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**New assessment procedures for overseas trained medical practitioners in
Australia**

Robyn R. Iredale
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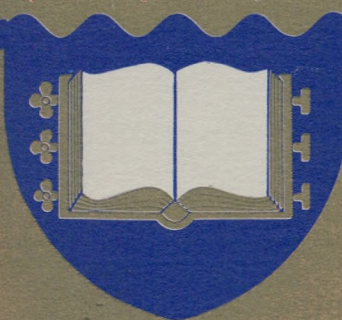
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New assessment procedures for overseas trained medical practitioners in Australia

Abstract

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The aim of this paper is to outline the major problems that have existed in the past decade with respect to the assessment and registration of overseas medical practitioners in Australia and to discuss the changes proposed by the AMC Working Party.



THE CENTRE FOR
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New Assessment Procedures
For Overseas Trained Medical
Practitioners in Australia

Robyn R. Iredale

Occasional Paper no. 24

NEW ASSESSMENT PROCEDURES
FOR OVERSEAS TRAINED
MEDICAL PRACTITIONERS IN AUSTRALIA

Robyn R. Iredale

Submission to the Australia Medical Council on the
Interim Report,
Working Party to Review the AMC Examination.

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ISBN 0 86418 133 7

Occasional Paper Series No. 24, October 1990

**NEW ASSESSMENT PROCEDURES FOR OVERSEAS TRAINED
MEDICAL PRACTITIONERS IN AUSTRALIA**

**Submission to the Australian Medical Council on the *Interim Report,
Working Party to Review the AMC Examination.***

**Robyn R. Iredale
Research Fellow,
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University of Wollongong**

ABSTRACT

In July 1990, the Australian Medical Council's Working Party to Review the AMC Examination released its Interim Report. The Report marks a significant step forward in the attitude and approach to overseas trained medical practitioners already in Australia. However, the implementation of the report will depend on a significant commitment of resources by both State and Commonwealth Governments together with a similar change in attitude among some of the medical boards and other assessing/accrediting authorities.

The aim of this paper is to outline the major problems that have existed in the past decade with respect to the assessment and registration of overseas medical practitioners in Australia and to discuss the changes proposed by the AMC Working Party.

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LIST OF RECOMMENDATIONS

Recommendation 1: The National Office on Overseas Skills Recognition should spell out clearly the need to separate assessment and human resource issues.

Recommendation 2: All agencies responsible for the assessment and accreditation of overseas trained medical practitioners should keep comprehensive records and be required to provide statistical data on applications, assessment procedures and outcomes, to the National Office on Overseas Skills Recognition.

Recommendation 3: The practice of automatically accepting some specialist qualifications and not even investigating others needs to be reviewed.

Recommendation 4: The exercise of discretionary power by boards should be public and publicised and reasons should be stated for each instance of its exercise.

Recommendation 5: Each Specialist College should develop a set of guidelines or criteria for entry to its specialty. These should be nationally based competency standards.

Recommendation 6: The NSQAC should be responsible for assessing all overseas trained specialists.

Recommendation 7: The Appeals Committee of NSQAC should operate independently and should provide for personal interview and the presentation of theatre log books, references of co-workers and other relevant information.

Recommendation 8: Specialist registers should be established in each state and territory and basic registration as a general practitioner should not be a requirement for specialists.

Recommendation 9: The Commonwealth, State and Territory Governments should co-operate to ensure the adequate provision of bridging courses.

BACKGROUND

It is claimed that Australia, on the whole, is well served in terms of medical practitioners. It has one of the highest ratios of medical practitioners to patients in the world: the ratio is currently around 1:513. Not only does it have one of the highest ratios but it is argued that the standard of medical practice is one of the best in the world.

Notwithstanding these two factors, there is still a general shortage of medical practitioners in many rural areas of Australia as well as in the outer parts of some of the major cities. Moreover, while cities and larger urban centres are reasonably well supplied with specialists, people in country areas have to travel long distances and often wait up to six months in order to get an appointment with a specialist.

On top of these general shortages, Aboriginal and non-English speaking background immigrant communities frequently lack medical practitioners who are sensitive to their cultural differences and who are able to communicate in their own language. The use of an interpreter in a medical situation is very often inappropriate and many non-English speaking immigrants fail to get the services that they require because of the lack of appropriate doctors.

For example, the female Arabic community in Sydney does not have access to an Arabic-speaking woman obstetrician/ gynaecologist. The outcome is that many women refuse to go for regular check-ups and pap smears. An apparently higher than average rate of cervical cancer amongst this group of women is currently being investigated.

Other groups lack psychiatrists and gerontologist, to name only two, who are able to communicate in their language. At present there are no Aboriginal doctors in Australia and the consequences of this for Aboriginal health are enormous.

The 1986 Census revealed that there were over 150 languages spoken in Australia: around two million people spoke a language other than English in their home. More than three quarters of these were born overseas and therefore had widely varying levels of English.

The shortage of appropriate medical practitioners to meet the needs of immigrant communities has been a constant problem since the start of Australia's massive post-war immigration program. But the situation has become more conspicuous with the rapid influx of people from many different countries in the 1970s and 1980s. The introduction of Australia's non-discriminatory immigration program has meant a widening in the range of source countries.

It appears that this influx of immigrants has not been matched by a corresponding increase in the number of overseas trained doctors entering the medical workforce in Australia. But figures on the number of overseas trained medical practitioners who have gained registration each year are unfortunately not available from the state medical boards and so this cannot be ascertained.

The number of medical practitioners entering Australia in the past four years has been significantly lower than the numbers that arrived in the late 1960s and throughout the 1970s. A peak of 813 was reached in 1977/78 but this translated into a net gain of only 523, as around 300 medical practitioners left Australia in that year.

The last four years has again seen a gradual increase in the number of immigrant doctors coming to Australia as permanent settlers: from 212 in 1985/86 to 352 in 1988/89 and 432 in 1989/90. Most of this increase has been as a result of increased employer nominations and of increased numbers qualifying in the Independent/Concessional Category under the 'points system'. Under this system, points are allocated for education, training, English language ability, age, etc and providing the applicant scores enough points, she/he is granted a visa to enter Australia.

The majority of medical practitioners currently entering Australia do not have their qualifications assessed before arrival. Some qualify for automatic registration with a state or territory medical board. Most of the remainder are required to sit an examination administered by the Australian Medical Council (AMC). This applies for both general practitioners and specialists, on the whole.

The AMC conservatively estimates that there are 800 to 1000 overseas trained medical practitioners in Australia who are seeking registration. This figure is derived from the number of people who have applied to sit their examination and who have not yet passed.

Overseas trained doctors, however, maintain that the overall number is much higher: they claim that many people have never approached the AMC with respect to sitting the examination for various reasons.

THE REQUIREMENT FOR REGISTRATION AND THE ROLE OF MEDICAL BOARDS

Medical practice in Australia carries the legal requirement of registration. Medical boards in each state and territory control entry to the medical profession. The structure of the boards and their mode of operation vary.

There is no uniformity in the medical qualifications that are automatically accepted and there is little reciprocity with respect to overseas trained medical practitioners between the states and territories. Most states and territories continue to offer automatic registration to medical practitioners who have completed their basic training in the UK, Ireland and New Zealand. The exceptions are NSW, which only accepts New Zealanders, and South Australia, which does not accept Republic of Ireland qualifications. Tasmania is the only state to continue to automatically accept Canadian and South African qualifications.

This picture represents a very different one from that which prevailed in the 1970s. Many primary medical qualifications from Commonwealth countries were automatically acceptable for registration. Overseas medical practitioners who did not possess such qualifications were provided with the opportunity for supervised hospital practice: satisfactory completion of this period led to registration.

Three major categories of medical registration exist throughout Australia: full registration for general practitioners and specialists; specialist registration in some states, and various forms of provisional, conditional, limited and temporary registration. In 1990, the available forms of registration in each state were:

NSW -	full, limited and conditional;
Queensland -	full, specialist, limited and provisional;
Victoria -	full, temporary, provisional and conditional;
South Australia -	full, specialist, limited and provisional;
Western Australia -	full and provisional;
Tasmania -	full and limited;

ACT - full;
 Northern Territory - full, provisional and conditional.

Full registration enables unlimited practice and is achieved by automatic recognition of the primary medical qualification, a pass at the AMC examination or is granted at the discretion of a Board.

A separate specialist register only exists in Queensland and South Australia: in the latter the practitioner must have an acceptable primary qualification but in Queensland this is not necessarily the case.

Various forms of restricted registration, provisional, conditional, limited or temporary, are available in all but the ACT. These forms of registration are used, at the discretion of the Boards, to enable overseas qualified medical practitioners with non-automatically acceptable medical training to fill positions in isolated locations or particular institutions or services, or to undertake teaching, research or postgraduate study.

Requirements for registration under the individual state and territory Medical Practitioner Acts vary. Attempts to achieve national registration of medical practitioners have been made at various times in the past but there has been no real movement in this direction, in spite of the advent of the AMC in 1986.

Registration in one particular state or territory, on the whole, does not enable entitlement to automatic registration in another, even though this provision is available for Australian trained medical practitioners. NSW has moved furthest in this direction by accepting overseas trained medical practitioners who have been registered and who have had five years' medical experience in another state or territory and whose primary medical qualification was registrable in NSW at the commencement of their practice in the other state or territory. The Northern Territory Medical Board also grants registration to overseas qualified medical practitioners who have been registered and practising without restriction elsewhere in Australia for a minimum of five years. The stipulation of a five year time limit seems to be rather unjustified but nevertheless NSW and the Northern Territory do permit some mobility.

ASSESSMENT PROCEDURES FOR THE RECOGNITION OF OVERSEAS TRAINED MEDICAL PRACTITIONERS

Up till 1978, the major mode of assessment of people with unrecognised medical training was by means of supervised practice for a period of two to three years in the main teaching hospitals. In 1978, the Committee on Overseas Professional Qualifications (COPQ) which was located in the Department of Immigration in Canberra introduced the first national medical assessment examination. The examination was adopted from the Victorian Foreign Practitioners Qualification Committee examination which had been in use.

The examination was compiled and administered by the Australian Medical Examining Council (AMEC), an independent Expert Panel associated with COPQ, consisting of Medical Board representatives from each state and territory. The examination consisted of two parts: a 150 Multiple Choice Question (MCQ) paper and an oral Clinical Examination covering medicine, surgery, obstetrics and gynaecology, paediatrics and psychiatry. An English test which was originally part of the AMEC examination later came to be administered by COPQ as a separate aspect.

In the first two sessions of the examination, October 1978 and March 1979, the pass rate was 18 per cent. Criticism, especially by the Federal Fry Committee (1982:200), resulted in some changes and in 1984 the overall pass rate reached 55 per cent. Much of this rise was due to the newly introduced provision that candidates could only attempt Part II (the Clinical Examination) if they had already passed Part I (the Multiple Choice Question paper). This also meant that a failure at Part II no longer required re-sitting Part I as well as Part II.

Pass rates varied substantially by English speaking versus non-English speaking background: the pass rate was 61 per cent for English speaking (country of qualification) candidates compared with 30 per cent for candidates with primary qualifications from non-English speaking countries.

The formation of the Australian Medical Council occurred on 1 January 1986. The AMC is an independent standards and examination body incorporated under the Associations Incorporation Ordinance of the Australian Capital Territory. It is a non-

statutory body which reports to the Commonwealth, State and Territory Ministers of Health and to each of the state and territory medical boards.

The AMC's two major functions are the accreditation of Australian medical schools and the assessment of overseas qualified medical practitioners. The accreditation of Australian medical schools was undertaken by the General Medical Council (GMC) of the UK till 1985. This link was finally severed in 1986 but some Australian medical schools still remain 'unaccredited' by the AMC. Medical faculties that had reduced the period of formal study from six to five years have been required by the AMC to return to a six year training program.

At the time of the AMC's formation, the assumption seemed to be that the latter function would consume the lesser of its resources. But over time the number of candidates applying to sit the AMC examination has meant an increase in the proportion of the AMC's resources devoted to this aspect of its work.

Since the AMC assumed responsibility for the medical examination to assess overseas medical practitioners there has been a significant increase in the number of candidates presenting for the examination. The number of new candidates presenting has risen from 163 in 1985 to 306 in 1989. The pressure on resources imposed by this dramatic increase, together with the persistent criticism of the AMC examination by candidates, their advocates and various government inquiries (Federal Fry Committee of Inquiry - 1982, Doherty Report on Medical Education and Medical Workforce - 1988, the Committee to Advise on Australia's Immigration Policy - 1988 and the NSW Fry Committee of Inquiry - 1989), led the Council to agree to the establishment of a Working Party to review the structure and content of the examination in June 1989.

Before considering the review of the examination, two other issues must be discussed. The first concerns the statistics and figures contained in Chapter IV of the AMC Working Party's Report. The second relates to the mixing of assessment and human resource or workforce issues.

COMMENTS ON THE AMC'S PROJECTIONS REGARDING THE NUMBER OF FUTURE EXAMINATION CANDIDATES

Chapter IV addresses the issue of the number of overseas trained doctors presenting for the AMC assessment process. The following table was used by the Working Party as a basis for projecting the number of overseas medical practitioners likely to present for the examination.

TABLE 1 : AMC EXAMINATIONS 1986 - 1990

RATE OF GROWTH					
DOCTORS SEEKING TO ENTER MEDICAL WORKFORCE			AMC WORKLOAD		
YEAR	NEW CANDIDATES [NUMBERS]	COMPLETED ALL PARTS [NUMBERS]	TOTAL MCQ [EPISODES]*	TOTAL CLINICAL [EPISODES]	TOTAL EXAMINED [EPISODES]
1986	189	80	340	207	547
1987	205	74	440	170	610
1988	239	76	466	153	619
1989	306	114	519	231	750
1990	[228]**		[378]**	-	-

NOTES : * EPISODES = CANDIDATES EXAMINED PER SESSION
- INCLUDES REPEATING CANDIDATES

** SERIES 1 1990 FIGURES

Source: Table 4, *Interim Report, Working Party to Review the AMC Examination*, AMC Inc., Canberra, May 1990, p. 18.

The above table shows that there were 189 new candidates for the MCQ in 1986, 205 in 1987, 239 in 1988, 306 in 1989 and 288 in the first half of 1990. This 1990 figure does not include the Series II figure for 1990 which were not available to the Working Party.

That is, there has been a steady increase in the number of new overseas trained medical practitioners seeking to attempt the AMC examination since 1986. In 1987 the increase was 8.5 per cent, in 1988 it was 16.5 per cent, in 1989 it was 15.4 per cent and in the first half of 1990 it was 44 per cent.

The first session of 1990 saw a disproportionate number of new candidates apply: the main reason given by the overseas medical practitioners was that they finally felt that the examination may be fair as there was a new examination committee. This increase was maintained in the second session in 1990 when 268 new candidates presented. The overall figure for new candidates in 1990 was 499.

Another problem with the table is that there is no distinction between candidates who sat the MCQ examination in Australia and those who sat overseas. Figures obtained from the AMC show that 131 (26%) of the 499 who sat for the first time in 1990 were overseas. This 131 may eventually migrate to Australia but until they are actual immigrants it is not reasonable to imply that they are part of the medical human resource stream.

The Working Party used the figures to 1989/90 to project the number of new candidates who would present for the AMC examination up till 1994/95. The result is a projected increase to almost 900 new candidates in 1994/95. This represents an increase of 200 per cent on the 1989 figure and 80 per cent on the 1990 figure.

On the other hand, the number of candidates passing has not increased commensurably: 80 completed all components of the AMC examination in 1986 compared with 114 in 1989. The ratio of candidates who completed all components to new candidates was 1:2.4 in 1986 and 1:2.7 in 1989 - that is, the ratio declined from 1986 to 1989.

This trend occurred in spite of the AMC's persistent claims that the examination is not used as a tool for limiting the number of overseas medical practitioners entering the workforce in Australia. The AMC Working Party's Report (1990:18) states that:

The most widely held misconception about the AMC appears to be that its examination is a device used by the “medical profession” for regulating the medical workforce and maintaining a “closed shop”. As the submissions indicate, this view is not limited to overseas trained doctors alone.

It appears that the rapid increase in 1990 has been taken as the trend in determining the future projections, instead of being analysed to see whether it represents the true situation. Those working in overseas qualifications units, immigration and migrant employment do not feel that this assumption is warranted and they feel that the large number who presented for the first time in 1990 is an aberration.

They maintain that many people have been waiting for years to attempt the examination. In the meantime they have been studying English, as well as medicine, and working in other jobs in order to support their families and to save up the money to attempt the examination. The perception that the examination was unfair and that there was little chance of passing it dissuaded many people from ever attempting it before. There was also a widespread feeling that it would be unwise to waste one of the limited number of possible attempts.

Added to these factors was the general lack of bridging courses: many people felt that their lack of familiarity with the Australian medical system would preclude the possibility of their passing the examination.

Further, many specialists felt that it was intrinsically unfair for them to have to sit the AMC examination, and they have resisted this step until they felt that there was a chance of passing the examination.

Moreover, in the last couple of years, the information provision and counselling aspects of the AMC's services have improved dramatically and this has also led more people to want to attempt the examination.

All of these factors need to be taken into account in using current figures to make projections. The use of raw statistics, without any analysis, can lead to unreasonable projections and inflammatory diagrams. The use of such figures by professional associations and the media may lead to a misunderstanding about the size and scope of medical migration.

It may also lead to calls for more restrictive entry procedures for doctors than for other occupational groupings. Attempts by the Australian Medical Association (AMA) to

secure agreement regarding the imposition of a quota on the number of overseas trained medical practitioners who may enter Australia each year are unacceptable for the reasons discussed in the next section.

HUMAN RESOURCES AND CONTROL OF THE SIZE OF THE MEDICAL LABOUR MARKET

The Australian Government, like the Canadian and other governments, must be concerned with the costs of health services: this cost has been linked to the size of the pool of medical practitioners. Control of the medical personnel pool is seen by some people - including some people in policy positions - as crucial to the control of health care costs.

Such people argue that a declining doctor:patient ratio will lead to overservicing by doctors. In other words, medical practitioners will provide more services per patient at increasing cost to the government, without a corresponding increase in actual health benefit to the patient.

The solution, it is proposed, is to control the number of medical practitioners. Since limiting the number of Australian medical students can only be done to a certain extent, it is argued by people who want to limit the pool that control of entry of overseas trained doctors is the most viable option.

As mentioned above, the question of a surplus is already debatable. Add to this the increasing health needs of an aging population and the shortage of practitioners in some specialties and the question of a surplus or future surplus remains even more unclear.

Whether there is a surplus or not, limiting the number of overseas trained medical practitioners must be questioned. Immigrants have already overcome significant hurdles in completing their training and migrating to Australia. They are legitimate members of Australian society and have an equal right to practice, provided they are of comparable competence, to those trained in Australia. The basis of Australia's immigration policy is permanent settlement and given this policy, it is important that all immigrants have access to fair and equitable assessment of their skills.

The need to keep workforce and assessment issues separate has been spelled out in a number of Australian documents as well as overseas. The Federal Fry Report (1982) felt that assessing bodies should be publicly accountable for their judgments and that they should also try to divorce their role in assessing qualifications from other functions which might influence such assessments, such as immigration and human resource issues.

More recently the Ontario Government's Report, *ACCESS !*, from the Task Force on Access to Professions and Trades (1989: xiii-xiv) states that:

Much appears to depend upon the personal information received by the assessors, upon the inclinations of the assessors, and upon the human resource needs of the occupation. These factors can, and do, change. The standard of competence required for entry, however, should not.

Recommendation 1: The National Office on Overseas Skills Recognition should spell out clearly the need to separate assessment and human resource issues.

As the assessment of medical qualifications is carried out by a range of bodies which have a relatively low level of public accountability it is essential that proper data be collected and be available for scrutiny. It is essential that all relevant organisations collect accurate statistics on clients, both applications and outcomes.

Recommendation 2: All agencies responsible for the assessment and accreditation of overseas trained medical practitioners should keep comprehensive records and be required to provide statistical data on applications, assessment procedures and outcomes, to the National Office on Overseas Skills Recognition.

REVIEW OF THE AMC EXAMINATION

The Council approved the following general terms of reference for the review:

- * To review and make recommendations on the structure, content and associated procedures of the AMC examination.

In particular:

- (a) to identify alternatives to the existing examination format

(b) for each alternative, to address:

- the academic/technical appropriateness of the format
- the organisations and administrative implications
- the resource and cost implications

(c) to rank each of the alternative assessment options in terms of their logistic viability and implementation.

- * In preparing its report the Working Party was asked to have regard to Recommendation ii(xxvii) of the Doherty Report, the concerns about the AMC examination documented by the Doherty Committee and the recommendations adopted by the Council from the report of the Working Party on Examination Standards.
- * The Working Party was to report to the Annual General Meeting of the Council in 1990.

The Working Party consulted widely, including with Overseas Trained Doctors (OTD's) and received a total of 34 written submissions. The Report became publicly available in July 1990 and has been widely circulated for discussion purposes.

The Report came up with a number of major findings:

1. There should be separate pathways to recognition and registration for general practitioners and specialists. The Report (1990:15) states that:

If a single pathway is used to assess the medical knowledge and clinical skills of all categories of OTD's many competent overseas trained specialists will continue to be at a disadvantage compared to their colleagues with general medical practice backgrounds.

2. The AMC examination should be modified in a number of ways. The Working Party (1990:17) found that:

The present AMC examination represents conventional 1950's and 1960's assessment methods.When this system was introduced in 1978 as a national examination for OTD's it had the advantages of being relatively simple to administer and could build on existing clinical infrastructures. Since that time

there have been considerable changes in the assessment of medical knowledge and clinical competence and in the provision of training for practitioners entering general medical practice. The AMC needs to take these developments into consideration in formulating an appropriate assessment procedure for OTD's.

The Report states that the MCQ paper is the most controversial part of the examination: it is seen to discriminate against OTD's from non-English speaking backgrounds and it has been criticised for failing to effectively test medical knowledge and skills.

The Working Party noted the 1989 Australian Council for Educational Research (ACER) Report finding on COPQ examinations: the ACER identified the need for a substantial injection of developmental funding for the professional examinations conducted under the auspices of COPQ. While COPQ had not conducted the AMC examination for five years, the basic format had remained the same and some of the people who had been on COPQ's Expert Panel had transferred to the AMC's Examination Committee.

The Working Party (1990:36) found the major technical criticism of the AMC examination to be that:

By focussing on the standard of Australian MBBS graduates, it tends to measure what is easy to measure rather than what needs to be measured to evaluate competence for clinical practice.

This was a recent change: from 1 January 1989, the examination tested at the MBBS graduate level, whereas previously it had been assessing at the level of graduates who had completed one year of internship. This change enabled those graduates from overseas who had not completed any hospital practice to sit the examination where formerly they had been barred.

3. The absence of adequate and appropriate bridging courses and of alternate remedial action either before or after sitting the AMC examination was highlighted. The report pointed out three major issues:

- (a) that the demand for places in bridging courses significantly outstrips the supply;
- (b) courses are regarded by some as a 'palliative' solution, to make up for the deficiencies of the AMC examination, rather than as a means of adapting to medical training and practise in Australia; the overall emphasis has been on

achieving the highest success rates at AMC examinations thereby affecting the selection criteria for bridging courses;

(c) much funding of bridging programs has been on a seeding or one - off basis.

While pointing out these problems, the Report (1990: 34) states that:

The AMC should continue to advocate the provision of bridging courses and should liaise with the course co-ordinators and provide such assistances as it is able.

EVALUATION OF MAJOR FINDINGS OF AMC WORKING PARTY'S RECOMMENDATIONS.

TWO SEPARATE ROUTES TO REGISTRATION

The recommendation regarding two pathways for the assessment of overseas trained medical practitioners whose basic qualifications are not automatically recognised for registration purposes in Australia is sound. The Report (1990:37) recommends:

- a) An assessment procedure administered by the Specialist Colleges for OTD's who:
 - *hold a postgraduate qualification
 - *have been registered and have practised as one overseas
 - *have indicated their intention to enter specialist medical practice in Australia.

- b) An assessment procedure administered by the AMC for OTD's who have elected to enter general practice in Australia and are seeking general registration.

Each of these pathways will be analysed in detail.

Specialists

A separate register for specialists exists only in Queensland and South Australia. While the situation in Queensland enables those without a recognised primary qualification but with a recognised specialist qualification to gain specialist registration, in South Australia specialist registration is only available to those with both a recognised primary and postgraduate qualification.

In the remaining states and territories, practice in a medical specialty requires basic registration as a medical practitioner. Medical specialists, therefore, are required to complete all the requirements for registration as a general medical practitioner. In NSW, Victoria, Western Australia, Tasmania, the Northern Territory and the ACT, a medical practitioner with an unregistrable primary qualification who has not passed the AMC examination would not be eligible to work either as a general practitioner or as a specialist, even if she/he held an acceptable specialist qualification.

The standard response by the NSW Medical Board to specialists who apply for registration is:

The Board relies on advice published by the National Specialist Qualification Advisory Committee of Australia (NSQAC). According to this advice your qualification obtained in (country specified) is not eligible for registration.

In 1970 when the Federal Government provided for the payment of medical benefits at higher rates for specialist medical services under the National Health Scheme and in the absence of comprehensive registration of specialists, provision was made in the National Health Act 1970 for the establishment of Specialists Recognition Committees in each state and territory. The function of the Committees was to determine whether individual medical practitioners should be granted recognition as specialists for the purpose of rebates. These provisions continued under the Health Insurance Act 1973.

To ensure national uniformity, the Presidents of the state/ territory medical boards and the Specialist Recognition Committees agreed to the establishment of the National Specialist Qualification Advisory Committee (NSQAC). A Specialist Recognition Appeal Committee was also established.

The role of NSQAC is to maintain a list of acceptable and recognisable qualifications for entry to a list of specialties decided by the Committee. While NSQAC was established

as an advisory committee, over time it has assumed a greater role and its advice tends to be taken as the 'last word' by medical boards. Most boards pass the responsibility for assessing overseas specialist qualifications on to NSQAC.

Overseas trained medical specialists with qualifications from some institutions, all in English speaking countries, are automatically recognised by NSQAC. This pattern has arisen on account of the trend in the past for Australian specialists to do their specialist training in the UK, Ireland, New Zealand and the USA. In these countries they could work and study in English.

NSQAC, to continue this pattern, recognised the specialist qualifications gained from universities and medical schools in these countries. At the same time it did not investigate the postgraduate qualifications of other countries, some of which have internationally acclaimed standards and traditions of medical science and education. If NSQAC does not have the qualification on its list of 'recognisable' qualifications, the applicant is informed, through the board, that the qualification cannot be assessed and therefore cannot be recognised.

A system where only a limited number of qualifications are matched against a list of 'recognisable' qualifications from a few countries is unsatisfactory. The NSW Fry Committee (1989:130-131) stated:

The Committee appreciates that a firm definition of who is entitled to be termed a specialist is necessary for the administration of the Health Insurance Act and entitlement to specialist consultant payments. However, it seems that a good many countries' specialist qualifications are simply not investigated and assessed by NSQAC.

As to the requirement that there be a firm offer of employment, it is difficult to see the direct relevance of this to the assessment of qualifications.

These current arrangements for the assessment of specialist qualifications gained overseas are inadequate. The manner and mode of assessment was handed over to NSQAC, and the Specialist Committees, by the Government. Clearly this produced an unsatisfactory result.

Recommendation 3: The practice of automatically accepting some specialist qualifications and not even investigating others needs to be reviewed.

The only exception to this would be if a medical board used its discretionary powers to grant some form of limited registration to enable practice confined to the particular specialty. There appears to be very limited use made of discretionary powers contained in Medical Acts to grant registration to specialists.

For example, the NSW Medical Board granted limited registration to two specialists in 1987 and to 12 in the twelve months prior to 31 March 1989. The NSW Board has the discretionary power to grant registration to a specialist. The requirements set down by the Board are: ten years' experience, a recognised postgraduate qualification and the offer of a suitable position in a hospital. Normally the recognition is done by another body, NSQAC or the specialist college, though in exceptional circumstances the Board may assess the postgraduate qualifications itself.

An ear, nose and throat specialist with 20 years' experience and who was formerly a Professor of Medicine in West Germany arrived in Australia in 1980. He applied to the NSW Medical Board for limited registration as a specialist, and after an 18 month assessment period he was informed in 1986 that his qualifications and experience would enable him to be registered provided he had a job offer. When he approached the Board regarding a position which had been offered to him at Murwillumbah Hospital, NSW, the Board decided that the position was unacceptable as 'adequate supervision' could not be provided. Consequently, he did not gain registration.

In this instance, the applicant maintains that he was not informed of the need for a 'satisfactory' offer of employment until he approached the NSW Medical Board about the Murwillumbah hospital job. The absence of adequate information and of clear guidelines on when discretion is used by boards poses a serious problem.

Recommendation 4: The exercise of discretionary power by boards should be public and publicised and reasons should be stated for each instance of its exercise.

While the AMC's recommendation regarding specialists is well founded it spells out that its successful implementation is dependent on the role of the Specialist Colleges. The Report says this role is crucial if there is to be a change in the assessment of overseas specialist qualifications.

The Working Party Report highlights some positive progress that has been made in this direction by the NSW Medical Board following a recommendation of the NSW Fry Report. It notes (1990:42) that:

The Royal Australian College of Physicians, which represents one of the largest disciplines, has responded positively and is considering an appropriate assessment procedure. The Royal Australian College of Obstetricians and Gynaecologists has also agreed to develop a procedure to assess overseas specialist qualifications.

These positive responses are welcome but there are 13 Specialist Colleges in Australia and some are more responsive than others. Some are organised on a national basis whereas others have state branches that operate fairly independently.

A better solution would be for each Specialist College to develop guidelines or a checklist of requirements and then for the NSQAC to conduct the assessment. A person's training and experience would be assessed against a list of criteria in order to gain recognition.

Recommendation 5: Each Specialist College should develop a set of guidelines or criteria for entry to its specialty. These should be nationally based competency standards.

Recommendation 6: The NSQAC should be responsible for assessing all overseas trained specialists.

At the moment there is an Appeals Committee attached to NSQAC but it does not appear to overturn many decisions (rejections) by Specialist Recognition Committees.

Recommendation 7: The Appeals Committee of NSQAC should operate independently and should provide for personal interview and the presentation of theatre log books, references of co-workers and other relevant information.

If the above recommendations were implemented, it would take the actual assessment out of the hands of the Specialist Colleges and minimise the chance of labour market conditions affecting the assessment process and outcome. As pointed out above, assessment and workforce issues should not be confused.

The AMC's position on this is not clear. Whereas on page 9 it unequivocally denies that the AMC itself is involved in regulating the size of the medical workforce, on page 40-41, the Report states:

Overseas trained specialists will need to be made aware of the situation in Australia for their particular specialty (i.e. that some are adequately covered) and warned that workforce constraints may limit their access to bridging courses and opportunities for work as a specialist.

While advising people of the difficulties of getting retraining prior to migration is advisable, the Report's suggestions (1990:41) that they be 'required to formally identify themselves as specialists at the time of migrant entry to Australia' and that they be 'required to sign a declaration of awareness before commencing the assessment procedure' would seem inappropriate.

These two suggestions carry overtones that are not acceptable. They imply that overseas trained doctors are not disclosing their specialty training when applying to come to Australia. This, in fact, may happen as many people wishing to migrate have heard about the difficulties and they may feel that if they state their professional status they will be denied entry to Australia. This even applies to refugees.

The second suggestion, regarding the signing of a statement of 'awareness' is not acceptable from the point of view of labour market control. The situation should exist whereby a person's qualifications are assessed on their merits and the person should then be able to enter the labour market and compete openly. There should be no signed documents of 'awareness' about either the difficulty of the process or the absence of adequate bridging or upgrading options.

The Ontario Task Force, mentioned earlier, investigated the aspect of declarations of prior knowledge by overseas physicians of the situation and whether immigrants could in fairness be permitted to insist on their right to licensure. The Task Force concluded (1989:296) that such conditions of entry cannot be relied upon.

Once accepted to this country, a person must come free to work in the field he or she chooses, bringing all the skills he or she acquired.

The situation for overseas trained specialists has not been easy. Nor has that for Australian medical practitioners wanting to become specialists. The labour market position in a specialty has been a significant factor in the past in determining how many

new trainees would be admitted to the specialty. The number of training positions has been closely controlled by the Specialist Colleges and the relevant Health Departments which fund training positions.

The AMC proposes that the Committee of Presidents of Medical Colleges should be consulted on the overall strategy that they have recommended for specialists. This should include the opportunities for extra training for overseas specialists who are assessed as having some gaps in their knowledge, as far as practice in Australia is concerned. At the moment such people are told that they require additional training but provision for such training is generally not available.

As well as the issues of assessment and bridging/upgrading, the question of specialist registration must also be addressed. This is a matter for the individual state and territory boards. As already stated, specialist registers currently exist only in South Australia and Queensland but other states and territories have provision for restricted registration (limited or provisional categories) and in some cases discretionary provisions.

The AMC's Report (1990:39) says that:

It will be necessary in each State and Territory to establish a separate mechanism to register overseas trained specialists whose specialist qualifications and clinical expertise are recognised but are not eligible for general registration in the relevant State or Territory. Although uniform approaches to the registration of medical practitioners is seen as desirable, the legal reality is that each State and Territory has its own legislative provisions for registration.

.....The Working Party notes that the record of legislative change to Medical (Practitioners) Acts is not encouraging.

The Report suggests that each state and territory should review its own legislation and determine the most appropriate way to register specialists. The NSW Medical Board in its Discussion Paper on *Proposals for the Introduction of the New Medical Act* (March 1990:19) discusses the concept of a separate category of specialist registration in the following terms:

The Board has carefully considered all the arguments and believes that it can achieve the same ends, where appropriate, through the exercise of its discretionary power.

The Board can refer overseas trained specialists to the appropriate Royal Colleges for advice as to whether or not their training and qualifications are

equal to those in Australia, and may, if satisfied, grant discretionary registration with appropriate conditions.

The NSW Medical Board's recommendation against the establishment of a separate register does not auger well. It contradicts the recommendation of the NSW Fry Committee as well as the AMC's recommendation. Moreover, the Board does not provide any indication of how the existing situation will be improved. Confusion has existed about who is to assess the specialists and in some instances there has been no organisation willing to conduct the assessment. This is illustrated by the following case.

A European dermatologist applied for registration to the NSW Board but was advised that she was not eligible for specialist (discretionary) registration under Section 16 (c)(ii) of the Medical Act. A letter (21/10/87) from the Acting Registrar said:

I note that you have been unsuccessful in your attempt to have the Australasian College of Dermatologists assess your qualifications. The Board understood that the College was the appropriate body to assess your qualifications and in good faith, suggested submission of your qualifications to the College, based on that understanding.

Finally the Board does not see its role as being that of an agent for medical practitioners who are not eligible for registration under the provisions of the Act. Clear mechanisms exist whereby practitioners may become eligible for registration in this State and the Board readily provides information on these to practitioners who enquire of it.

In response to this letter the applicant wrote to NSQAC and received the following reply (4/1/88):

The National Specialist Qualification Advisory Committee (NSQAC) does not assess individual practitioners' qualifications and training.....

You will appreciate that NSQAC has been unable to undertake much evaluation of Czechoslovakian qualifications as it has proved difficult to obtain sufficient details from training courses and examination standards from that country.

The Australasian College of Dermatologists is the Advisory Body to NSQAC on dermatological qualifications and training. You could approach that body for a detailed evaluation of your qualifications.

The applicant then wrote to the Australasian College of Dermatologists and received a reply (28/1/88) from the Secretary which contained the following:

I am rather puzzled that the NSQAC should have referred you to the College for evaluation of your qualifications. They should have advised you that the NSQAC itself does not recognise your European qualifications in dermatology.

The AMC Working Party's Report (1990:42) concludes by saying:

It is reasonable to assume, however, that if the question of specialist registration is not taken up in a positive manner by the Specialist Colleges and the profession as a whole, Governments will legislate to regulate specialist medical practice in a manner that will not necessarily give the same priority to clinical expertise and standards as is the case under the current arrangements.

Exactly how this would come about is not clear: registration boards have been established so that they are independent of State Governments and the Commonwealth has no legislation to control state/territory registration practices. Either the states and territories would have to review their Medical Acts or the Commonwealth Government would have to enact legislation to override the states and territories.

Nevertheless, the AMC Working Party is sounding a warning to the Specialist Colleges that they need to improve their record in this area and this warning is overdue. The warning, however, also needs to be directed at the registration boards.

Recommendation 8: Specialist registers should be established in each state and territory and basic registration as a general practitioner should not be a requirement for specialists.

General Practitioners

The major recommendation of the Working Party in relation to general practitioners is that the AMC examination should be replaced by an examination similar to that currently administered by the Family Medicine Programme (FMP) of the Royal Australian College of General Practitioners. This would mean a change from the standard of an Australian medical graduate at the point of graduation to a standard equivalent to the level of medical knowledge and clinical competence of a practitioner entering general medical practice in Australia.

A two staged assessment is envisaged:

Stage 1: A preliminary screening examination, administered by the AMC - based on FMP question banks and additional FMP-validated question items drawn from existing AMC banks.

This Preliminary Screening Examination (PSE) would be to differentiate candidates on the basis of their knowledge. It would function as a filter and not as a barrier. The candidate's performance in this examination would determine their track for stage 2.

Stage 2: A barrier assessment of clinical knowledge with the following alternatives:

i) a fast track system of assessment of clinical competence based on a clinical examination which is modified from the current one for candidates with a strong performance in the Preliminary Screening Examination. The modifications would include the addition of a formal component to the clinical to evaluate the communication and counselling skills of the candidate at the level of a general practitioner.

ii) completion of a bridging course and the clinical examination for candidates with performance scores equivalent to the FMP trainees at the commencement of their FMP but with some gaps in their medical knowledge.

iii) a performance score at the PSE which indicates a standard less than that of new FMP trainees and major gaps in medical knowledge would require the candidate to complete an accredited Graduate Diploma/ Certificate course at an Australian medical school: the course would include a formal assessment of clinical competence and there would be no need to complete the clinical examination.

iv) candidates whose PSE score was below a minimum standard and who possessed substantial gaps in their basic medical knowledge would be directed to seek admission to undergraduate MBBS degree courses in Australian medical schools.

The introduction of a four track system is a sound concept, though in reality only three tracks will be available to most people. A flexible system was advocated in the past by

the Federal Fry Committee as well as by a number of submissions to this Working Party. The problem, however, is that there are so many other organisations upon whom the suggestion is reliant, in order for it to work, that it may very well not be put into place or else take a long time to implement.

Before discussing this issue, the recommendations of the Working Party with respect to the AMC examination will be reviewed. Recommendation 6 relating to the maintenance of the MCQ component of the examination, albeit in an expanded and more innovative format (recommendations 7, 8 and 9), is supported. It is proposed that there be 200 questions, instead of 150, and that some interpretive and data analysis questions be introduced. The introduction of subject exemptions in the MCQ has not been recommended and the reasons for this have been well explained to and accepted by overseas trained doctors. The removal of the limit on the number of possible attempts at the PSE is welcomed though adequate counselling must be made available to ensure that candidates do not make unwarranted extra attempts in an effort to qualify for a higher stream for stage 2. The Working Party has not made it clear how this issue will be dealt with.

The Working Party has recommended the retention of the clinical examination, in a modified (i.e. expanded) form, for streams i and ii, after the PSE (recommendation 12). As will be argued below this is not justified and the arguments for supervised internship or accredited bridging programs have been dismissed by the Working Party (recommendations 14 and 15).

While suggesting an innovative proposal such as the four track system, the AMC has not supported a number of other suggestions that have been made that could have contributed to a more equitable and appropriate system of assessment.

A good result at the FMP examination would lead directly to a modified clinical examination for the best candidates and to a bridging course followed by the same clinical examination for the next group. The suggestions put to the Working Party regarding the integration of clinical assessment into either supervised practice or a bridging program were rejected for these two groups. But this element has been built into the concept of the graduate diploma/certificate course for the group with the third level of success at the FMP examination. This is an interesting but inconsistent dichotomy.

The major arguments used by the Working Party against supervised practice and accredited bridging courses are:

- educational limitations;
- problems of consistency of standards;
- lack of consistency of the assessment process;
- resource limitations in teaching hospitals and universities;
- lack of guaranteed funding for bridging courses.

These arguments for rejecting the proposals and retaining an AMC barrier clinical examination seem somewhat hollow. The FMP examination is set at the level of MBBS plus a number of years (how many?) of practical experience; therefore clinical skills will already have been assessed to some extent. The need for a centralised clinical examination, after this examination, seems to have little justification.

A better option would be to come up with some proposal for the integration of clinical experience in an Australian setting and an on-the-job assessment of clinical skills. The first three arguments listed above against any such proposals would seem to be surmountable by introducing a common set of guidelines and national competency-based standards. The resources issues must be addressed no matter which scenario is adopted.

It is worth noting that once foreign medical graduates in Ontario, Canada, have passed the same basic medical examination as that which applies for all Canadian trained medical students, they move into a two year internship program in the same way as Canadian graduates. There is no formal clinical examination after this but they are all assessed continuously on their clinical skills during the two placements that they undergo in that time. Arguments about consistency of standards, resource limitations, etc do not seem to apply.

The advantages of a period of clinical placement and associated assessment would be the opportunity for all overseas trained medical practitioners to become familiar with Australian medical practice. While a period of two years would be excessive in the Australian context, given that the FMP examination is pitched at a higher level than the Canadian qualifying examination, most overseas doctors acknowledge that they would appreciate a period of supervised practice in a hospital setting to learn the medico- legal

issues, the drugs that are prescribed in Australia and the nuances of Australian medical practice and bedside manner.

The NSW Medical Board has already introduced (on 1 January 1990) a requirement that all candidates who are successful at the AMC examination must complete one year of internship in a public hospital before being eligible to gain registration and enter private practice. It would make sense to integrate the clinical assessment into this period for stream i and stream ii, after the latter have completed their bridging program.

The Working Party also rejected, for the present, the notion of building up a list of automatically accreditable qualifications. The basis for the rejection was the resource implications of this proposal. Nevertheless, the Working Party (1990:32) stated that:

the AMC should continue to review the situation and explore the possibility of some appropriate accreditation procedure at a future time.

Recommendation 16 which refers to the possible expansion of the automatic recognition of overseas medical qualifications is out of line with the Commonwealth Government's strategy on skills recognition. This strategy, both domestically and internationally, is moving strongly in the direction of competency assessment rather than reciprocal acceptance of formal qualifications.

BRIDGING COURSES

The support offered by the Report for the need for bridging and reorientation courses (recommendation 17) is appropriate. The AMC's functions do not include the provision of such courses and the comments about the ad hoc and 'seeding' nature of funding for such courses is accurate. A coordinated approach needs to be taken to the issue of bridging courses if the AMC Working Party's proposals are to work. The bridging course for stream 2 and the diploma/certificate course for stream 3 are integral to the whole proposal.

Recommendation 9: The Commonwealth, State and Territory Governments should co-operate to ensure the adequate provision of bridging courses.

ENGLISH LANGUAGE ASSESSMENT

The Working Party also addressed the question of English language assessment and training. It somehow has the impression that NOOSR is going to discontinue altogether the testing of English in respect of medical practitioners. The Report (1990:35) states that:

The Working Party is concerned that the Commonwealth's reluctance to commit long-term funds to bridging courses does not impair the remedial English programmes. It is also concerned that the Commonwealth may abandon the OET (Occupational English Test) as part of its stated reform program for the recognition of migrant qualifications.

This seems to be a matter of miscommunication as according to NOOSR it is not discontinuing the test but is contracting the testing out to an accredited testing authority. This is a move that must be welcomed.

There is some feeling, including amongst overseas trained medical practitioners, that the level of English required in the OET is too low. The counselling and case management aspects of private practice necessitate a more sophisticated level of English than is currently required for operating effectively.

Recommendation 19 of the report calls for the AMC to advocate an expansion of the provision of remedial courses and bridging courses in English. This recommendation is supported as the provision of such courses has been inadequate in the past. TAFE Colleges were some of the first bodies to put together such courses in the early 1980s but overall their provision has been sporadic and subject to funding limitations.

COORDINATION

The AMC Working Party's proposal needs the support of the following bodies at each stage:

Stage 1 - the AMC and the Family Medicine Programme of the Australian College of General Practitioners;

Stage 2 - (i) and (ii) State Government Health Departments, National Office of Overseas Skills Recognition, university medical schools;

(iii) AMC, university medical schools and state medical boards;
Commonwealth Department of Employment, Education and Training
(DEET);

(iv) AMC, university medical schools and DEET.

The AMC Report itself states (1990:45):

There are, however, some limitations and constraints on the link with the FMP and these will need to be addressed in the development of an appropriate assessment system and its associated procedures.

This is not to say that the new proposal for assessing general practitioners is not valid but its viability is questionable, especially in the short run. Some of the difficulties are: courses in universities often take two to three years to develop; bridging courses have up till now been sporadic in most states and territories; funding for bridging programs is not guaranteed; there is as yet no arrangement for using the Higher Education Contribution Scheme (HECS) for short courses, and overseas trained medical graduates have been trying for decades to retrain through Australian medical schools.

For the proposal to be implemented fully it will be necessary to have the full co-operation of all the relevant bodies and a level of financial commitment that till now has not been forthcoming. The AMC in making this proposal has been forward looking and ambitious in its expectations that the associated bodies will come to the party. The position of the AMC in relation to all the other relevant bodies is not one of control. The AMC is an autonomous body and has no power to insist that its recommendations are taken up.

This, in fact, highlights the major dilemma: the lack of an organisation which has responsibility for the overall situation. The interrelation of State/Territory and Commonwealth Governments, together with the AMC, universities and public teaching hospitals, means that an intricate network must be relied upon to implement the recommendations.

CONCLUSION

The Government's reform policy embodied in the document *Migrant Skills: Improving the Recognition Processes*, calls for the introduction of national competency-based skills standards against which the skills of the overseas trained may be assessed.

The Working Party's proposals go some way towards addressing this issue but in each area of medicine there is a need for a comprehensive list of the skill requirements defined as being necessary to properly carry out the functions. The best means of measuring each applicant against these lists of competencies must then be devised.

The major recommendation of the Working Party, that there be two separate pathways for the assessment of overseas trained general practitioners and specialists, is very sound. The dilemma facing specialists, in the past, has resulted in enormous financial loss as well as emotional stress.

The implementation of the proposal for specialists relies on the cooperation and goodwill of the specialist colleges and NSQAC. To this end the Working Party has proposed that the AMC sponsor a national debate on this issue. The Working Party (1990:56) recommends that:

as a first step the Council should convene a national conference involving the Presidents of the Specialist Colleges, the Medical Boards and the Commonwealth (Health Insurance Commission) to address the major issues involved in the assessment and registration of overseas trained specialists.

This approach must be the first step. But in the event that it does not produce the desired outcomes, some other approach must be taken by the Commonwealth Government to help overcome the problem facing overseas trained specialists.

The recommendations relating to general practitioners represent a major improvement on the current situation but have not been as innovative as they could have been in some respects. Maybe the decision not to recommend supervised practice or accredited bridging programs in place of the AMC clinical examination represents a political summation of the reality of getting such programs in place. Nevertheless, such options should still be considered more fully. They would enable the assessment practices in medicine to fall more in line with the Government's emphasis on competencies.

The proposals that relate to general practitioners are more in the hands of the AMC but they still require the cooperation and support of the medical boards for approval, and the universities for the development of courses. The funding of such courses needs to be resolved and the Working Party (1990:56) recommends that:

further discussions take place with NOOSR and the Department of Community Medicine at Monash University to convene a joint DEET-AMC sponsored Workshop on the implications and development of a University award course for OTD's as part of the general assessment process.

Both of these proposals are sound but they indicate the fundamental difficulties facing the AMC Working Party's proposals: responsibility for the assessment of overseas medical practitioners is divested in a range of organisations and the role of the AMC does not give it the authority to carry out its proposals.

At the moment the report is an interim one and the final review will be completed by the middle of 1991, with reform proposals which are accepted being implemented by early 1992. This is an ambitious timetable but in order for it to be achieved the Commonwealth Government must consider the role of the AMC and of NOOSR itself in the implementation of its strategy on migrant skills. Neither body at the moment has the capacity to ensure that the final recommendations that emerge are satisfactory or that they are fully implemented in the near future.

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