Dr Peter Arnold is a South African medical graduate, but he did his internship and post-graduate training in Australia. A suburban general practitioner for 25 years, he was a member of the New South Wales Medical Board from 1987, serving as Deputy President from 1993 to 2000. From 1991 to 1992 he was a member of Australian Health Ministers Advisory Council (AHMAC) Implementation Working Group on the Mutual Recognition of Medical Practitioners. He is a past president of AMA New South Wales and of the General Practitioners Society in Australia. He was Chairman of the Federal Council of the AMA from 1995 to 1999.

My paper gives some of the history and background on which each of the other speakers will elaborate. I must acknowledge the help I received from Andrew Dix, of the NSW Medical Board, and Ian Frank, of the Australian Medical Council, both of whom kindly checked the facts in this paper. Any opinions expressed are, of course, my own.

I must also pay tribute to the late Dr Bernie Amos, who, when President of the Board in 1987, furthered my interest in medical registration by appointing me Chairman of the Board's Registration Committee.

Some history

Probably few people know that New South Wales is the world's home of medical registration. It would probably come as a surprise to know that medical registration, when originally introduced, had nothing to do with standards of medical care. The world's first legislation establishing a Medical Board for the recognition of qualified practitioners was concerned with dead people—with the reliability of evidence given at inquests.

It was drafted here, in the colony of New South Wales, in 1837, shortly before Tasmania became a separate colony. Because the wheels of government moved slowly in NSW even then, the legislation came into effect in the daughter colony some months earlier than in NSW. It was followed in 1858 in the UK with the establishment of the General Medical Council, then in New Zealand in 1867 and reached the USA, first in Texas, in 1873.

No. XXII.

Medical Witnesses at Inquests.

An Act to define the qualifications of Medical Witnesses at Coroners' Inquests and Inquiries held before Justices of the Peace in the Colony of New South Wales. [12*th October*, 1838.]

Preamble. 1 Vic. No. 3.

WHEREAS an Act was passed in the present Session of the Legislative Council intituled "*An Act to provide for the "attendance of Medical Witnesses at Coroners' Inquests and "Inquiries held before Justices of the Peace*" wherein it was amongst other things enacted That whenever upon the summoning or holding of any Coroner's Inquest or the holding of any Inquiry before a Justice of the Peace it should appear to the Coroner that the deceased person was not at or immediately before his or her death attended by any legally qualified Medical Practitioner then it should be lawful for such Coroner or Justice or Justices as the case may be to issue a summons for the attendance as a witness at such Inquest of such legally qualified Medical Practitioner in actual practice as should reside nearest to the place where such Inquest was holden and whereas it has thereby become necessary to declare who shall for the purposes of that Act be deemed a "legally qualified Medical Practitioner" Be it therefore enacted by His Excellency the Governor of New South Wales with the advice of the Legislative Council thereof That no person from and after the first day of January next shall for the purposes of the said recited Act be deemed a legally qualified Medical Practitioner unless such person shall have proved to the satisfaction of the President and any other Member of a Medical Board to be hereafter appointed that he is a Doctor or Bachelor of Medicine of some University or a Physician or Surgeon licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland or a Member of the Company of Apothecaries of London or who is or has been a Medical Officer duly appointed and confirmed of Her Majesty's sea or land service.

Who shall be deemed a legally qualified Medical Practitioner.

Governor to appoint a Medical Board and remove any or all the Members thereof whenever he may think fit.

2. And be it further enacted That it shall and may be lawful for the Governor or Acting Governor for the time being to appoint a Committee consisting of not less than three Members being of the Medical Profession one of whom shall be nominated President together with a Secretary under the style and description of "The New South Wales Medical Board" and it shall be lawful for the said Governor or Acting Governor for the time being to remove the said Members or any of them and upon the removal death or resignation of the said Members or any of them to appoint such other person or persons as he shall think fit and any person desirous of being declared a legally qualified Medical Practitioner as aforesaid shall submit his degree diploma or other certificate or proof of his being so duly qualified for the examination and approval of the said Medical Board and shall obtain from the said Medical Board a certificate of his being so qualified.

Persons desirous of being declared legally qualified Medical Practitioners to submit their diplomas or other certificates for approval of the Board.

Recognition of degrees

NSW being a British colony, it was logical that the Act recognised British degrees. Not until the 1880s did graduates emerge from Australian universities. Progressive amendments to the legislation recognised their qualifications and those of some other colonies.

The *status quo* was first challenged by the arrival of European doctors after World War II, about whom more later. At first, they were required to complete the last few clinical years of medical studies. Later, they were given the opportunity to work in remote areas for some years before being allowed to practise in Sydney. With the demise of the 'White Australia' policy, and the commencement of migration from the Indian sub-continent and the Middle East, came a second challenge to the exclusive recognition of degrees from the 'white' Commonwealth.

Maintaining standards

Attempting to maintain medical standards, but facing the almost insuperable difficulties of assessing doctors trained at thousands of medical schools and colleges in hundreds of countries and in many languages, the NSW Board attempted to evolve policies which would protect the public from inadequately trained doctors. In 1978, the introduction of national examinations for overseas trained doctors set a national standard for the appraisal and registration of individual doctors. This was set up under the auspices of the Commonwealth's Committee on Overseas Professional Qualifications and administered through the Australian Medical Examining Council (AMEC). The Australian Medical Council took over the responsibilities of AMEC in 1986.

Continuing the colonial tradition, UK graduates were exempted from the AMC exam until 1987, when claims of 'discrimination' forced the NSW government to insist that they, too, pass that exam. Today, all graduates, other than those from New Zealand, because of all our conjoined colleges, has to do the AMC exam, unless they are specialists. Professor Davidson's paper elaborates on the way in which specialists are assessed.

The problems facing overseas-trained doctors

The major difficulty for immigrating overseas trained doctors (OTDs), called international medical graduates (IMGs) in the USA, lies in the decay of their clinical skills during the years in which they are migrating. Many come from lands where, as members of a religious or other minority, they have been persecuted or discriminated against. They might have spent years in displaced persons' camps or *in transit* in countries where they were not able to practise medicine.

To qualify for the AMC exams, they must first satisfy English language proficiency requirements (in the form of the Occupational English Test (OET) or the International English Language Testing System (IELTS), administered by the Commonwealth independently of the AMC. They must then enrol for the multiple choice question examination of the AMC. Although these are run five times a year, there is a long waiting list. Being an MCQ test, it requires an excellent comprehension of English, but not necessarily any great facility at communication. Once through that exam, they can enrol for the clinical examinations. Once again, because of the huge numbers, the wait might well be another year. It must be appreciated that these clinical examinations require the co-operation and time of hundreds of role-players, patients and specialists in our public hospitals, over and above the co-operation and time needed for the assessment of the students in our own medical schools. This has proven extremely onerous for role players, patients and examiners.

What to do while waiting

What can they do during these years of waiting? Board policy has changed over the decades, from the denial of any medical employment until the AMC exams were passed, through a phase where failure meant immediate loss of registration, to a situation now where migrant doctors waiting to sit the AMC exams can work in hospital and general practice positions ('Areas of Need') which are unable to be filled by local graduates. The hospitals or practices must convince the NSW Department of Health that they have advertised in Australia extensively and repeatedly, without success. They are then permitted to look for OTDs, both in Australia and overseas. The

Department publishes all vacant Area of Need positions on its website.

Will the doctor be safe?

In 1998, the Board set up two panels to determine whether or not each doctor is likely to be safe in the particular position at the particular hospital or general practice, and to advise the Board whether or not the doctor should be registered for that specific Area of Need position only. The hospital panel consists of three specialists, usually in Emergency Medicine, Psychiatry and either Surgery or Medicine (the first two being the most commonly sought-after areas of practice). The other panel comprises three general practitioners. The task of the hospital panel is considerably easier than that of the GP panel, as successful applicants will be working in more consistently supervised environments. This is reflected in the recommendations made by the panels to the Board. The rate of non-recommendation is higher for the GP applicants than for the hospital applicants. This relates to the relative lack of supervision of GPs in remote areas compared with hospital doctors. For instance, over the past twelve months, 107 doctors have been assessed. The GP panel has declined to recommend 30 out of 65 candidates (46%), while the hospital panel has declined to recommended five out of 42 (12%).

In the seven years of Area of Need assessments, 266 general practitioners and 222 hospital doctors have been registered. Fourteen of these 488 (2.9%) have subsequently been found, during probationary periods, not to be capable of working safely in the position specified and have had their registration revoked.

Validating documentation

The most recent safeguards by the Board have been the insistence on receiving certificates of good standing from the medical registration boards in whichever countries a doctor has been working for the five years prior to applying in NSW, and participation in the document verification service organised by the US Educational Council for Foreign Medical Graduates. Fraudulent certificates have not been unknown in the US ad elsewhere. Dr Patel managed to pull the wool over the eyes of the Queensland Medical Board.

The assessment of safety

A few words about our method of assessment of the doctor's safety in the particular position at the particular hospital.

The hospital supplies the Board with a detailed job description as well as a description of the 'environment' of the hospital:

- what facilities it provides (X-ray, pathology etc.);
- what kinds of specialists attend and what hours are they on duty or on call;
- what types of patients it will transfer to a larger hospital (usually one of the Sydney teaching hospitals), how they will be transported and how long it will take;
- the supervision under which the doctor will work;
- the names of the supervisors;
- whether or not the doctor will be working at nights and on weekends, etc.

The doctor's *cv* is lodged with the Board. Before a doctor is actually registered on our recommendation, they will be required to produce their Certificate(s) of Good Standing and their original degrees, passports, valid work visas and so on.

The Hospital panel has a bank of clinical scenarios, based on patients seen by members of the panel. The panel members have, for each scenario, an outline of the topics which the candidate should discuss during their response to the scenario. Our primary concern is whether or not the candidate will be working *safely* in that particular position. We do not attempt to grade the doctor.

The doctor's supervisors initially report monthly to the Board on the doctor's progress.

As you will hear from Professor Davidson, specialists are assessed by their relevant College, not

by the Medical Board's panels.

Two continuing dilemmas

This introduction would not be complete without mention of two serious social issues:

- the ethics of our recruitment of doctors from third world countries where medical skills are so badly needed; and
- the manner in which OTDs are received in Australia, professionally and socially.

Time does not allow more than a brief discussion.

The ethics of the recruitment of doctors from the Third World

With the world-wide shortage of doctors, is it fair that we allow (and depend on) the importation of doctors from the third world? Probably not fair to the people of their countries. Is it fair to the doctors themselves? All have been trained in western (mostly British) medicine and many are frustrated by the lack of facilities, equipment and opportunity to advance at home in their areas of special interest.

Very many come from minority groups in disfavour, and discriminated against, in their home countries: Coptic Christians from Muslim Egypt, Muslims in a minority in Christian or Hindu countries, Sunni in a Shia-dominated country and *vice versa*, Chinese in a minority in a country in the Indian sub-continent or South-East Asia, Hindus in a Muslim country, Zoroastrians in Iran and so on. Their situation brings to mind those European doctors (mostly Jewish) who fled Europe immediately before World War II, or who arrived after the war *via* the DP camps.

One of the most impressive doctors I have met in these interviews was a young Iranian. As a Zoroastrian, he was excluded from medical school in Iran. Speaking only Farsi, he went to Italy, learnt Italian, qualified at medical school and returned to Iran. He was unable, as a Zoroastrian, to obtain a job. Speaking only Farsi and Italian, he came to Australia, learnt English and passed the AMC exams at his first attempt.

A helping hand or a threat?

As for the social and professional treatment of these foreigners, they frequently encounter apprehension, suspicion, doubts about their professionalism (obviously) and, recently, if they are Muslims, frank resentment. Some people living in the Areas of Need welcome doctors, regardless of skin colour or religion. Some resent having to rely on 'second-class' doctors. I have already mentioned the OTDs' difficulties in trying to subsist while studying for and writing the AMC exams. What I have not mentioned is the additional burden of trying to study for the exams while working in an overworked and (by definition) under-doctored Area of Need. Those working with Area of Need registration encounter additional difficulties by virtue of their not being Australian residents: they must pay public school fees, are not eligible for Medicare, and cannot obtain credit cards.

The need for co-ordination and a welcoming attitude

There is a sore need for co-ordination between the recruiting agencies, the Department of Immigration, the federal and state health authorities, the AMC, the Medical Board, the employers and the local communities in which they work.

Now that the AMA has a British Hindu as its federal President, a Chinese Australian as its federal Vice-President, and Italian Australians as its federal Treasurer and as its NSW President, perhaps the time is opportune for the AMA to turn its gaze towards the OTDs and to find a way to welcome them into its ranks.