that the AMC exams are an artificial structure designed to limit or exclude OTDs from entry into the medical profession. I have refuted the possibility that the low pass rates of the examinations reflect major deficiencies in either training in OTDs country of origin or lack of command of English. I have shown that the social and financial barriers created by this process of accreditation are neither fair nor just and are discriminatory. I have argued that the control the medical elite has over structures of medical care in Australia reflects an implicit pattern of social closure that operates at an informal, personalised and culturally specific level. I have shown that entry to this elite is sanctioned by the government and largely determined by this elite, maintaining prestige, status and political power, and in turn, high monetary rewards. It has been shown that arguments made by the medical elite to try to discredit the competency of OTDs are

not valid and are historically repetitive. This, according to Parkin (1974), is social control in its most exploitative form.

It has also been shown that this wealthy and prestigious medical elite are able to wield enormous power in the political processes, affecting decisions on migration. The methods used are seen to be anti-democratic and against international conventions of fairness, justice and non-discrimination. This elite has defined its own social reality in anglophilic terms, refusing to accept the fact that Australia is a multicultural society and will become more so.

The implications are far wider than the effect on a relatively small number of OTDs. The consequences of these actions will be felt by the community at large and is a matter for concern. According to Weber, bureaucratic administration is the main characteristic of all contemporary forms of social life. His fears were that bureaucratic rationalisation could have the effect of taking away power from sources of democratic authority that were centred in the political process. Weber refers to the threat of technocratic or plutocratic structures, where lengthy training may mean that recruitment may only be afforded by a few. He was chiefly concerned about "excessive formalism". Decisions are made without reflection and focus is centred on the most pressing demands (Waters 1989, pp. 328-329). The Foucaultian concept of "panopticism" is also relevant, emphasising the development of a form of social surveillance by the "archetypal" professions, the medical men and the police who replaced priests as guardians of social reality.

While it has been shown that many other professions are moving towards more egalitarian methods of assessing overseas competency and skills, the medical profession is alone in receiving legitimation from the state to increasingly become more rigid and inflexible in its attitudes towards OTDs who seek permanent residence in Australia. It is evident that the medical elite, the bureaucrats and the politicians are intent on maintaining wealth, prestige and status along traditional

class, ethnic and gender lines and "aliens" are not to be entrusted to the sacred realm of medicine, nor to the funds available through Medicare.

Turner (1987, pp. 210-211) says:

The technological and bureaucratic imperatives of modern medicine have resulted in the search for a more effective administration of health-care systems and a more rational approach to the organization and rationing of health care. These trends clearly point to a widening of medical control and the medicalisation of deviance and disease under the common bureaucratic policing of society. There is a convergence on a new global pattern of population regulation and management. This is the bio-politics of the modern period of rational capitalism and state socialism.

This thesis has discussed in detail the mechanisms of this process, one which must be resisted in the interests of the health and well-being of the wider multicultural community.

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APPENDIX I

Changes to Medical Assessment
between 1969 and June 1990

(Human Rights Commission 1991, pp. 70-71)

CHANGES TO MEDICAL ASSESSMENT BETWEEN 1969 AND JUNE 1990

Date	Activity	Change
1969	Formation of COPQ	State assessments, provisional registration
1971	Working Party on Medicine	continued
1973	Joint Committee on Medicine	
1974	Expert Panel in Medicine	
1977	Agreement to introduce AMEC	Conditions of AMEC examination
1978	Formation of AMEC and establishment of AMEC exam	Part I } 3 attempts in all Part II }
1980	NSW Section 21C repealed allowing supervised hospital experience	\$250 per attempt and \$200 for certificate
1982	AMEC exam amended	Failure at Part II did not require resitting Part I - 3 attempts possible at each part
1983	AMEC exam amended as a result of Fry Report	English separated from multiple choice questions, unlimited attempts at English Unlimited attempts at Part II \$250 for certification
1985	AMEC - fee structure amended	Fees amended per attempt to: \$30 English paper \$300 multiple choice questions \$300 Clinicals \$400 Certification
1986	AMC took over administration of exam	Number of attempts per part, and new fee structure English (COPQ) no limit \$30 Multiple choice questions 3 \$500 Clinicals 3 \$500
1987	COPQ English test reviewed	English may be attempted pre MCQ or post MCQ paper, except candidates who fail MCQ paper must pass English before attempting MCQ paper again
1988	Fee schedule	\$25 payable on application \$25 certificate fee
1989	New fee structure level Level of AMC exam set at final year medical course	English \$120 per attempt \$30 application fee to AMC MCQ paper \$591 Clinicals \$591
	New English test administered	Certificate fee \$30 50% pass mark and

1990

by COPQ/NOOSR

Exemptions from NOOSR

English test

Eligibility criteria changed

standardised scoring introduced

For candidates from English speaking countries

Registration in another country no longer
required, one year internship not necessary

APPENDIX II

Australian Medical Council Exam Results for
Multiple Choice Questions and Clinicals
(by number of attempts): 1978 - 1990

(Human Rights Commission 1991, pp. 50 - 53)

AMC EXAMINATION: RESULTS OF MULTIPLE CHOICE QUESTIONS

PAPER 1978-90

Table 1 : MCQ EXAMINATIONS 1978 - 1990

(By Country of Training)

Australian Medical Council Incorporated

Report on number of attempts for MCQ Exams for period : 7BA to 90A (inclusive)
For all centres.

As at : 10:06:19 25 MAY 1990 - Page 1

Country of Training	No. SITTING					No. PASSING				
	1	2	3	4+	Tot	1	2	3	4+	Tot
AFGHANISTAN	9	4	2	4	19	1	1	0	1	3
ARGENTINA	7	3	2	4	16	1	1	0	1	3
AUSTRALIA/PNG	1	0	0	0	1	1	0	0	0	1
AUSTRIA	4	2	1	0	7	3	2	1	0	6
BANGLADESH	17	12	6	6	41	2	4	1	1	8
BELGIUM	9	4	2	1	16	3	1	1	0	5
BOLIVIA	1	0	0	0	1	0	0	0	0	0
BRAZIL	8	3	2	3	16	5	0	1	1	7
BULGARIA	3	2	2	1	8	0	1	2	1	4
BURMA	24	10	2	1	37	3	5	2	1	11
CAMBODIA	2	2	0	0	4	0	0	0	0	0
CANADA	21	5	2	0	28	17	2	1	0	20
CHILE	7	2	2	0	11	3	0	2	0	5
CHINA	4	1	0	0	5	0	0	0	0	0
COLOMBIA	1	0	0	0	1	1	0	0	0	1
CZECHOSLOVAKIA	38	18	13	3	72	10	6	9	1	26
DENMARK	6	4	0	0	10	1	3	0	0	4
DOMINICAN REPUBLIC	2	2	0	0	4	0	1	0	0	1
ECUADOR	1	1	0	0	2	0	1	0	0	1
EGYPT	215	122	60	42	439	50	49	25	15	139
EL SALVADOR	2	0	0	0	2	0	0	0	0	0
ENGLAND	2	0	0	0	2	1	0	0	0	1
FIJI	18	7	3	9	37	4	2	0	2	8
FIJI/INDIA	1	0	0	0	1	0	0	0	0	0
FINLAND	1	0	0	0	1	1	0	0	0	1
FRANCE	12	6	4	6	28	1	1	1	1	4
GERMANY	68	27	14	1	110	17	10	9	0	36
GHANA	1	1	0	0	2	0	0	0	0	0
GREECE	20	9	4	2	35	3	2	0	1	6
GUATEMALA	4	4	3	0	11	0	1	1	0	2
HONG KONG	85	18	3	0	106	54	10	3	0	67
HUNGARY	21	11	8	5	45	6	2	3	2	13
ICELAND/SWEDEN	1	0	0	0	1	0	0	0	0	0
INDIA	382	174	64	41	661	129	94	37	12	272
INDONESIA	14	7	2	0	23	4	4	2	0	10
IRAN	36	16	5	7	64	10	5	2	3	20
IRAQ	8	3	0	0	11	2	0	0	0	2
IRELAND	1	0	0	0	1	0	0	0	0	0
ISRAEL	6	2	2	3	13	0	0	0	1	1
ITALY	31	12	4	4	51	5	5	2	1	13
JAMAICA	5	0	0	0	5	5	0	0	0	5
JAPAN	1	0	0	0	1	1	0	0	0	1
KOREA	1	0	0	0	1	0	0	0	0	0
LEBANON	6	1	0	0	7	2	0	0	0	2
LIBYA	2	1	1	0	4	1	0	1	0	2
MALAYSIA	35	8	1	0	44	23	5	0	0	28
MALTA	1	1	0	0	2	0	1	0	0	1
MEXICO	8	3	1	0	12	2	2	0	0	4
MEXICO/AUSTRALIA	1	0	0	0	1	1	0	0	0	1
MOZAMBIQUE	1	0	0	0	1	0	0	0	0	0

Table 1 : MCQ EXAMINATIONS 1978 - 1990 (Continued)

Australian Medical Council Incorporated

Report on number of attempts for MCQ Exams for period : 78A to 90A (inclusive)
For all centres.

As at : 10:06:27 25 MAY 1990 - Page 2

Country of Training	No. SITTING					No. PASSING				
	1	2	3	4+	Tot	1	2	3	4+	Tot
NETHERLANDS	14	8	6	0	28	8	3	2	0	13
NICARAGUA	1	1	0	0	2	0	1	0	0	1
NIGERIA	2	0	0	0	2	0	0	0	0	0
NTH IRELAND	1	0	0	0	1	0	0	0	0	0
PAKISTAN	35	24	14	15	88	5	9	6	3	23
PERU	2	0	0	0	2	1	0	0	0	1
PHILIPPINES	94	33	15	15	157	7	6	2	5	20
PNG	11	6	2	1	20	3	1	0	1	5
POLAND	82	43	14	6	145	18	21	7	2	48
POLAND/UK	2	1	1	1	5	1	0	0	0	1
PORTUGAL	4	2	1	0	7	2	2	1	0	5
ROMANIA	18	5	2	0	25	3	1	0	0	4
RUSSIA	2	0	0	0	2	0	0	0	0	0
SINGAPORE	37	9	1	0	47	20	6	1	0	27
SOUTH AFRICA	181	42	12	4	239	111	24	7	3	145
SPAIN	9	7	4	3	23	2	2	2	0	6
SRI LANKA	176	58	23	6	263	88	10	10	6	134
SUDAN	6	1	0	0	7	2	0	0	0	2
SWEDEN	4	1	1	0	6	2	1	1	0	4
SWITZERLAND	10	3	0	0	13	6	2	0	0	8
SYRIA	12	8	5	0	25	2	3	2	0	7
TAIWAN	6	0	0	0	6	0	0	0	0	0
TANZANIA	1	0	0	0	1	1	0	0	0	1
THAILAND	7	2	0	0	9	2	1	0	0	3
TURKEY	23	14	6	6	49	4	6	2	4	16
UGANDA	4	1	0	0	5	1	0	0	0	1
UK	13	1	0	0	14	7	1	0	0	8
UK (CONJOINT)	1	0	0	0	1	1	0	0	0	1
URUGUAY	5	1	0	0	6	1	1	0	0	2
USA	29	5	1	0	35	19	4	0	0	23
USSR	35	20	10	8	73	4	5	0	1	10
VIETNAM	67	39	15	23	144	17	25	5	5	52
WEST GERMANY	1	0	0	0	1	0	0	0	0	0
YUGOSLAVIA	35	18	9	12	74	5	3	3	2	13
ZAMBIA	2	0	0	0	2	1	0	0	0	1
ZIMBABWE	8	3	1	0	12	4	2	0	0	6
TOTALS	2095	864	358	243	3560	721	301	157	77	1336

Table 2 : CLINICAL EXAMINATIONS 1978 - 1990

(By Country of Training)

Australian Medical Council Incorporated

Report on number of attempts for Clinical Exams for period : 78A to 90C (inclusive)
For all centres.

As at : 10:12:04 25 MAY 1990 - Page 1

Country of Training	No. SITTING					No. PASSING				
	1	2	3	4+	Tot	1	2	3	4+	Tot
ARGENTINA	2	0	0	0	2	2	0	0	0	2
AUSTRALIA/PNG	1	0	0	0	1	1	0	0	0	1
AUSTRIA	2	1	1	0	4	1	0	1	0	2
BANGLADESH	8	5	1	0	14	1	4	1	0	6
BELGIUM	3	1	0	0	4	1	1	0	0	2
BRAZIL	4	2	1	1	8	1	1	0	0	2
BULGARIA	1	1	1	0	3	0	0	1	0	1
BURMA	6	4	2	0	12	2	2	1	0	5
CANADA	16	1	0	0	17	11	0	0	0	11
CHILE	2	1	0	0	3	1	1	0	0	2
COLOMBIA	1	1	1	0	3	0	0	1	0	1
CZECHOSLOVAKIA	18	11	5	2	36	7	5	4	0	16
DENMARK	4	1	0	0	5	3	1	0	0	4
EQUADOR	1	0	0	0	1	0	0	0	0	0
EGYPT	86	62	31	52	231	20	23	10	10	71
FIJI	5	2	1	0	8	3	0	0	0	3
FINLAND	1	0	0	0	1	0	0	0	0	0
FRANCE	3	1	0	0	4	2	1	0	0	3
GERMANY	29	10	3	3	45	16	6	1	1	24
GREECE	5	3	1	1	10	1	1	0	0	2
GUATEMALA	2	1	1	2	6	0	0	0	0	0
HONG KONG	47	11	4	0	62	22	6	4	0	32
HUNGARY	7	3	2	0	12	4	1	2	0	7
INDIA	209	100	45	43	397	76	46	22	16	160
INDONESIA	7	4	2	1	14	3	2	1	1	7
IRAN	12	4	1	0	17	1	3	1	0	5
IRAQ	2	0	0	0	2	1	0	0	0	1
ISRAEL	1	0	0	0	1	1	0	0	0	1
ITALY	10	4	1	2	17	5	3	0	0	8
JAMAICA	5	1	0	0	6	3	1	0	0	4
JAPAN	1	1	0	0	2	0	1	0	0	1
LEBANON	1	0	0	0	1	0	0	0	0	0
LIBYA	2	1	0	0	3	0	1	0	0	1
MALAYSIA	23	8	0	0	31	9	5	0	0	14
MALTA	1	1	0	0	2	0	1	0	0	1
MEXICO	3	1	0	0	4	1	1	0	0	2
MEXICO/AUSTRALIA	1	0	0	0	1	1	0	0	0	1
NETHERLANDS	10	5	4	0	19	3	1	2	0	6
PAKISTAN	16	5	0	0	21	6	4	0	0	10
PHILIPPINES	14	8	5	17	44	1	3	0	1	5
PNG	4	1	0	0	5	3	1	0	0	4
POLAND	40	24	11	9	84	16	11	6	3	36
POLAND/UK	1	0	0	0	1	0	0	0	0	0
PORTUGAL	3	1	1	0	5	1	0	1	0	2
ROMANIA	2	1	1	0	4	0	0	1	0	1
SINGAPORE	23	5	2	0	30	16	3	2	0	21
SOUTH AFRICA	126	26	6	3	161	91	18	1	2	112
SPAIN	3	1	1	0	5	0	0	0	0	0
SRI LANKA	111	49	14	15	189	37	30	5	3	75
SWEDEN	2	1	1	0	4	0	0	0	0	0

Table 2 : CLINICAL EXAMINATIONS 1978 - 1990 (Continued)

Australian Medical Council Incorporated

Report on number of attempts for Clinical Exams for period : 70A to 90C (inclusive)
For all centres.

As at : 10:12:10 25 MAY 1990 -- Page 2

Country of Training	No. SITTING					No. PASSING				
	1	2	3	4+	Tot	1	2	3	4+	Tot
SWITZERLAND	5	2	1	0	8	3	1	0	0	4
SYRIA	7	3	1	0	11	2	2	1	0	5
TANZANIA	1	0	0	0	1	1	0	0	0	1
THAILAND	2	2	0	0	4	0	1	0	0	1
TURKEY	9	2	0	0	11	6	2	0	0	8
UGANDA	1	0	0	0	1	1	0	0	0	1
UK	5	0	0	0	5	4	0	0	0	4
UK (CONJOINT)	1	0	0	0	1	1	0	0	0	1
URUGUAY	1	1	1	0	3	0	0	1	0	1
USA	17	4	1	0	22	8	3	1	0	12
USSR	8	3	1	0	12	5	2	1	0	8
VIETNAM	36	25	11	21	93	8	14	2	4	28
YUGOSLAVIA	10	4	2	3	19	1	2	0	2	5
ZAMBIA	1	1	1	0	3	0	0	1	0	1
ZIMBABWE	4	0	0	0	4	3	0	0	0	3
TOTALS	995	421	169	175	1760	417	215	75	51	758

APPENDIX III

Australian Medical Council: Changes in Procedures for AMC Exams (from July 1992)

(Australian Medical Council 1992, pp. 1 - 6)



AUSTRALIAN MEDICAL COUNCIL

IMPORTANT NOTICE: CHANGES IN THE PROCEDURES FOR THE AMC EXAMINATION [ISSUED JULY 1992]

AUSTRALIAN HEALTH MINISTERS' DECISION ON QUOTAS

The 1992 Australian Health Ministers' Conference announced a national strategy to address Australia's medical workforce requirements. The initiatives adopted by the Health Ministers include:

- a reduction of the number of medical practitioners entering Australia on temporary visas to meet local health service needs;
- a review of migration procedures to adjust the points system for medical qualifications;
- setting quota limits on the AMC examination in line with the entry quotas for Australian medical schools.

The Health Ministers have now announced the details of the quota arrangements for the AMC examination. Commencing in July 1992 the following provisions will apply to AMC examinations:

- A limit of 200 places in any one year has been set on access to the AMC clinical examination. This quota will be determined on merit order performance in the MCQ examination. The quota will be subject to review by the Health Ministers.
- Those overseas trained doctors who have already passed the AMC MCQ examination or have commenced but not yet passed the clinical examination will be permitted to continue with the clinical examination outside the quota but subject to the normal requirements of the AMC examination.

*** WHAT WILL HAPPEN TO THE AMC EXAMINATIONS IN 1992 AND 1993?

In 1991 the AMC announced changes to the MCQ and clinical examinations which would be introduced in 1993. Because of the Health Ministers' decision to introduce quotas in the second half of 1992, the Council has decided not to change the format or content of the AMC examination for 1992/93. Both the MCQ and clinical examinations conducted between July 1992 and June 1993 will follow the current format as set out in the Examinations Specifications booklet.

PLEASE NOTE: As from 1 January 1993 all AMC candidates will be required to have passed the Occupational English Test before they may sit the MCQ or clinical examination, unless granted an exemption.

The OET is now administered by the National Languages and Literacy Institute of Australia (NLLIA). The NLLIA has advised that the OET will be conducted on the following dates in 1992 and 1993:

IN AUSTRALIAN CENTRES		IN OVERSEAS CENTRES	
DATE OF OET EXAM.	CLOSING DATE FOR APPLICATIONS	DATE OF OET EXAM.	CLOSING DATE FOR APPLICATIONS
24 October 1992	22 August 1992	24 October 1992	22 August 1992
13 March 1993	30 January 1993	13 March 1993	30 January 1993
10 July 1993	29 May 1993		
13 November 1993	2 October 1993	13 November 1993	2 October 1993

Applications to sit the OET should be sent direct to the NLLIA and not to the AMC. The contact address for the NLLIA is:

The National Languages and Literacy Institute of Australia
Level 3/112 Wellington Parade
EAST MELBOURNE VIC 3002 Tel: 03 416 2422 Fax: 03 416 0231

Exemptions from the OET will only be granted where a candidate:

- * can provide satisfactory evidence of having passed a vocational test of English for medical practitioners, such as the English test component of the ECFMG in the USA or the PLAB examination in the UK; OR
- * can provide documentary evidence of birth or formal primary and secondary education in a country where English is the native language not merely an official language.

Applications for exemption should be forwarded to the AMC.

***** HOW WILL THE QUOTA BE APPLIED TO THE MCQ EXAMINATIONS IN 1992/93?**

The quota has been set at 200 for the year 1992/93. Since the AMC will be conducting two (2) MCQ examinations in this period - one in October 1992 and one in April 1993 - the quota will be divided equally between the two MCQ papers. That is, the limit of 200 for 1992/93 will be made up of 100 selected from the October 1992 MCQ and 100 selected from the April 1993 MCQ.

***** HOW WILL THE QUOTA CUT-OFF WORK?**

The quota is the cut-off point above which candidates will be eligible to sit for the AMC clinical examination. The criteria for selection within the quota is as follows:

- A: You must be within the group of the top 100 candidates in the examination who meet the minimum performance requirements; AND
- B: The minimum performance requirements are an overall score of 50% or better and not less than 40% in any of the five component subjects examined.

The quota will operate as follows:

- When the results for an MCQ paper have been processed all candidates will be listed in descending merit order of their overall score (% correct) for the examination.
- Starting with the highest overall score obtained in the MCQ paper, the cut-off point moves down the scores of candidates until a total of 100 candidates is obtained, who:
 - * have overall scores higher than 50%; AND
 - * have scored not less than 40% in any of the five component subjects examined.

The operation of the quota is illustrated in FIGURE 1. All candidates who have not yet passed the MCQ examination are advised to carefully study the quota procedures.

If less than 100 candidates qualify in the October 1992 MCQ examination the shortfall in quota places will be added to the April 1993 MCQ examination. That is, if only 94 candidates qualify in the October 1992 MCQ paper, the cut-off for the April 1993 MCQ examination will be increased to 106, subject to the minimum performance requirement of 50% overall and not less than 40% in any component subject.

***** DO I HAVE TO OBTAIN PASSES IN ALL COMPONENTS IN ORDER TO QUALIFY FOR A QUOTA PLACE?**

NO. The quota cut-off is determined on the basis of the overall score. A candidate does not have to obtain a passing score (50% or better) in each of the five component subjects examined (eg. Medicine, Paediatrics, Psychiatry, Surgery and Obstetrics/Gynaecology), but will have to score 40% or better in each of these subjects AS WELL AS passing the overall examination (50% or better) in order to qualify for a quota place.

***** IF I MISS OUT ON A QUOTA PLACE HOW MANY TIMES CAN I SIT THE MCQ EXAMINATION PAPER?**

There will be no limit on the number of attempts that a candidate may have at the MCQ examination paper. After three unsuccessful attempts at the MCQ examination a candidate's performance will be reviewed and

FIGURE 1: OPERATION OF THE QUOTA ON THE AMC EXAMINATION

If a group of 367 candidates sit the MCQ paper with the highest overall score of 77% and the lowest score of 33% and the distribution of scores as illustrated below, the quota cutoff would operate as follows:

OVERALL SCORE % CORRECT	DISTRIBUTION (NUMBER CANDS. WITH THE SAME OVERALL SCORE)	CUMULATIVE NUMBER OF CANDIDATES	QUOTA MERIT ORDER
77	X	1	1/367
76	X		2/367)
	X (3)		2/367) SHARED
	X	4	2/367)
75	X (2)		5/367)
	X	6	5/367) SHARED
74	X	7	7/367
73	X		8/367)
	X		8/367)
	X (5)		8/367) SHARED
	X		8/367)
	X	12	8/367)
72	X		13/367)
	X (3)		13/367) SHARED
	X	15	13/367)
71	X	16	16/367
70	X		17/367)
	X		17/367)
	X (6)		17/367) SHARED
	X		17/367)
	X		17/367)
	X	22	17/367)
.	.	.	.
.	.	.	.
57	X		92/367) SHARED
	(X) [3 - 1*]		(NOT ELIGIBLE FOR QUOTA)*
	X	93	92/367) SHARED
56	X		94/367)
	X (4)		94/367) SHARED
	X		94/367)
	X	97	94/367)
55	X		98/367) SHARED
	(X) [4 - 2*]		(NOT ELIGIBLE FOR QUOTA)*
	(X)		(NOT ELIGIBLE FOR QUOTA)*
	X	99	98/367) SHARED
QUOTA	X	100	100/367
CUTOFF			
CANDIDATES WITH OVERALL SCORES ABOVE THE QUOTA CUTOFF WHO ARE NOT ELIGIBLE FOR THE QUOTA AS THEY FAIL TO MEET THE MINIMUM PERFORMANCE CRITERIA - LESS THAN 40% IN ONE OR MORE OF THE FIVE COMPONENT SUBJECTS EXAMINED.			
57	(X)	101	101/367
55	(X) [2]		102/367)
	(X)	103	102/367) SHARED
CANDIDATES WHOSE OVERALL SCORE IS OUTSIDE THE QUOTA LIMIT			
53	X	104	104/367
52	X		105/367)
	X (3)		105/367) SHARED
	X	107	105/367)
51	X	108	108/367
50	X		109/367)
	X (3)		109/367) SHARED
	X		109/367)
49	X	111	112/367)
	X (4)		112/367)
	X		112/367) SHARED
	X	115	112/367)
.	.	.	.
.	.	.	.
35	X	363	363/367
34	X		364/367)
	X (3)		364/367) SHARED
	X	366	364/367)
33	X	367	367/367

* NOTE: If a candidate scores above 50% overall but less than 40% in one or more of the five component subjects examined he/she will not be eligible for a place within the quota.

the candidate will be provided with advice and counselling. The computer-generated feedback to candidates will also be amended to reflect the new cut-off mechanism.

***** CAN I APPLY MY SCORE IN ONE MCQ EXAMINATION PAPER TO ANOTHER SERIES FOR THE PURPOSES OF THE QUOTA?**

NO. Each examination varies slightly in the question content and range of conditions examined. It will not be possible to apply the results from one MCQ series to the ranking for quota purposes in another MCQ series.

***** IF I HAVE ALREADY PASSED THE MCQ EXAMINATION BUT HAVE NOT YET COMMENCED THE CLINICAL EXAMINATION WILL THE NEW QUOTA LIMITS APPLY TO ME?**

NO. The Health Ministers have agreed that as a transitional arrangement, candidates who have already passed the MCQ examination before July 1992 but have not yet commenced the clinical examination will be allowed to proceed to the clinical examination. However, they will be subject to the same performance requirements and examination procedures which will apply to all clinical candidates.

***** WILL THE TRANSITIONAL ARRANGEMENTS ALSO APPLY TO CANDIDATES WHO HAVE COMMENCED THE CLINICAL EXAMINATION BUT HAVE NOT YET PASSED?**

YES. The transitional arrangements will also apply to these candidates and they will be subject to the same performance standards and examination procedures which apply to all clinical candidates.

AMC CLINICAL EXAMINATION

***** WILL THERE ALSO BE A QUOTA ON THE RESULTS OF THE CLINICAL EXAMINATION ALONG THE LINES OF THE QUOTA ON THE MCQ EXAMINATION?**

NO. The quota on the AMC examination will be an entry quota, which only has the effect of limiting the numbers of candidates who can present for the clinical examination based on performance at the MCQ examination. The outcome of the clinical examination will be determined only by the performance of the individual candidates and will not be subject to any quota limit.

CHANGES IN PROCEDURES FOR THE AMC CLINICAL EXAMINATIONS IN 1992/93

There will be no change in the format and content of the AMC clinical examination in 1992 and 1993.

The programme of clinical examinations for the period July to December 1992 is fully allocated to candidates who passed the MCQ examination before July 1992 and there is a large waiting list.

In line with the quota arrangements introduced by the Health Ministers, the following procedures will apply to AMC clinical examinations from the beginning of 1993.

The clinical examinations will be conducted in four (4) series during 1993 with specified closing dates for applications.

PROPOSED CLINICAL EXAMINATION PROGRAMME FOR 1993

Note: This is a provisional programme only. The final dates and centres for the 1993 clinical examinations are still being finalised and will be notified to all clinical examination candidates as soon as they are available.

*** SERIES 1 1993:**

Examination Dates:	March	March/April
Examination Centres:	Brisbane	Adelaide
Applications Closing Date:	1 December 1992	

* SERIES II 1993:

Examination Dates:	April/May	May
Examination Centres:	Melbourne	Sydney
Applications Closing Date: 1 February 1993		

* SERIES III 1993:

Examination Dates:	August	September
Examination Centres:	Sydney	Adelaide
Applications Closing Date: 1 June 1993		

* SERIES IV 1993:

Examination Dates:	October	November
Examination Centres:	Brisbane	Melbourne
Applications Closing Date: 1 August 1993		

[It is expected that ancillary clinical examinations will also be conducted in Sydney and Melbourne as part of the 1993 clinical examinations programme.]

All applications for clinical examinations conducted in 1993 must be submitted on a new Application Form which is available on request from the AMC.

In each series of examinations a set number of places will be held for candidates sitting the clinical examination for the first time together with a number of places for repeating candidates to ensure that all candidates have an opportunity to complete the clinical examination as quickly as possible.

After the closing date, all candidates who have applied for a clinical examination will be listed in merit order of their performance in the MCQ examination and previous clinical examinations, and scheduled for the relevant examination.

If the number of candidates who have applied exceeds the number of places available for the particular series, priority will be given to candidates in order of merit with a reserve list of stand-by candidates. The following priority order will apply to the listing of clinical candidates:

- * For clinical examinations scheduled for the remainder of 1992 (up to 31 December 1992) priority will be given to candidates who have already been placed in an examination without reference to their merit order performance in the MCQ examination.
- * For clinical examinations conducted from 1 January 1993 the following priority order will apply:

PRIORITY ORDER	CRITERIA
1.	Candidates in merit order of performance in the MCQ examination who are attempting the clinical examination for the first time.
2.	Repeat candidates who have been granted an exemption in one or more components of the clinical examination on the basis of their performance in previous attempts.
3.	Repeat candidates without exemptions, ranked in merit order of performance at the MCQ examination.

Normally a maximum of three (3) attempts will be permitted at the clinical examination. After two (2) unsuccessful attempts the candidate will be offered special counselling as appropriate.

Candidates who are unsuccessful after the permitted number of attempts at the clinical examination will be required to resit the MCQ examination and compete for one of the quota places.

***** WHAT HAPPENS TO ME IF I HAVE ALREADY APPLIED TO SIT THE CLINICAL EXAMINATION AND HAVE BEEN GIVEN A PLACE IN ONE OF THE EXAMINATIONS TO BE CONDUCTED DURING 1992?**

Under the transitional provisions approved by the Health Ministers you will be permitted to continue with your current examination. However, if you withdraw from your current clinical examination place, you will be re-scheduled in merit order as set out above. Depending on your previous performance at the MCQ and clinical examinations (if you have exemptions) you may be placed higher or lower in the clinical examination queue.

***** WHAT HAPPENS TO ME IF I HAVE APPLIED FOR THE CLINICAL EXAMINATIONS BUT HAVE NOT YET BEEN ALLOCATED A PLACE IN THE EXAMINATIONS BEING CONDUCTED IN 1992?**

All candidates who have not yet been allocated a clinical examination place in 1992 will be placed in a merit order ranking based on their performance at the MCQ and previous clinical examination attempts (where applicable). As vacancies occur, candidates will be allocated places in merit order priority. Candidates who are not placed in a 1992 clinical examination (the final clinical examination in 1992 will be conducted in November) will need to apply for placement in the 1993 series of clinical examinations under the new arrangements.

NEW PROCEDURES FOR THE ASSESSMENT OF OVERSEAS TRAINED SPECIALISTS

After 1 January 1993 overseas trained specialists who do not hold recognised primary qualifications will be able to apply through the AMC to have their specialists skills assessed by the relevant Specialist Medical College in Australia. The assessment procedures will follow the formal assessment programme of the relevant College as applied to local trainees.

Overseas trained specialists who are assessed by the relevant College as comparable to the standard of an Australian trained specialist will receive an AMC Certificate endorsed for the particular field of specialty or sub-specialty. This will enable the overseas trained specialist to apply for registration (limited to the designated field of specialty).

The details of the assessment procedures are now being finalised and the AMC will issue a separate information leaflet and application forms for specialists as soon as these are available.

CHANGES IN MIGRATION PROCEDURES

In order to be eligible to sit the AMC examination an applicant who is resident overseas **MUST**:

- A. have been granted migrant entry to Australia (that is, issued with a resident status visa by the Department of Immigration, Local Government and Ethnic Affairs); OR
- B. have applied for migration to Australia and been advised in writing by the Australian Government Office overseas to obtain assessment of qualifications.

In cases where an applicant resident overseas is applying for migrant entry, the eligibility to sit the AMC examination is provisional only and the AMC Certificate cannot be issued until permanent resident status has been granted. If the application for migrant entry is rejected by the Department of Immigration, the candidature for the AMC examination will cease.

The Australian Government has recently implemented changes to migration procedures which may have an impact on overseas trained doctors who do not hold resident status in Australia and have applied to sit the AMC examination.

***** If you are currently a candidate for the AMC examination or are intending to apply for the AMC examination you should contact the Australian Government Office that is processing your application and confirm the status of your migrant entry application.**

APPENDIX IV

Australian Medical Council information leaflet to
Overseas trained doctors on recognition of
qualifications in Australia

(Australian Medical Council 1991b, pp. 1 - 4)



RECOGNITION OF MEDICAL QUALIFICATIONS IN AUSTRALIA

[ISSUED MARCH 1991]

AN INFORMATION LEAFLET FOR ALL DOCTORS WHO HAVE BASIC MEDICAL QUALIFICATIONS OBTAINED OUTSIDE AUSTRALIA WHO WISH TO PRACTISE IN AUSTRALIA

If you are a resident overseas it is important that you study this leaflet **BEFORE** leaving your country of origin. It gives important information about:

- the employment situation for doctors in Australia;
- the legal requirements for medical practice in Australia.

FOR THOSE DOCTORS WHOSE MEDICAL QUALIFICATIONS ARE NOT RECOGNISED IN AUSTRALIA, THIS LEAFLET CONTAINS ESSENTIAL INFORMATION ABOUT:

- the eligibility requirements for the Australian Medical Council examination;
- the prospects of overseas trained doctors entering medical practice in Australia;
- access to medical training and supervised practice in Australia.

Many overseas trained doctors wishing to practise in Australia have arrived in Australia without being fully informed about these matters. In some cases the necessary prerequisites for registration have been incomplete and access to further training in Australia has not been available. In such cases, the doctors concerned have been faced with the difficult choice of either returning to their country of origin to complete the necessary requirements, or seeking other employment in Australia.

If **YOU** are uncertain about the recognition of your medical qualifications in Australia, it is in your own interest to contact the relevant Medical Board or the Australian Medical Council as set out in this leaflet, and confirm the requirements **BEFORE** you leave your country of origin.

WHAT ARE THE JOB OPPORTUNITIES FOR MEDICAL PRACTITIONERS IN AUSTRALIA?

- In 1989 the Australian Health Ministers Conference established a National Committee to review Australia's medical workforce requirements, in light of claims that Australia is oversupplied with doctors.
- While there are shortages of doctors in some rural areas and within the public hospital system, health authorities consider that there is an over-supply of doctors in the major metropolitan areas.
- The Commonwealth Government is currently conducting a major review of the health care system in Australia and has foreshadowed reductions in the intakes into Australian Medical Schools and the medical workforce.

WHAT ARE THE LEGAL REQUIREMENTS FOR MEDICAL PRACTICE IN AUSTRALIA?

- Each State and Territory in Australia has separate laws for the registration of medical practitioners and these are administered by separate Medical Boards and Councils.
- Before you can practise medicine in Australia you must be registered as a medical practitioner under the laws of the State or Territory in which you intend to reside and work.
- Registration in one State or Territory will not give you the right to practise medicine in another State or Territory unless you are also registered there.
- All State and Territory Medical Boards, with the exception of New South Wales, recognise the basic medical qualifications obtained from approved medical schools

located within the United Kingdom, the Republic of Ireland and New Zealand.

- Please note that basic medical qualifications awarded by United Kingdom medical schools for courses of training completed outside the United Kingdom are not generally recognised in Australia.
- As from 1 October 1987 New South Wales has only recognised basic medical qualifications obtained from Australian and New Zealand medical schools.

DETAILS OF BASIC MEDICAL QUALIFICATIONS WHICH ARE CURRENTLY RECOGNISED FOR PURPOSES OF REGISTRATION BY STATE AND TERRITORY BOARDS ARE SET OUT ON PAGES 3 & 4 OF THIS LEAFLET.

- Registration for specialist practice varies from State to State in Australia but acceptable primary qualifications are normally required before registration will be granted. This means that persons wishing to practise as a specialist must be on the general medical register before their specialist qualifications can be recognised. Generally, specialist qualifications obtained in the United Kingdom are recognised. However, if you have specialist qualifications in medicine it is in your interests to obtain further information on the recognition of specialist qualifications from:

NATIONAL SPECIALIST QUALIFICATIONS

ADVISORY COMMITTEE (NSQAC)

PO BOX 100
WODEN ACT 2606
AUSTRALIA

THE AMC EXAMINATION

WHAT IS THE AMC EXAMINATION?

- If your basic medical qualifications are not recognised in Australia you may be eligible to sit the examination of the Australian Medical Council (AMC). The AMC Certificate will confer eligibility to apply for registration in any State or Territory of Australia subject to the registration requirements of each State or Territory Medical Board or Council. **THIS MAY INCLUDE A PERIOD OF SUPERVISED MEDICAL PRACTICE TO BE DETERMINED IN EACH CASE BY THE RELEVANT MEDICAL BOARD OR COUNCIL.**

NOTE: THE AMC CERTIFICATE IS EVIDENCE OF A MINIMUM STANDARD OF BASIC MEDICAL EDUCATION AND DOES NOT CONFER RIGHT OF PRACTICE. THE FINAL DECISION TO REGISTER A MEDICAL PRACTITIONER RESTS WITH THE MEDICAL BOARD IN EACH STATE AND TERRITORY. SUCCESSFUL COMPLETION OF THE AMC EXAMINATION DOES NOT AUTOMATICALLY LEAD TO REGISTRATION IN VARIOUS STATES WHICH HAVE SPECIFIC REGISTRATION REQUIREMENTS RELATING TO INTERNSHIPS, RESIDENCY AND LENGTH OF PRIMARY MEDICAL DEGREE.

- The AMC is the national standards and examining authority in Australia for basic medical education and is independent of State and Commonwealth Governments. The

membership of the AMC includes representatives of State and Territory Medical Boards, the Australian (University) Vice-Chancellors Committee and the National Office of Overseas Skills Recognition formerly the Council on Overseas Professional Qualifications.

- The AMC examination consists of:
 - (a) a written examination comprising a multiple-choice-question (MCQ) paper; and
 - (b) a clinical examination.
 Candidates must pass the MCQ paper before proceeding to the clinical examination. In addition, all candidates must pass the English Test administered by the NATIONAL LANGUAGES INSTITUTE OF AUSTRALIA on behalf of the AMC, unless granted an exemption.
- Eligible candidates may sit the MCQ paper at an Australian Government Office overseas but the clinical section of the examination must be taken in Australia.

ARE YOU ELIGIBLE TO SIT THE AMC EXAMINATION?

- To be eligible to take the AMC examination you must:
 - (1) (A) If residing in Australia—
 - be an Australian citizen or hold "permanent resident status" issued by the Commonwealth Department of Immigration, Local Government and Ethnic Affairs.
 - (B) If residing overseas—
 - have applied for migrant entry and completed the preliminary migration procedures.
 - (2) hold a basic degree in medicine and surgery* issued by a medical school listed in the WHO publication, *World Directory of Medical Schools*, or other publications approved by the Council.

*NOTE: Degrees in traditional Chinese medicine and the degree of Doctor of Osteopathy (USA) are not recognised for the purposes of eligibility to sit the AMC examination.

CHANGE IN ELIGIBILITY CRITERIA

NOTE AS FROM 1 JULY 1989 THE AMC NO LONGER REQUIRES CERTIFIED DOCUMENTARY EVIDENCE OF COMPLETION OF INTERN TRAINING, CURRENT REGISTRATION OR CERTIFICATE OF GOOD STANDING AS ELIGIBILITY REQUIREMENTS FOR ITS EXAMINATION. INDIVIDUAL MEDICAL BOARDS AND COUNCILS WILL REQUIRE PROOF OF INTERN TRAINING AND MAY REQUIRE EVIDENCE OF CURRENT REGISTRATION OR GOOD CHARACTER BEFORE GRANTING REGISTRATION TO CANDIDATES WHO HAVE PASSED THE AMC EXAMINATION.

WHAT ARE THE EDUCATIONAL STANDARDS REQUIRED FOR MEDICAL PRACTICE IN AUSTRALIA, AND THE STANDARDS OF THE AMC EXAMINATION?

- The standard of the AMC examination is based on the level of clinical proficiency and medical knowledge of a newly qualified graduate from an Australian medical school WHO IS ABOUT TO COMMENCE A 12-MONTH ROTATING INTERNSHIP.
- The basic medical course at Australian universities is generally of 6 years duration and is preceded by usually not less than 6 years of primary school and a further 6 years of secondary school education.
- Entrance standards for medical schools in Australia are very high with only 2-5% of the top secondary school matriculants qualifying for entry.

- MEDICAL EDUCATION AND PRACTICE VARIES CONSIDERABLY FROM ONE COUNTRY TO ANOTHER. DOCTORS TRAINED IN OTHER SYSTEMS OF MEDICAL EDUCATION AND PRACTICE MAY EXPERIENCE DIFFICULTY IN ADAPTING TO THE REQUIREMENTS FOR PRACTICE IN THE HEALTH CARE SYSTEM CURRENTLY OPERATING IN AUSTRALIA.

WHAT ARE THE PROSPECTS OF OVERSEAS TRAINED DOCTORS SUCCESSFULLY COMPLETING THE AMC EXAMINATION REQUIREMENTS AND ENTERING MEDICAL PRACTICE IN AUSTRALIA?

Since the establishment of the national qualifying examination for overseas trained doctors in 1978 some 40% of doctors attempting the examination have passed. In many cases this required multiple attempts at the MCQ and clinical examinations before obtaining a final overall pass.

WHAT ARE THE FACTORS AFFECTING THE SUCCESS OF AN OVERSEAS TRAINED DOCTOR SEEKING REGISTRATION IN AUSTRALIA?

- While there have been many exceptions, over recent years AMC examiners have found that many candidates attempting the examinations were poorly prepared or lacked experience in some areas of medicine examined.
- The following factors are believed to contribute towards low pass rates of overseas trained doctors:
 - (a) Systems of medical training and practice in most countries are geared to the health needs of the local community and the nature and extent of clinical training facilities available. These differences in standards, emphasis and experience in clinical practice are believed to contribute to the difficulties experienced by overseas trained doctors attempting AMC examinations.
 - (b) In some cases AMC examiners have found that the type and standard of internship (pre-registration supervised practice) received did not include each of the disciplines of medicine, surgery and obstetrics/gynaecology or the general exposure of the candidate to clinical practice was inadequate.
 - (c) Where the first language is not English, many candidates experience difficulty with the AMC examination.

NOTE: (1) It is essential for overseas trained doctors to have a good command of written and spoken English. Australia is an English speaking country and as a medical practitioner in the Australian health care system, the overseas trained doctor will be expected to communicate with his/her patients, other doctors and allied health personnel as well as keeping up with changing medical information.

(2) All overseas trained doctors who sat for and passed the AMC examination must also have passed a formal English examination set by the National Languages Institute of Australia on behalf of the AMC (unless a formal exemption has been granted), before they can obtain their AMC certificate.

- (d) Overseas trained doctors, who obtained their basic medical qualifications many years prior to attempting the AMC examinations, or who have been in specialist medical practice for some time, have also experienced difficulties with the AMC examination which is designed

to evaluate basic medical knowledge and general clinical proficiency.

- The minimum time taken to complete the requirements for the AMC examination for candidates resident in Australia is 6 months and candidates resident overseas is 12 months. (Candidates have taken from 3 to 6 years to complete all the requirements.)
- A limit of 3 attempts now applies to each section of the AMC examination.

WHAT PROVISIONS EXIST IN AUSTRALIA FOR BRIDGING COURSES?

- The results of the AMC examination indicate that a percentage of overseas trained doctors will require further training or bridging education in order to meet registration requirements in Australia.
- At present there are only a limited number of bridging programmes available in Australia.
- Access to university medical schools is severely limited and strict quotas are imposed on available places. Only a very small number of overseas trained doctors have succeeded in gaining entry to formal medical training in Australia.

WHAT FINANCIAL SUPPORT IS AVAILABLE FOR OVERSEAS TRAINED DOCTORS SEEKING REGISTRATION IN AUSTRALIA?

- At present there are no special provisions for overseas trained doctors to receive income support while preparing for the AMC examination.
- Many doctors rely on unemployment benefits for support. However, the conditions of the benefits may restrict opportunities for study and preparation.

WHAT ARE THE PROCEDURES FOR ASSESSING OVERSEAS MEDICAL QUALIFICATIONS IN AUSTRALIA?

QUALIFICATIONS CURRENTLY RECOGNISED IN AUSTRALIA [SEE PAGES 3 & 4]

- If your basic medical qualifications are currently recognised in the State or Territory of Australia where you wish to reside and practise you should write directly to the Medical Board or Council of that State or Territory to confirm your eligibility for registration.

NOTE: Even if your basic medical qualifications are registrable in one State or Territory, under current legislation you must pass the AMC examination if

you wish to practise medicine in another State or Territory which does not recognise your qualifications.

QUALIFICATIONS NOT CURRENTLY RECOGNISED IN AUSTRALIA (OR IN THE STATE OF INTENDING RESIDENCE)

PERSONS RESIDENT OVERSEAS

NOTE: Doctors resident overseas are not eligible to sit the AMC examination unless they have applied for and completed the preliminary application procedures for migrant entry to Australia.

- If you are normally resident overseas and have lodged an application to migrate with an Australian Government Office overseas, you will be notified in writing to obtain an assessment of your qualifications.
- You should complete the *Preliminary Application Form* which is attached to this leaflet and return it direct to the AMC together with:
 - A copy of the letter from the Australian Government Office advising you to obtain an assessment of your qualifications;

AND

- the assessment fee of \$A30 which should be in Australian currency and made payable to the AMC.
- The AMC Secretariat will send you a copy of the "INFORMATION BOOKLET FOR CANDIDATES", which sets out the application and examination procedures in detail, together with the necessary application forms.
- You should complete the forms as shown in the accompanying instructions and return them to the AMC Secretariat. If you are eligible to sit the AMC examination you will be notified in writing by the AMC Secretariat. The AMC will also notify the Australian Government Office so that your migration application can proceed.

NOTE: IF YOUR MEDICAL QUALIFICATIONS ARE NOT CURRENTLY RECOGNISED IN AUSTRALIA IT IS IN YOUR OWN INTEREST NOT TO LEAVE YOUR COUNTRY OF ORIGIN BEFORE YOUR ELIGIBILITY TO SIT THE AMC EXAMINATION HAS BEEN CONFIRMED.

PERSONS RESIDENT IN AUSTRALIA

- If you are an Australian citizen or you are living in Australia and have been granted "Permanent Resident Status" you may apply direct to the AMC Secretariat in Canberra.

AUSTRALIAN MEDICAL COUNCIL

PRELIMINARY APPLICATION FORM FOR THE AMC EXAMINATION

PLEASE USE BLOCK LETTERS AND PRINT CAREFULLY

NAME (FAMILY NAME/SURNAME)

GIVEN NAMES

ADDRESS FOR CORRESPONDENCE

STREET NUMBER AND NAME

SUBURB

TOWN

COUNTRY

POSTCODE

DATE OF BIRTH/...../.....

DATE OF ARRIVAL
IN AUSTRALIA/...../.....

HAVE YOU COMPLETED A 12 MONTH INTERNSHIP
OR PERIOD OF COMPULSORY SUPERVISED TRAINING YES/NO

PRIMARY MEDICAL QUALIFICATION - TITLE

NAME OF SCHOOL OR COLLEGE

DATE OF ISSUE/...../..... COUNTRY OF TRAINING

NOTE: THIS FORM SHOULD BE RETURNED DIRECTLY TO THE AMC TOGETHER WITH THE \$A30
ASSESSMENT FEE

OFFICE USE ONLY

FILE NUMBER

DATE RECEIVED

FEE RECEIPT No.

BOOKLET/FORMS SENT

APPENDIX V

**Statement on Appropriate Numbers of Overseas
Trained Doctors endorsed by the Australian Medical Association,
the Committee of Deans of Medical Schools and the Committee
of Presidents of the Medical Colleges**

(available from the Australian Medical Association)

STATEMENT ON APPROPRIATE NUMBERS OF DOCTORS AND THEIR
SOURCES REQUIRED TO MEET AUSTRALIA'S FUTURE NEEDS
FOR MEDICAL CARE

Endorsed by the AMA, The Committee of Deans of Australian Medical Schools and the Committee of Presidents of Medical Colleges.

In explaining its rationale for certain measures contained in the 1991/92 Federal Budget, the Australian Government stated its belief that Australia now has an excessive number of doctors. The medical profession of Australia has long held a similar view.

An oversupply of medical practitioners is not in the best interests of the Australian community. Excessive numbers of medical practitioners may have the following adverse effects:

alteration to the pattern of medical services and increased health care costs;

reduced opportunities for medical practitioners, many of whose services are underutilised, to maintain their technical skills and professional competence; and

social and economic waste arising from the provision of long, expensive and highly specific training for employment that a proportion of those trained will be unable to obtain.

Australia's supply of medical practitioners has grown at a rate well above the overall population increase in recent years.

The Doherty Committee's 1988 report Australian Medical Education and Workforce Into the 21st Century quantified this growth to 1986⁽¹⁾.

TREND IN THE DOCTOR:POPULATION RATIO (DPR) IN AUSTRALIA

Year	DPR	Source
1929	1:1161	Med. J. of Australia 1929
1943	1:1178	Cilento 1944
1953	1:857 (Vic)	Poate 1953
	1:863 (NSW)	Poate 1953
1964	1:899	Last 1964
1967	1:823	Scotton 1967
1972	1:721	Karmel Report 1973
1979	1:574	Committee of Officials 1980
1986	1:476	1986 Census unadjusted
1986	1:438	DOH/AIH study 1987

The 1986 study recognised that further allowances for the impact of increasing numbers of female medical graduates working part-time for periods during their careers were needed. Even so it concluded that the doctor-to-population ratio is likely to decline only slowly over the next 30 years to levels comparable to those of similar western countries⁽²⁾. The increase in the number of medical practitioners has been produced from two sources, namely the output of Australian medical schools and the influx of overseas trained graduates.

The existing and projected rate of increase in the number of doctors practising in Australia cannot be sustained without unacceptable costs to Australian health care and to the broader community. As indicated in the Government's Budget Statement, the only practical restraints on future increase are curtailment of one or both of the previously specified growth factors. For reasons set out below, it must be new registrations of foreign graduates which is reduced, not the output of Australian medical schools.

Australian medical school entry is already highly competitive, with fewer than 1 in 10 qualified applicants gaining selection. On the basis of their outstanding performance in competitive examinations conducted in other countries, Australian graduates repeatedly demonstrate their high quality as medical practitioners. A high quality of medical service available to the Australian community is guaranteed by the Australian medical schools. The Australian community will not tolerate a reduction in medical school numbers, thus denying our own children an opportunity to practise medicine, while an undiminished flow of foreign graduates continues.

Australian medical schools exist for purposes beyond the production of the required numbers of medical graduates for Australia. Despite the paucity of their funding, they have an enviable tradition of world class pure and applied research. They constitute centres of clinical excellence in treatment and in training which could not exist without the academic environment of university medical schools. They permit the creation and maintenance of multi-disciplinary "super specialist" units at national level with a capacity to provide world-class treatment for the Australian community. They provide the essential research on which advances in medical practice, cost containment, efficiencies in diagnosis and greater effectiveness in health promotion, prevention of illness and the management of disease depend. Over the past five years, the medical schools have reduced their output of graduates by 15%. Any further reductions could jeopardise the continued existence of some medical schools. Moreover, should the intake of students to Australian medical schools be reduced in 1993, there will be no effect on the number of graduates entering the practice of medicine with full registration until the year 2000.

As the Government acknowledged in Budget Related Paper No 9, Australia has been almost uniquely permissive among English speaking countries in the numbers of overseas trained doctors it has permitted to gain local, unrestricted registration⁽³⁾. There exists a considerable mismatch between the countries where most overseas trained doctors migrating to Australia gain their medical qualifications and the countries of origins of the bulk of immigrants. In contrast, the intake of Australian high school students to Australian medical schools is now representative of the cultural backgrounds of all major community groups in the country.

Statistically, overseas trained doctors are rather less likely than local graduates to practise long-term outside major metropolitan areas; thus they contribute substantially to the relative oversupply of doctors in city areas. Furthermore, the training received by many overseas trained doctors is sufficiently different from that of Australian graduates to make these overseas trained doctors unsuitable to enter local medical practice without expensive retraining.

Numerous overseas trained doctors experience further difficulties in adjusting to the norms of Australian clinical practice because of their quite different cultural backgrounds and poor grasp of colloquial and professional English.

It appears entirely appropriate to insist that overseas trained doctors entering Australia should be informed explicitly that they should have no expectation of an automatic right to practise medicine here. Rather, as is the case for local aspirants to a medical education, a quota should be applied. The recommendation by the Doherty Committee (that a quota be set at 10% of the previous year's output from Australian medical schools for the number of overseas trained doctors permitted to sit the clinical section of the AMC examination) appears equitable.

REFERENCES

1. Committee of Inquiry into Medical Education and Medical Workforce. Australian Medical Education and Workforce Into the 21st Century, AGPS Canberra 1988, p 372, Table 11.3.
2. Ibid pp 433-441.
3. Department of Health, Housing and Community Services. 1991-92 Budget Related Paper No 9: Health Care in Australia - Directions for Reforms in the 1991-92 Budget, AGPS Canberra 1991, pp 16-17.

APPENDIX VI

Extracts from Report of Committee of Inquiry into Medical
Education and Medical Workforce (Doherty Committee)
indicating Attitudes towards Overseas Trained Doctors

(Committee of Inquiry 1988, pp. 470 - 474, 479 - 480)

The Committee concerns itself in this section very largely with the overseas trained doctors who wish to practise medicine and who have the right to remain permanently in Australia. It recognises that overseas trained doctors come to Australia to seek postgraduate training or work experience on a short term basis, and believes that this role is relevant to Australia's position of leadership in the field of medical education. It believes that the training received should be appropriate to the health needs of the country from which the trainees come, and entry to Australia should involve a commitment to return to the home country on completion of training.

* *Present immigration policies and methods of migration by overseas trained doctors*

- * The several categories under which overseas trained doctors may migrate to Australia, and the numbers migrating in the past three years under the various programs, are detailed in Table 11.50.
- * These categories are no different to the avenues available to the general community, with the notable exception that skilled labour and business migration of doctors, primarily the Employer Nomination Scheme, is only permitted under controlled circumstances of employer sponsorship to specific employment situations where there are no suitable local applicants for the position.
- * While present immigration policy could be regarded as admirable in that doctors are viewed as well-educated graduates with all the necessary intellectual skills to adapt and cope in a new country, it fails to recognise the very important considerations of the medical workforce. For example, the majority of overseas trained doctors admitted are either general practitioners or specialists who are forced into general practice, which is not seen as an area of undersupply in Australia.
- * The present policy treats all graduates, regardless of origin and training, as equally qualified. This is admirable as overtly avoiding any suggestion of racial discrimination and is supported on those grounds, but overlooks what are seen as very real differences in educational standards of many overseas medical schools.
- * The Committee was informed that many overseas trained doctors were poorly advised or prepared to encounter unfamiliar western patterns of disease or style of medical practice generally conducted in Australia.

Furthermore, it was submitted to the Inquiry that, on arrival in Australia, the overseas doctor was, often for the first time, made fully aware of the examinations which must be passed and the standard at which they are conducted. This experience was made worse by the advice that high fees are payable to sit the examination and that very few opportunities are provided for tuition and preparation of the candidates.

- * This relatively permissive immigration policy for overseas trained doctors resulted, the Committee was told, in a chaotic situation in which the doctors themselves believed that there were professional plots to exclude them from practice, and at the same time, professional associations of Australian doctors condemned the immigration policy which was perceived to be a major factor responsible for an oversupply of doctors in the Australian medical workforce.

The Committee accepts that medical immigration policy and procedures should be improved.

Issues raised in submissions concerning future migration policies for overseas trained doctors

- * A number of submissions (for example, from the Federal and Western Australian branch of the AMA, the Royal Australian College of Medical Administrators, and the Committee of Deans of Australian Medical Schools), argued that medical practice for overseas trained doctors should not be permitted at the expense of opportunities for young Australians who are excluded from entry to our own medical schools by the quota system. For example, the Committee of Deans submitted:

- * The large scale admission of overseas graduates has been a major factor in the growing numbers of medical practitioners in Australia. As presently handled, this source of doctors is an unmanaged and apparently unmanageable factor in any work force equation. We see the application of strict guidelines to medical immigration as an essential step; consideration of alterations to medical school intakes should only take place after the supply of overseas graduates has been tightly controlled.

- * Many of these submissions called for tight controls on the entry of overseas trained doctors and on their ability to practise in Australia. The form of this control was often not specified, although several variations were postulated. It was suggested, for example, that overseas doctors should be able to take up only those positions which demonstrably were unable to be satisfactorily filled by doctors living in Australia. These positions would generally be in specialties with acute shortages and in certain geographical areas that lacked adequate numbers of practitioners. A similar proposal would require licensing (with conditions) of overseas trained doctors for a specific purpose.

- * Other suggestions went further. For example the Health Insurance Commission proposed that new registrations of overseas trained doctors should be "restricted by regulated availability of required preregistration training positions" and that if such registration was

- * facilitated in order to meet particular specialty, university or hospital needs, the doctor should be ineligible for at least five years to enter preregistration training programs required for entering the general medical workforce.
- * The most stringent suggestion was that all positions occupied by overseas trained doctors should be on a contract basis only for a strictly defined period, after which they should be compelled to return overseas.
- * Other submissions took the middle ground. For example, the NSW Department of Health perceived immigration by overseas trained doctors without automatically registrable qualifications as a potential source of interns, resident medical officers and doctors in under-serviced areas of health care.

Organisations representing overseas trained doctors in Australia, such as the Overseas Trained Doctors' Association and the Overseas Medical Graduates Association, did not take strong positions one way or the other on the level of migration of overseas trained doctors to Australia. The main concern they expressed was for those overseas trained doctors in Australia who are trying to qualify for practice by passing the AMC exam. This is discussed below.

Some submissions argued that the various ethnic minorities were well enough represented among doctors and medical students already in Australia to make it unnecessary or undesirable to import doctors to service our multicultural society.

Conversely, other organisations, such as State and Federal Ethnic Communities' Councils, and State Ethnic Affairs Commissions, advocated that migration of overseas trained doctors was desirable. The reason argued was that such doctors, in addition to providing diversity and enrichment to the Australian medical profession, had greater cultural awareness and language proficiency for their own communities in Australia. They argued that there was a demonstrable need for doctors from those countries whose communities resident in Australia lacked such doctors, on the grounds that these doctors provided better overall care. In consultations, the Federation of Ethnic Communities' Councils of Australia argued that it was not enough to say that there were too many overseas trained doctors coming into Australia; some ethnic groups might have inadequate services whereas other ethnic groups might be generously provided with doctors from their own communities.

Medicare statistics provided by the Department of Community Services and Health indicated that migration of overseas trained doctors in the past had not been matched with general migration from their countries. For example, the number of active fee-for-service general practitioners in Australia whose basic medical qualifications were

obtained in Italy, Greece or Yugoslavia totalled 57 in 1986. This was despite the fact that in the post-war years a large part of Australia's migration was from those countries. The Committee notes that at least some of the needs of migrant communities are now being met more fully by children of these migrants, graduating from Australian medical schools.

Conversely, the number of active fee-for-service general practitioners whose basic medical qualifications were obtained, for example, in India and Sri Lanka numbered 805 in 1986, yet overall migration from these countries had been relatively small.

Statistics provided by the AMC indicated that the number of Egyptian doctors migrating to Australia, particularly under the Family Reunion Program, was disproportionately large compared to the Egyptian (and other Arabic speaking) population resident in Australia.

Some submissions argued the particular need to bring in doctors in the very early years of a migration program from the countries in question (e.g., to care for refugees from areas such as Indo-China, the Middle East and South America). The South Australian Health Commission, for example, indicated in its submission that:

Whilst it is possible to train local graduates in particular languages and cultures in order to develop an affinity with those cultures, the necessarily long lead time to adequately train doctors in this manner suggests that this is not a viable option. Further, there is a view that it is impossible for non-ethnic doctors to help people within refugee communities and the only way to do this is to provide appropriate ethnic health care workers.

Similarly the Queen Elizabeth Hospital in Adelaide in its submission called for special training programs for Vietnamese and Cambodian doctors in order to increase the number registered.

Several submissions also argued that there were several areas of medical practice in which it was particularly important to have practitioners attuned to the cultural and language needs of non-English speaking people. Psychiatry, geriatrics (for an ageing migrant population), paediatrics and obstetrics and gynaecology were specialties commonly listed.

It should not be assumed that all overseas trained doctors would automatically provide care for people largely drawn from their own particular ethnic group. While it was accepted that many would, it was also put to the Inquiry that a number did not. The South Australian Health Commission quoted its own experience with Australian

graduates from non-English speaking backgrounds: "...it is not necessarily the case that graduates from particular ethnic communities will choose to practise in their communities."

Some submissions argued that a distinction could be made between overseas trained doctors who were refugees and those who entered Australia under other migration programs. Special consideration for refugees, namely the unrestricted right to practise in Australia subject to demonstrating satisfactory standards, was advocated on the grounds that refugees had been forced to leave their country for various political and other reasons. Denial of the right to such practice was seen by some as unfair.

It is assumed that doctors from the United Kingdom and Ireland enter mainly under the Employer Nomination Scheme and the Family Reunion Program. The Royal Flying Doctor Service in its submission and in consultations noted, for example, that it had to recruit the majority of its doctors from overseas (primarily the United Kingdom and New Zealand).

It was further argued that some doctors who entered under the Employer Nomination Scheme to fill positions after unsuccessful attempts to recruit Australian-trained doctors, remained in those positions for a relatively short time. They then took up positions in the medical workforce for which suitable Australian-trained doctors were available.

A crucial issue was perceived to lie in the standards of medical practice of overseas trained doctors. The submission by the Committee of Heads of Australian Medical Schools expressed concern shared by a number of respondents about the standards of practice of many overseas trained doctors:

Our concern relates to the registration of graduates from medical schools about which there is little or no information, and whose hospitals and internship programmes have not for the most part been evaluated or accredited by an appropriate authority...Most importantly, the training of these graduates has often been grossly deficient in clinical aspects and bears little relation to Australian conditions, diseases, or health care systems and standards...We view the future of Australia's medical and health care as lying much more soundly in the hands of local graduates...

A large number of submissions, particularly by overseas trained doctors and organisations representing ethnic community interests, argued the importance of access to "bridging" courses, i.e., retraining and re-orientation

Options (f) and (g) are attractive in that they combine the control of numbers with evaluation of standards. The AMC has considered similar approaches, but a requirement for training, either before or after the AMC examination, would require large numbers of training places and would have cost implications.

Options (e) to (g) would allow priority for a quota place to be given to specialists in undersupplied specialties, to refugees or to doctors whose ethnic communities in Australia need more doctors from their country. Doctors from New Zealand could, if need be, also be made part of the quota, but be given priority for places. The quota would desirably be set as a percentage (say ten per cent) of the output of Australia's medical schools. It would also be desirable to ensure that the level of medical competence of those taking up quota places was such that they had a reasonable chance of success in the AMC examinations. This could be achieved by application of the quota to those doctors who had successfully completed the AMC Multiple Choice Question examination, but before the clinical examination was attempted.

A number of submissions, from both foreign and Australian trained doctors, recommended a period of supervised practice in hospitals or other settings after passing the AMC examination but before undertaking unsupervised practice. Under present arrangements such practice would seem a further safeguard to assure maintenance of medical standards and to give the overseas trained doctor the necessary self-confidence in his or her level of clinical skills in the Australian context.

Conclusions and recommendations

The Committee endorses the following propositions concerning the place of overseas trained doctors in the Australian medical workforce.

- . Australia's medical needs to a very large extent can be met best by locally trained graduates. These graduates should, and do, include students from non-English speaking backgrounds and other cultures (Chapter 12);
- . in areas where medical needs currently cannot be met by local graduates, efforts should be made in the long term to develop the necessary skills and expertise locally. In the short term all other means to meet those needs locally should be explored;
- . overseas trained doctors may have characteristics which make them suitable to provide culturally and linguistically appropriate care for certain segments of the population;
- . practice standards of overseas trained doctors should be equal to those of doctors trained in Australia, and overseas trained doctors should be expected to attain the necessary standards for registration in Australia;

* overseas trained doctors have a place in the short term in providing skills that currently may be lacking in the Australian medical community, for example, in particular specialties, geographic or other service areas, or in academic and research positions. Access to these positions as a means of entry to the general medical workforce should be prevented;

. the number of newly arrived overseas trained doctors eligible to seek to practise in the general medical workforce in the future should be a defined proportion of Australian graduate output.

The Committee proposes that the admission of overseas trained doctors to unrestricted registration be controlled and follow a process which will be responsive to workforce considerations, resources available for examination, the authority of State registration boards and the interests of overseas trained doctors themselves. The major components of this process would be:

- . a quota imposed before admission to the AMC clinical examination;
- . availability of pre-examination bridging courses and, where necessary, post-examination clinical experience to all accepted into the quota;
- . discretion to State registration authorities to admit outside the quota, with registration usually restricted to a particular post, place and period.

The Committee recommends that:

11(xii) Australian immigration policies for overseas trained doctors be revised to provide:

- *comprehensive information to intending migrants about opportunities in medical practice in Australia;*
- *advice about the examinations which must be passed before registration can be obtained;*
- *advice about the cost of sitting the examinations and their frequency and the venues at which examinations are conducted;*
- *advice about any financial assistance likely to be available to intending applicants;*
- *advice about bridging and other courses available to intending applicants for the Australian Medical Council examinations, and about any necessary*