Overseas-trained doctors in Aboriginal and Torres Strait Islander health services: many unanswered questions

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ABSTRACT

- Aboriginal and Torres Strait Islander health services are heavily dependent on overseas-trained doctors (OTDs).
- These OTDs are increasingly from countries with variable English language and educational equivalency compared with locally trained doctors.
- Aboriginal and Torres Strait Islander health services create particular demands for all doctors, such as negotiating "cultural domains" and acknowledging the contribution of Aboriginal health workers.
- Little is known about the roles and experience of OTDs in health service provision in Indigenous communities.
- Barriers to effective research into the experience of OTDs include privacy legislation and a lack of standardised data.
- Researching the narratives of OTDs in Indigenous health services offers an opportunity to explore the diversity and complexity of the cultural interfaces in health service provision.

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In 2004, the Australian Medical Association estimated a national shortfall of 430 full-time equivalent medical practitioners providing services to Aboriginal and Torres Strait Islander peoples, with the shortfall in primary health care services being 250 full-time equivalent practitioners.[1] To overcome some of this shortfall, Aboriginal and Torres Strait Islander health services in urban, outer-metropolitan, rural and remote areas are designated "areas of need" and are heavily dependent on overseas-trained doctors (OTDs) to maintain their complement of medical practitioners.[2]

In rural and regional areas in the period 1995–96 to 2003–04, there was an 8.8% increase in Australian-trained general practitioners, compared with an 80% increase in overseas-trained GPs.[3] The proportion of medical registrants who are conditionally registered temporary resident doctors increases with remoteness, particularly in Western Australia and Queensland.[4] However, there are no publicly available national data on the percentage of OTDs working in state, private or community-controlled Aboriginal and Torres Strait Islander health services.

High mobility in the rural workforce, and among OTDs in particular, raises particular concerns for both preventive programs and continuity of health care.[5] In addition to these general concerns, working in Aboriginal and Torres Strait Islander health services places particular demands on doctors, including the need for advocacy skills,[6] accommodation of an equitable professional environment that acknowledges the particular contribution of Aboriginal health workers, a sense of accountability to community,[7] and the recognition of different cultural "knowledges", including Aboriginal knowledge about illness and wellbeing.[8,9]

Since the mid 1990s, the source countries of OTDs have become increasingly diverse, extending to countries where English language and educational equivalency compared with locally trained doctors is variable.[10-12] Given the differential experiences of professional and social integration into medical practice by country of origin,[13] it is likely that the additional demands of adaptation to Indigenous community health services may compound these stresses. However, we know little of how language, class, culture, ethnicity and sex mediate the relationships between OTDs, their colleagues, and the communities being served.

This article arises from an ongoing study of the experience of OTDs working in primary health care roles in public, private and community-controlled health services for Aboriginal and Torres Strait Islander communities.[14] Despite the widespread employment of OTDs in Australia's rural and remote areas, and in Aboriginal and Torres Strait Islander health services, there remain a number of largely unanswered questions regarding the appropriateness of their training, orientation and support, and their integration into Indigenous communities.

Issues affecting OTDs in Indigenous health care

Relocation and orientation for practice

Recent surveys of OTDs working in rural and remote locations give some insight into the types of problems experienced with relocation to a new country and its impact on the employment experience.[15,16] In addition to challenges such as fulfilling immigration and medical registration requirements, meeting costs incurred in relocation, and insufficient orientation to local practice and community, respondents reported difficulties with the remoteness of the area, the degree of morbidity and mortality encountered, the "culture of services", and relationships with colleagues. Discrimination and negative attitudes towards OTDs from local communities were often reported.

A study into the support and training needs of GPs and GP registrars working in Indigenous health found that formal training before starting work was not uniformly provided,[17] although a number of important initiatives exist for GPs working with Indigenous populations, in partnerships offering localised, community-based cultural orientation and support.[18]

Communication in practice

There is now national consensus on core cultural competencies in the training of Australian doctors for effective delivery of Indigenous health.[19] The concept of "cultural safety", underpinning New Zealand's statutory approach to cultural competency training, has introduced the critical role of practitioners' own attitudes and values as central to the acquisition of cross-cultural competencies.[20,21] However, cultural education programs for health professionals have been limited by factors such as the extent and timing of training, the need for better assessment of participants' learning needs, and greater Indigenous involvement in cultural training and evaluation.[22] At the interpersonal level, Indigenous social health researcher McDonald argues the need for developing the capacity to engage in ongoing "intercultural dialogue" with Indigenous staff

Overseas-trained doctors (OTDs) in Aboriginal and Torres Strait Islander health services: future research avenues

- How do OTDs negotiate multiple "cultural domains" when practising in an Aboriginal and Torres Strait Islander health environment?
- Are perceptions of the worth of OTDs in Indigenous communities mediated by perceptions of their "foreignness"?
- How do the experiences of OTDs working in urban and outer-metropolitan Indigenous settings compare with their Australian-trained counterparts in rural and remote areas?
- How do the past employment and experiences of doctors, whether trained overseas or locally, have a bearing on the specific skills and attributes required to function effectively in the sociocultural environment of Aboriginal and Torres Strait Islander health, particularly in remote areas?
- How might good qualitative research, grounded in the local practice environment, contribute to the development of vocational assessment criteria of doctors' suitability for practice in an Indigenous and/or remote environment? ◆

and patients and the capacity to switch between Western and Indigenous modes of knowledge and practice.[23] OTDs must learn to negotiate multiple "cultural domains" — their own, the local Indigenous culture, and the broader Australian culture — when practising in Indigenous health services.

Integration and retention

Issues affecting retention of OTDs and locally trained doctors in rural and remote areas have much in common, in particular, concerns over children's schooling and work opportunities for spouses. Additional hurdles, particularly for conditionally registered OTDs, such as lack of flexibility in practice conditions, and inadequate supervision and educational support, have been noted as constraints to professional integration.[24,25] The ability to retain links to their own cultural and religious communities has a positive effect on levels of life satisfaction,[26] although this varies in importance for doctors from different ethnic and cultural backgrounds.[10] Acceptance by the local community is a key factor influencing a positive view of work location.[15]

Barriers to effective research in this area

The contribution of OTDs to Aboriginal and Torres Strait Islander health services, particularly in rural and remote areas, is evident. But while much core literature in this area is policy driven, it lacks the necessary depth of research to inform and refine policy. The available workforce data on OTDs in Indigenous health services — from medical registration boards, rural workforce agencies, state governments and community-controlled health services — are not standardised, and the dynamic nature of the sector is poorly captured. Attempts to establish these data are constrained by privacy legislation (particularly in remote areas where OTDs are potentially identifiable), differences in data collection, and gatekeeper resistance.

Further, differing jurisdictions create additional administrative hurdles: for our research, 10 case studies required 15 ethical review processes. Health services and OTDs have been cautious about participating in the research, given the largely negative publicity generated by the inquiry into Dr Jayant Patel.[27]

The collection of longitudinally linked data has been underutilised, despite its suitability for studies of transient or mobile populations, such as conditionally registered OTDs with uncertain residency and practice outcomes. While ethnographic and other qualitative methodologies have begun to be used to research patient–doctor communication in the Aboriginal health care setting, this has not been extended to communication with OTDs, or the multiple "cultural spaces" within these environments.

Conclusion

There is much about the OTD experience that can be extrapolated from available sources. What cannot be so easily inferred is the experience of OTDs' simultaneous engagement in Australian social and professional life, and the particular demands of Indigenous health, society and culture. It is this conjuncture that is rich with potential knowledge (Box). For OTDs, it would give voice to their double transition — the challenges and uncertain expectations of relocation and integration. For Aboriginal and Torres Strait Islander health services, it would provide insight into the background, experiences and culture of OTDs, particularly in communities where relationships with non-Aboriginal, and especially transient, practitioners are characterised by significant cultural and linguistic distance.

Researching the narratives of OTDs in Aboriginal and Torres Strait Islander health services offers an opportunity to explore the diversity among non-Indigenous health service providers — both Australian-trained and OTDs — and the complexity of the cultural interfaces in health service provision.

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Competing interests

None identified.

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