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House of Representatives
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Submission No. 34
(Overseas Trained Doctors)
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Submission to the Inquiry into Registration Processes and Support for Overseas Trained Doctors

30th January, 2011

Dear Mr. Ali and Committee members,

Thank you for considering my submission. I hope that I might have the chance to augment it, by making myself available to the hearing to verbally present the case and answer questions.

Much of my submission is concerned with some basic injustices facing overseas-born doctors. However, at the outset I would wish to emphasise the essential democracy in the process being undertaken here and offer my praise and gratitude for it.

INTRODUCTION

I anticipate that many submissions to this enquiry will centre around personal accounts of overseas-born doctors' (and their families') experiences in Australia and of the injustices of the system. I, too, will add my voice to this during my submission.

It might be possible for the committee to disregard *all* of these submissions, should a strict, unwavering and narrow view of the 'terms of reference' for the hearing be adopted. I would urge that this not be the case.

Whilst not clearly falling neatly into any of the terms of reference, the stories should be clearly noted and included - as they indict the system *as a whole*. The likely contents of these submissions need very careful consideration if one wishes to view Australia as an egalitarian, 21st century entity - in line with its first-world counterparts.

It may also be of note that many doctors who *should* come forward with submissions will not, due to fear for their professional position and, thus, visa eligibility and ability to remain in Australia. This, itself, is a

worrisome insight into the system as it stands.

The current situation regarding Pre-Employment Structured Clinical Interviews (PESCIs) - that has led to this hearing - has only been made possible by the background legislation surrounding overseas-born doctors. That legislation is, by its very nature, discriminatory and has provided fertile ground for all the discriminatory practices that have followed. The particular issue of the PESCIs may be regarded as fruit of this poisonous tree which, if only plucked and the tree not comprehensively dealt with at its very roots, will simply bud once more with other, sanctioned, discriminatory practices.

I will separate my submission into three sections and endeavour to keep each part as concise as possible.

a) A precis of the legislative and other arguments surrounding overseas-born doctors, using my situation as an example.
b) Address the first term of reference
c) Address the third term of reference, with some extrapolation to include a potential solution to workforce issues.

I have chosen to make this a personal account, with legal references and wider concepts revolving around the situation in which I find myself. The rationale for choosing this style rather than a more academic, purely factual, 'third person' approach (probably more in keeping with most submissions to governmental hearings) is because the issue *is* intensely personal and has had significant ramifications for my family.

My Situation and The Legislative Background to Current Events

I am a doctor, having been born, raised and completed undergraduate medical training in the UK in 2001[1].

My wife, child and I gained temporary residence status in Australia in 2004, entered the country in January, 2005, gained permanent residence in May, 2007 and became citizens on Australia Day, 2011. We have had two further children in Australia - our home.

I completed my Australian Medical Council (AMC) exams in 2006[1] - thus proving my skills and knowledge equivalent to Australian-trained graduates. Of note is the fact that this examination process was dropped for UK graduates by the AMC shortly thereafter, in acknowledgement of the equivalent level of a UK medical undergraduate degree (the AMC 'Competent Authority' pathway).

I have Fellowship of the Australian Royal College of General Practitioners, am currently working towards a second fellowship and have practised medicine in Australia for significantly longer than in the UK. During my entire time in Australia, I have taken part in training numerous Australian undergraduates and qualified doctors.

Despite all of the above, I am subject to the workforce restrictions imposed by s19AB of the Health Insurance Act, 1973 - whereby I am only allowed to work in areas deemed Districts of Workforce Shortage (DWS) for a period of ten years (less reduction for remote work) after arrival in Australia [2].

I find it impossible to comprehend why I do not have *exactly* equal access to workplace opportunities as my Australian-born colleagues. Quite clearly, I am identical in *every* respect, other than place of birth.

So, how is this policy, underpinned by s19AB, defended by governmental bodies? Usually with three

counterarguments to my stance that I should be treated equally to my fellow citizens, rather than suffering discrimination based on place of birth:

i) It is argued by the Department of Health and Ageing (DoHA) that it is not where I was *born*, but where I *trained* to which s19AB pertains."

In reality, this is not so.

1) Foreign-born medical students *in Australian universities* are subject to the very same ten year moratorium restrictions upon qualifying. They *trained* here – the same as all their peers. But they were not *born* here. This rather gives the lie to the premise that it is the place of training rather than place of birth that counts.

2) The fact that I attained my medical qualification in London was obviously a direct consequence of having been born and raised in London. It would be quite unreasonable to have expected me to undertake my undergraduate studies in Australia. I believe that it is similarly unreasonable to restrict my practise now for not having done so.

Possibly the most nonsensical part of it all is that I qualified from a university that ranks 7 th best in the world – with the closest Australian university ranking 20 th [3]. One would have thought that Australia would actively embrace such highly trained (and at somebody else's expense) graduates.

ii) A second defence put forward is that s19AB legislation does not stop me *practising*, merely restricts my patients from claiming Medicare rebates for my service.

This is accurate. But the appropriate rebuttal stems from s10 of the Racial Discrimination Act, 1975 [4]. It is the '*effect*' of the law – not its specific wording – that is of importance. This has been repeatedly demonstrated in *Bropho vs. Western Australia, Gerhardy v Brown, Mabo v Queensland [no 1] & Purvis v New South Wales [Department of Education & Training].*

The *effect*, as all general medical practitioners know, is that if a patient is unable to access Medicare rebates for ones service, there will be a very severe restriction on ones ability to practise – to the extent where it may be impossible to generate an income at all.

iii) The third common objection to my stance that I am the subject of discrimination is that I "knew what I was getting into" before I came to work in Australia. This choice was 'informed consent' to be bound by the laws surrounding work restrictions here.

True again.....in my case. But, it would seem from online chat in the various medical fora (and others) as well as personal correspondence to which I have been privy, *not* in the case of other doctors. It is not a great mental leap to imagine that the complex medical practice laws – involving federal and state legislation, AMC, medical board and colleges' criteria – may be exceedingly difficult to interpret from a foreign country when one's first language is not English.

In direct support of this is the Long Report of 2006[5] - recently released to me via the Freedom of Information Act (FOI), having been deliberately and consistently suppressed by DoHA since 2007. In fact, DoHA went to great lengths not to release this embarrassing report; only the threat of publicising its non-disclosure to this hearing forced their hand.

In 2006, Eleanor Long wrote a highly critical report of the workforce processes surrounding overseas-

born doctors - specifically regarding the arbitrariness and opaqueness of the system. The conclusions were almost totally ignored and the system is no more fair or clear than in 2006.

I have been informed (in one of the letters rejecting release of the report) that the 'DoctorConnect' [6] website has met the needs laid out in the Long Report, but that is manifestly untrue. In fact, at one point in 2010, I had to actually inform DoHA of a significant error pertaining to a critical and central piece of information on the website that calculated the length of the moratorium facing doctors! The rest of the website does nothing to make the system itself more accessible, comprehendible or streamlined.

To return to the argument of my acceptance of the system into which I was entering; Since when did foreknowledge of any discriminatory law make it suddenly non-discriminatory? s19AB is, at its core, still wrong.

The foreword to s10 of the Racial Discrimination Act is illuminating as it underpins the entire thrust of anti-discriminatory legislation:
If, by reason of, or of a provision of, a law of the Commonwealth or of a State or Territory, persons of a particular race, colour or national or ethnic origin do not enjoy a right that is enjoyed by persons of another race, colour or national or ethnic origin, or enjoy a right to a more limited extent than persons of another race, colour or national or ethnic origin, then, notwithstanding anything in that law, persons of the first mentioned race, colour or national or ethnic origin shall, by force of this section, enjoy that right to the same extent as persons of that other race, colour or national or ethnic origin.

Quite simply, my national origin has restricted my right to the freedom to choose where I work.

It is highly notable that New Zealand – which has a similar medical system to Australia - recognised the obvious discrimination in this policy by overturning their equivalent of s19AB in 1998. *(Northern Regional Health Authority v Human Rights Commission[1998] 2 NZLR 218)* . Why is Australia lagging behind its neighbour by thirteen years?

In fact, Australia is the only Western country – to my knowledge – that bases its medical workforce policy on the country-of-origin of its practitioners.

Quite apart from the legal argument above is the pragmatic argument that the policy surrounding regional workforce - as it has stood for fourteen years - has not worked. Rural healthcare is in a far worse state now than in the 1990s[7]. The system needs to *fundamentally* change.

And a social offshoot is the xenophobia/racism that discriminatory legislation makes more possible. It has been illustrated how both patients and employers make ethnicity-related choices, rather than professionalism-related choices, when choosing a doctor [8]. Arbitrary division between groups within a population, such as s19AB creates, give the opportunity for such demeaning practices.

Incidents such as the Cronulla riots and the Victorian Indian student assaults have done damage to Australia's international reputation – necessitating state and federal intervention abroad to help limit the impact of the latter. What can the world think when it looks at legislation that effectively subdivides the medical workforce so clearly along national/ethnic grounds?

How can our government reassure the world that the Australian populace is not racist or discriminatory when the Commonwealth itself ignores its *own* anti-discrimination legislation? Pots and kettles come clanging to mind. On issues such as this, one has to lead from the front. It is the role of good governance to minimise and extinguish such unwanted legislative effects, not create and endorse them.

Term of Reference 1

"Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions."

I do not intend to dwell on this term of reference other than firstly to expand on the Long Report [5] I mentioned earlier and secondly focus on the aspect of 'community acceptance'.

This is the first time that the Long report has been allowed into the public domain - with the first attempt made to access it (by The Australian newspaper) in 2007 [9]. I have kept the documented reasons given to me by the DoHA FOI section for their repeated refusal and they bear little scrutiny (I am happy to share copies of these upon request). It is *eminently* clear how the public may have been served by disclosure of the report and the pressure for action that would have resulted. Taking such action might have impacted upon the workforce in such a manner as to reduce the additional 4,600 rural deaths *yearly*, estimated by the Rural Doctors Association of Australia to have resulted from health and access inequalities between rural and metropolitan locales [10].

Eleanor Long set out clear ways to elucidate the workings of s19AB, and the exemptions to it, in her report. She laid out a streamlined process of application for overseas-born doctors – even going so far as to write the potential wording for relevant application webpages and subsequent correspondence from DoHA.

Whilst I fundamentally disagree with the *actual premise* of such a system to subdivide doctors based purely on place-of-birth even existing, her suggestions may well have *entirely obviated* the need for these terms of reference as part of this hearing. Had they been acted upon.

Indeed, to even be asking such questions regarding policy understandability by the integral stakeholders after almost a decade-and-a-half of having such a policy, must surely indicate that something is deeply wrong and needs correction.

As a more philosophical point; intrinsically fair and just legislation needs little explanation – it is, to a great extent, obvious in its intent. Unjust legislation requires voluminous explanation, in order to try and 'square the circle'. The opaqueness surrounding s19AB is simply what happens when attempts are made to defend the indefensible.

In terms of colleges' assessment processes, I believe that there should <u>not</u> be the current situation of differing outcomes depending on doctors' birthplaces. s19AA of the Health Insurance Act [11] is laudable in its *intent* – to better the (entire) medical workforce through fellowship. But the *result* is that a disproportionate number of those caught out by it are overseas-born doctors. In many cases (as other submissions will probably show) the sheer number of hurdles – professional, geographical and social – make fellowship exceedingly hard to attain.

So again, in its *effect,* s19AA falls foul of s10 of the Racial Discrimination Act and should be carefully examined accordingly.

The AMC examination process and any test of English should be fair but exacting. This should be the bar at which the entry standard is set - just as a standard is set for undergraduates in Australia before they may work as qualified doctors.

Once the AMC process is completed by a candidate, one may be sure that they are of a standard one would expect from any Australian trained doctor.

As an important aside, it should be clearly noted here that the AMC exam is set at a level *above* Australian university medical finals – the bar for entry of overseas-born doctors is *actually higher* than local graduates. When that fact is combined with the myriad experience many overseas-born doctors bring with them, the overall result is a highly qualified individual doctor in comparison to his/her Australian-trained peers at intern level.

We are told that this is, in fact, how things stand currently; AMC doctors = intern-level Australian-trained doctor. Despite the disparity between such practitioners in 'real life', at least this process makes some kind of sense; a certification of parity.

So, if that *is* the case, what is the basis for subsequent discrimination between groups of doctors? How can the *place* of undergraduate training matter if we are now all of an equivalent standard to our locally-trained colleagues?

And if it is *not* the case that the AMC exam produces 'equivalence' - perhaps somebody should tell those communities served by the below-standard doctors?

It cannot be both ways.....yet it is.

Overseas-born doctors are apparently professionally equivalent but are treated in such a legislative manner that - in the actual fact of day-to-day life - we are not equal to our colleagues.

This results in exactly the situation in which I now find myself - a citizen, having attained AMC equivalence (ironically, now not even required when trained in the UK), having attained my post-graduate fellowship here, taught in the training programs of local under- and post-graduates and worked here for the majority of my career.....but excluded from parity with my peers, despite anti-discrimination legislation in place to ensure such equality.

And the public has recognised this artificial two-tier system, hence the part of the second term of reference that asks how "*.... the community [can] better understand and accept registration decisions....*".

In answer; the community cannot, as long as federal legislation implies that foreign doctors are not equivalent (despite full registration) to Australian-born doctors.

And this extends to overseas-born doctors who fully trained and actually graduated in Australia; they are subject to the very same discrimination.

How can a populace be expected to accept medical registration decisions when its federal policy-makers so patently do not – and openly display that fact by enforcing a tiered system via Medicare rebates, the actual point-of-contact with the Medicare system for all patients? It is the most public form possible of pointing out the different classes of doctor.

Term of Reference 3

"Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies."

In some ways, the answer to this is quite straightforward. Have an entry system that is comprehensive, efficient, expeditious, rigorous and finite.

Currently, the AMC is actually an *impediment*, in many cases, to this aim.

The intention should be that any overseas doctor from any part of the world knows that a certain standard of English and knowledge of medicine (with all its composite parts) will need to be met in order to practise here. There will be sections of this that will have been satisfied already, during the candidates' undergraduate degree. These could fall into the category of 'recognition of prior learning', in much the same way that many degree courses and fellowships do presently.

In some cases, the AMC entry process would involve comprehensive assessment of all areas of language and medical knowledge. In others the assessment process may be reduced to a careful examination of the composite parts of the candidates' undergraduate degree course and English language skills – essentially what the 'Competent Authority' pathway is currently supposed to achieve.

It is worth noting that the only 'Competent Authorities' are those within English-speaking countries. Has the AMC *really* ruled out a prima facie assumption of competency in doctors from 75% of the world? This truly smacks of xenophobia.

Despite my misgivings above, once the process is completed the AMC-certified doctor should be regarded as *fully* equal to Australian graduates at (at least) the intern stage of their career, and be able to access the same working rights and 'real world' access to college fellowship. This is not currently the case.

My experience of the AMC assessment process was relatively benign, yet still involved a prolonged wait to complete its various parts (including six weeks simply for a signature on the certificate, once I had passed – a factor that delayed getting general registration with the medical board). The written examination was of very poor quality, containing historic medicine, significant and numerous 'typos' and double/triple negatives within the questions. As a native English speaker, I found it challenging – for all the wrong reasons. The clinical exam was little better – with only one actual patient amongst the cases and the rest of the 'patients' comprised of poorly prepared students with limited role-playing skills. In both sections, I dread to think how my non-native English-speaking colleagues fared – and not for their lack of medical knowledge.

The AMC has, historically, had long waiting times for its various components of assessment. Doctors can wait for years for initial testing, the clinical examination or re-takes. Communicating with the AMC has often been challenging – with severely restricted hours of access and consummate bureaucrats answering queries. It always felt to me like an insurmountable fortress – a real 'us versus them' mentality within the Council staff.

I cannot vouch for others' experiences with the AMC process, but if mine was in any way representative, the "*...necessary standards...by...regulatory bodies*" needs serious re-examination by this committee.

Two likely unintended consequences of both the AMC process and the ten year moratorium are these:

1) Medical graduates from first world/developed countries avoid coming to Australia for anything but a transient period. Presumably the very doctors most desired as permanent contributors to the medical workforce are the most put-off by the system as it currently stands. Additionally, viewing Australia through the prism of the AMC process, s19AB legislation and ten year moratorium described above, leave an impression of this country as (variously described to me by UK colleagues) "redneck", "hicksville" and "anachronistic". As a proud citizen, I am saddened by these views.....but even more so that I am unable to adequately refute them.

2) There is a disproportionately large pool of doctors from second and third world/developing countries who emigrate to Australia, for reasons ranging from financial difficulties to personal safety and family security. Given that Australia is potentially very well able to meet its own medical workforce demands, the World Health Organisation considers the current cure to the regional Australian healthcare situation to be a form of unethical poaching. It formed a policy to this effect in 2010[12] (having already passed a resolution on this issue in 2004 [13]). As a developed, Western country we have a duty to consider what impact we have in drawing from the meagre resources available to people in the developing nations and to shape legislation (and its implementation) appropriately.

Of course, the irony of this is that the current system of international medical recruitment/poaching acts as a 'venus flytrap' – highly appealing from the outside, but treacherous within.

If the objective is to *"...remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas..."*, the committee may perhaps look at:

- the concept of recognition of prior learning for graduates of equivalent medical training systems to Australia's
- outlining the group of AMC candidates who need the most assessment
- streamlining and drastically speeding up the process for those doctors who need more comprehensive assessment
- ensuring that the AMC process is clearly explained
- ensuring that the AMC is easily accessible and approachable
- incorporating practice-based and mobile computer-based examination of candidates, thus allowing assessment in regional locations to be made possible
- prioritising those AMC candidates who have positions rurally – to better streamline the process for augmenting the regional workforce

At this point, I would like to slightly step outside the strict remit of this hearing, extrapolate upon this term of reference and address the larger problem – of which the issue of overseas-born doctors is only a part.

Essentially, to put the issue in a single phrase, there is – and has been for some time - a serious deficit in the rural/remote medical workforce. The use of overseas-born doctors to plug this gap has not worked adequately – and has led to specific problems, hence this hearing.

The legislation – as I hope I have shown earlier – contorts itself to try to legally force overseas-born doctors to do the jobs that Australian-born doctors refuse to do (in numbers sufficient to come anywhere close to the need). The end result of this 'band-aid' approach to rural workforce legislation is, as highlighted earlier, actual needless death [10].

As a mental experiment, perhaps we could consider how things might have looked now in rural/remote healthcare had Australian graduates worked in these areas of greatest need over the past fourteen years.

A Proposed Solution to the Current Regional Workforce Deficiencies

I believe that the solution lies in the current crop of medical students. There is a significant bulge coming through the system and they will be ready for practise in the next few years. It is *vital* that they are directed towards regional work.

Mechanisms for achieving this lie perhaps through regulation of the location of training positions (ie. ratio of metropolitan:rural) or perhaps through creation of a mandatory rural part of the process of acquiring fellowship.

It cannot be doubted that those students studying in medical school are aware (perhaps more so than overseas-born doctors studying Australian geography from abroad) that Australia is a vast continent with a disparately placed population, some of which is quite deprived.

This population is entitled to healthcare provision by those entering our vocation. (And it is just that – a vocation. Not merely a nine-to-five job.) There is a moral obligation incumbent on doctors born, raised and educated in Australia to understand this geographic healthcare dilemma.

When a career in medicine is first contemplated (with all its attendant rewards over the long-term), this consideration and societal imperative should be part of the equation. This duty cannot and should not merely be devolved upon the overseas-born doctor group, as it has for so long.

But - and please note this - I am not suggesting that the term spent regionally should be charity work. Rural and remote work is tough and should be handsomely financially recompensed. Any doctor returning to metropolitan work after this period in their training should return enriched – in terms of knowledge, skills.....and financially.

A proportion of doctors will stay in the bush, thus providing long-term, ongoing medical care and training to the next generation. Anecdotally (and now with an emerging evidence base [14]) it seems that many long-term rural doctors just needed some early exposure to rural medicine - an initial 'push' to kick-start their careers outside of the metropolitan trajectory on which they had been.

Those who do return to the cities will be, perhaps, more highly skilled than any post-graduate training group to date. And this will surely benefit metropolitan areas. For example, A GP with the myriad practical skills attained during regional postgraduate training may well be content to undertake many of the more minor procedures currently often reserved for Emergency Departments. This would serve to provide some relief for our metropolitan hospitals.

Much as I profoundly disagree with the current s19AB legislation (and all that stems from it), the reality is that approximately 41% (52% in rural W.A.) of the rural/remote workforce is made up of overseas-born doctors and it is this reality upon which regional medical provision has become based. To suddenly rescind s19AB would be to pull the rug out from under rural and remote healthcare, as many of the affected doctors would immediately relocate to metropolitan areas. An untenable solution for workforce reasons both out bush and in town, and not one that I propose.

I suggest that the ten year moratorium (encompassed within subsections 1 and 2 of s19AB) be *gradually* phased out. This is accomplishable under the legislation – *as it currently stands*.

s19AB legislation also contains subsection 3. This allows for exemption from the ten year moratorium by dint of ministerial discretion. There is carte blanche within subsection 3 for the Minister for Health to exempt any practitioner for any reason.

This could be applied to successive groups of overseas-born doctors – perhaps related to time spent in Australia, practitioner's age, university of graduation or any other variable that would gradually diminish the size of the overall overseas-born doctor population affected by the current legislation.

The time-frame for progressive groups' exemptions would reflect the progress of the current glut of medical graduates through their postgraduate training, with its regional training component.

There would be no deficit in the medical provision to regional populations with such an advance-planned, steady 'workforce replacement' program. I am sure that numbers of doctors working regionally would actually be boosted in the short and medium terms and, with appropriate governmental supports, those workforce numbers sustained in the longer term.

CONCLUSION

Four days ago, on Australia Day, my family and I became citizens. We proudly recited the Pledge of Commitment and rejoiced in Australia's truly great recent history of inclusivity.

But I was also acutely aware that in this, the second decade of the twenty first century, current discriminatory legislation – anachronistic in comparison with other nations - continues to set me apart from my peers and adversely affects many, many others in its broad wake. The stark irony is that I made a conscious, informed decision to become Australian yet have diminished rights when compared with my fellow Australians, simply due to their fortuitous accident of birth.

The fertile ground prepared by s19AB has resulted in the direct reason for this hearing being convened. There will be tales of discrimination and misery that will be contained in the submissions it shall receive.....and, most tellingly, there will be many submissions never written, due to doctors' fears for their (and their family's) residency here. How could this ever have been allowed to become the situation and, further, allowed to continue until *2011*?

Australia – particularly rurally – has lost *so* much through a lack of far-sighted and fair medical workforce planning. This – my – country has been diminished by an attempt to misplace pragmatism above the imperative of justice to those who reside here. It is not a tenable long-term position and needs to be changed, to achieve the best for *all* parties.

Specifically:

- Swift resolution of the immediate injustices facing overseas-born doctors subject to the PESCIs
- Staged removal of the ten year moratorium
- Timely removal of s19AB from the statute book to comply with:
  - s10 of the Racial Discrimination Act, 1975
  - Part 1 of Article 23 of the Universal Declaration of Human Rights (United Nations General Assembly, of which Australia is a member)
  - United Nations World Health Assembly resolution WHA57.19
  - World Health Organisation Global Code of Practice on the International Recruitment of Medical Personnel
- Substantial changes to the organisation supply of doctors to the regional medical workforce
- Close examination of the current functioning and future role of the Australian Medical Council in processing overseas-born doctors

What is harder to codify or dissect is the essential inhumanity of the current system. The most vulnerable and dependant group of doctors have been subject to the vagaries and injustices of an inherently unfair system, with discrimination at its very heart. Families have suffered on this uphill journey – many of whom cannot access medical care (ironically, the very system being propped up by them), appropriate schooling for children or meaningful employment for spouses. Cut off from their cultures, language, friends and relatives, the situation is appalling for many. And they dare not complain, for fear of local xenophobia, institutional bullying and the threat of losing their job and, thus, visa to remain in Australia. And consider those who have been forced to leave – uprooting families after years of concerted effort to settle here. This is not becoming of a country such as ours.

And all that discrimination and misery for fourteen years has not even worked – just look at rural healthcare today.

We all - rural populations and overseas-born doctors - deserve better. We all deserve a 'fair go'.

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5 A Review of Section 19AB Guidelines and a Model for Revision, Dr. Eleanor Long, July 2006; File no. 2006/0422 212 (FOI Request No. 088-1011). *I am able to forward my copy of the document upon request.*

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