# ADTOA SUBMISSION - INQUIRY INTO THE ADMINISTRATION OF HEALTH PRACTITIONER REGISTRATION BY THE AUSTRALIAN HEALTH PRACTITONERS REGULATION AGENCY

International Medical Graduates (IMGs) currently make up the backbone of the medical workforce in rural and remote regions of Australia. Approximately one- third of the Medical workforce in Australia, and up to 50% of the doctors in rural and remote areas, are IMGs. In the past year there has been a mass de-registration of IMGs as a result of AHPRA policies/decisions which has affected tens of thousands of patients living in rural areas.

Two of the AHPRA policies that have had a significant impact on the deployment of critically needed medical services in rural areas involve the Pre-employment screening interview or PESCI and the English Proficiency standards adopted by the Medical Board.

The PESCI was adopted nationally in 2008 as a tool to "screen" potential IMG candidates for their suitability for area of need positions prior to starting work in Australia. The PESCI involves an oral exam where candidates are asked questions about hypothetical cases. While this type of exam is useful for providing feedback, it should not be used as a high stakes assessment because research shows it is difficult to standardize and is subject to bias. In fact this type of testing has been largely abandoned in many medical schools because of the low rates of reliability and validity.

Despite the fact that the PESCI was never designed to be a high stakes assessment, and the fact that it had not been properly standardized on Australian trained doctors, AHPRA started to use the PESCI to assess IMGs who were already working in Australia, some of whom had worked for as long as 25 years in this country. A large number of these IMGs failed the PESCI and were subsequently de-registered.
The impact of the loss of these doctors needs to be considered in the context that it is estimated that thousands of rural Australian die annually because of the current doctor shortages.

AHPRA, specifically the Australian Medical Board's English proficiency requirements have also needlessly robbed rural communities of critically needed doctors. There are two major problems with the current English proficiency policy. The first problem deals with the nature of the Occupational English test (OET) itself. In the last year this author has been contacted by thirty overseas trained health professionals regarding problems with the OET test. These problems have already been extensively described in numerous submissions to the Inquiry into and will not be repeated here. In summary concerns have been expressed that the standard of English expected of IMGs applying to work in Australia is equivalent to what would be expected of a professor teaching in an Australian University. In fact, according to a number of language instructors, many native English speakers, including Health Professionals, would struggle to pass the test. This author spoke to a senior reporter at the Australian who took part of the test as part of her investigation into the OET test. Her response was that while she did pass- but barely. In addition there have been major concerns about procedural irregularities, unfair testing conditions and lack of meaningful feedback. (See submissions 63, 64, and 101 House Standing Committee Health and Ageing – Inquiry into the Registration Processes and Support for Overseas Trained Doctors). While no one denies the fact that Health professionals must be proficient in English to provide high quality of care, the question needs to be asked why does an IMG need to speak professorial English in order to do a good job?

The second major hurdle for IMGs with regards to the English test is that the results are only good for two years even if the IMG has been living and working in Australia! There have been examples of IMGs who have worked in Australia for ten and 25 years respectively, as GPs, who have been asked to take the OET test! (Ibid submission 31) This means that IMGs often need to take the test multiple times! Interestingly, AHPRA does not require IMGs who have Australian qualifications to take an English test every two years. Member of Parliament Mr. Ken Wyatt has gone on record that he believes that the English proficiency policy may unlawful discrimination.

Following are a few representative cases involving IMGs whose personal and professional lives have been devastated by AHPRA policies.

## The Pre-employment structured clinical interview (PESCIs)

### Overview

Over the last year ADTOA has been contacted by at least 12 doctors who have been de-registered for failing a PESCI. In none of these cases had any complaints been lodged about the quality of care that they provided to patients. On average they had proved their clinical competence by working in Australia for an average of 6-7 years with a range from 2 to 10 years. Eleven of the doctors provided services to rural communities. Of the 12 doctors that were deregistered because of the PESCIs, three had to leave Australia at short notice because of their visa status (on temporary visas). A least two others lived under the threat of possible deportation because of their immigration status. Five of the doctors had taken all or parts of their RACGP exam, and were waiting for the results when they were asked to do the PESCI. None of them were granted an extension to get their results.

Of the three doctors who were forced to leave the country, two later found out that they had passed their fellowship exams! The third failed by less than one percent.

Common themes reported by the 12 doctors included:
**Moving goal post syndrome** – The majority complained of frequently changing rules, which affected their ability to practice, including the need to obtain Australian qualifications within a specified time period, and the need to do new exams (PESCIs and AMC). A number also reported that they believed that the Medical Board had unlawfully changed the conditions of their registration but that they did not have the financial resources to pursue legal action.
**Personal and professional devastation** – All of these doctors reported a devastating impact on their personal and professional lives. A number reported concerns about their ability to work in other countries because they had been de-registered and would need to provide this information to

prospective employers and respective registration authorities. Approximately half of the doctors were temporary residents and had school aged children. They described the impact of having to uproot their families and move from their homes as heart breaking.

**Health effects** - Approximately half described significant symptoms of anxiety and/or depression. Others developed somatic symptoms including new chest pain and hypertension, which they attributed to the extreme levels of stress that they were experiencing as a result of their experience with the Medical Board.

**Discrimination** – A number expressed the opinion that the majority of Australian trained GPs of the same cohort would not be able to pass the exam and that there were two sets of rules; one for Australian trained graduates and one for IMGs.

**Procedural irregularities and inappropriate assessment** – A number complained about the fairness and procedural irregularities. Specifically in some cases the PESCIs were taped and in other cases not. Candidates did not have access to their answers and were not given feedback as to why they failed. A number reported that the types of questions were not relevant to the nature of their practice. For example, one doctor who was applying to work as a skin cancer doctor was asked a question about their approach to an indigenous minor who presented with an unwanted pregnancy! Others were asked questions about acute emergencies when they primarily did after hours house -calls. Some also complained about the poor quality of examiners and the lack of clarity about what was expected of them. For example, were they were unsure whether they were expected to do a role-play or directly answer the question?

**Barriers to meaningful appeal** – The majority felt that they had strong grounds for an appeal but were unable to follow this route as it would cost them tens of thousands of dollars (lawyers estimates) and that they did not have the funds to pursue legal action. Others reported that they were unable to appeal because of their immigration status, in that they may need to leave the country and therefore would not have the opportunity to appeal.

**Case One – Dr. MR**

Dr. MR is a GP [redacted] with over ten years experience in General Practice. Dr. MR moved to Australia along with his wife, three month old son and four year old daughter to take up a position as a GP in a medium sized Queensland town. He worked under supervision without any concerns raised about his clinical competence for six years. In 2007, the Medical Board informed Dr. MR that he would need to achieve full registration by 2011.

**The timetable was changed without explanation or consultation at least three times in the next three years.**

Dr. MR sat part 1 of the RACGP exam in 2009. He scored 52%, which was not high enough to pass. Unlike Australian trainees, Dr. MR received no financial or academic support to prepare for his exams. The only time he had for studying was before and after his long workdays.

Dr. MR attempted parts 1 and 2 of the exam again in March 2010. While he was waiting for the results, the Medical Board of Queensland informed him that he would need to do a PESCI. This was despite the fact that Dr. MR still had another two years with which to pass his exams and was waiting for his results. The Medical Board refused to grant him an extension to get his results. Dr. MR paid $1650.00 and did a PESCI on June 4 2010. The PESCI was conducted by three GPs and involved four clinical scenarios. The interview was not audio or video recorded. Dr. MR was confident that he did well and was shocked when he received the results in which he was not recommended for registration. Dr. MR then found out that he had passed part 2 of the RACGP exam. Despite this AHPRA (which had started July 1 2010) deregistered him on August 23 2010.

The de-registration of Dr. MR caused a huge outcry in his community which was desperately short of doctors. Over 5000 patients signed a petition in protest to the Medical Board's decision. He also had an outpouring of support from his fellow GPs and local specialists.

Dr. MR was extremely fortunate in that his Medical Indemnity insurance agreed to cover the legal fees involved in launching

an appeal against the Medical Board. His counsel applied for a stay of the Medical Board decision pending appeal. The QCAT granted the stay on September 2010. If Dr. MR had not had this financial support he would have had to pack up with his family and leave Australia within 28 days.

Other GPs in similar situations have not been as fortunate, with some being forced to uproot their families and move on short notice after dedicating as much as 12 years of service to rural and remote Australia.

**This case highlights the following problems:**
**1. Constant shifting of the goal post –** The rules change all the time despite the lack of evidence for the need for the new rules and the fact that the new rules can significantly impact on an IMGs medical career in Australia.
**2. Inappropriate assessment –** It was totally inappropriate to use a screening tool, which had never been standardized, as a high stakes assessment. This raises serious concerns about the current Medical Board's competency as an accreditation authority**.**
**3. Harsh and rigid rules –** Refusal to grant extension to get exam results.
**4. Inappropriate assessment of risk to public –** There was no evidence that Dr. RM was a risk to the public given that he had worked successfully for seven years in Australia AND was under supervision.
**5. Discriminatory treatment of IMGs –** The Medical Board would not be able to deregister Australian doctors in the absence of concrete evidence of concerns about their competence.

Case 2 – Dr. JB

Dr. JB is a GP [redacted] with 18 years GP experience. He also had extensive experience in Family Medicine training and had been head of two accredited Family Medicine training programs. Dr. JB moved to Australia in April 2006 with his wife and two school aged children. Initially he worked for an after-hours service for one year where he worked over 80 hour weeks and was exploited by his employers.

Dr. JB was fortunate to find another position as a GP in [redacted]. During this time he was a preceptor for [redacted] He also became very involved in the community including the [redacted] and the [redacted].

In January 2010 Dr. JB enrolled in the RACGP PBA exam. In March his marks were released. He passed two of the three modules. The RACGP gave him three years to pass the remaining module. Despite passing two of the three modules AHPRA refused to renew his registration unless he passed a PESCI. Unfortunately he failed the PESCI and was deregistered in June 2010.

**AHPRA refused to extend his registration to allow him to redo the second module despite a letter of support for an extension of his registration written by the Censor in Chief herself!** As a result Dr. JB had to uproot his family including his two teenage children and move back to [redacted] in August 2010.

In the interim Dr. JB had his results reviewed by two other RACGP reviewers. After reassessment Dr. JB was deemed to have passed all 3 components thereby passing his fellowship exam. Unfortunately Dr. JB is unable to apply for fellowship because he is not currently registered to practice in Australia! In addition AHPRA has informed Dr. JB that if he wants to get registered again, he may also need to pass Part one of the AMC and pass an English test!!

This is not an isolated case. Dr. AB another GP who was waiting for her final RACGP results was also forced to do a PESCI by AHPRA. Similar to Dr. JB the Board refused to grant her an extension to see if she passed her fellowship exams. She was deregistered because she failed the PESCI and like Dr. JB had to uproot her school age children and move back to the Philippines. A few months after she had moved back she found out that she had passed her fellowship exams. She is currently in the process of reapplying for registration in Australia.

This case highlights the following issues:

1. Test validity – If the PESCI is valid (accurate) how is it possible for not just one but two people to have failed a "screening" test but have passed the much more comprehensive fellowship exam?
2.Harsh and rigid rules – These cases also highlight the harsh and rigid rules imposed by AHPRA in that it refused to grant extensions to doctors who were waiting to hear about their results even in instances where there was support for such an extension by the respective College.
3. Inappropriate assessment of risk – How is it possible to defend uprooting two families and destroying two careers on the basis that these doctors (who were both supervised) were a risk to public safety?

Case 3 – Dr. RS

Dr RS is a senior GP [redacted]. He moved to Australia in 2002. Prior to moving to Australia he worked as a rural GP in South Africa where he obtained extensive experience in emergency medicine and anaesthetics.

From June 2002 to April 2008 he held a number of hospital positions throughout Australia. In 2008 he took a position as a GP in an area of need where he worked until 2010.

In March 2008 he received a letter from the Queensland Medical Board, which stated that one of the conditions of his registration was that he had to obtain general/full registration by March 2012. In July 2010 he received another letter stating that the new date to obtain full registration was July 2011.

Since his arrival in Australia, Dr. RS did attempt the AMC clinical exam three times and was unable to pass these exams. It needs to be understood however, that it is extremely difficult for senior doctors like RS (late 50s and early 60s) who are nearing the end of their careers to pass exams that have been designed for recent graduates.

On June 2010 Dr. RS was made to take a PESCI even though he was given until July 2011 to obtain his registration. He described the interviewers as quite disorganized in their approach to the questions. He failed the PESCI and was

deregistered November 2010. AHPRA refused to give him any transcripts of the PESCI or any detailed feedback as to why he failed.

At the time of Dr. RSs de-registration there was a lot of media attention about a number of rural GPs who were held in high esteem by their communities who had also been de-registered for failing the PESCI. A number of these doctors appealed the decision and were successful in getting a stay of decision.

Dr. RS lodged a stay of decision with QCAT regarding an appeal and was due to present his case on February 24 2011. On February 2 Dr. RS received a letter from legal counsel for the Medical Board. In their correspondence they acknowledged that they were in the process of reviewing the PESCI process and that it would be likely that they would be implementing a new assessment method in the next six months.

In their letter they offered to reinstate Dr. RS under the following conditions:

1. That he withdraw his QCAT appeal.
2. That he submit a new registration application
3. That he work under level 2 supervision (patients reviewed daily)

If he met the above criteria, the Medical Board would waive the PESCI requirement, although he would still be subject to the "new" assessment process to be rolled out in the next few months.

After careful consideration Dr. RS decided to accept the Medical Board's offer. The primary reasons for his decision was that he did not have the tens of thousands of dollars to lodge a full appeal. Also as a temporary resident he was at risk of deportation if he remained de-registered even if he was awaiting an appeal.

Dr. RS spent the next two months obtaining the necessary documentation for registration as well as looking for an Australian trained doctor who was willing to provide level 2 supervision (Level 2 supervision is very difficult to arrange as it requires daily contact and the supervised doctor can not be on his own). Dr. RS was able to meet these conditions and was

ready to start back to work April 10.

In the meantime Dr. RS also made a submission to the inquiry into the Registration Processes and Support for Overseas Trained Doctors. [redacted]. Dr. RS was aware that his testimony could have negative repercussions on his ability to practice but he felt strongly that he needed to come forward and share his experiences in order to improve the system for others. His testimony regarding his treatment at the hands of AHPRA is now on public record as part of the Hansard record.

**On April 8, just two days prior to starting his new position, Dr. PR received a letter from AHPRA informing him he would need to do another PESCI!**

Initially Dr. SR thought this was just a mistake as the previous correspondence from the lawyers for AHPRA were very clear that the need to do the PESCI would be waived if he withdrew his appeal and reapplied for registration. AHPRA responded that their offer was only valid if he took up his previous position.

It is very clear upon reviewing the correspondence between Dr. RS and lawyers for AHPRA that this was never any discussion that this was a condition for reinstatement of registration. It is important to note that Dr. RS delayed putting in an application for permanent residency (this would have restricted his job opportunities as a permanent resident). Consequently he is once again facing potential deportation.

At this stage Dr. RS has decided not to fight the Medical Board's decision and is not going to apply for registration primarily because at the age of 62, by the time he meets all the requirements set out by the Medical Board, he will be ready to retire. This is not an unusual circumstance. Many of the IMGs affected by the "new rules" are highly experienced doctors who are in the latter stages in their careers. It is unrealistic to expect these doctors to drop their clinical work to prepare and study for exams, when by the time they have finished their

exams, they will be ready to retire.

This case is particularly concerning because it represents every IMG's worst fear - that their ability to practice in this country will be jeopardized if they challenge and/or speak out about the system. It is difficult to understand why the Medical Board rescinded its offer to waive the PESCI. Was it because the publicity over the PESCIs had died down? Was it because Dr. RS had spoken out publically about his treatment? Was it a combination of both?

A significant improvement in the national scheme is that now there are standards outlined in the National law that are supposed to guide the policies and actions of the professional boards regarding transparency, accountability and fair due process. In addition the Board's policies/action cannot breech anti-discrimination law. This is a significant improvement over the former system where there was little if no oversight of the separate Medical Boards, and minimal avenues for meaningful input from the government and other key stakeholders.

This begs the question how can the Medical Board continue to act in a manner that contravene the standards that are supposed to guide their actions? Also how is it possible for AHPRA to be able to implement policies that may be in breech of anti-discrimination law? Unfortunately the only way to challenge potentially unlawful actions/policies is through legal channels. As already mentioned, given the overwhelming costs involved, legal action is not a realistic option for most IMGs. Secondly, currently there is no mechanism in place to enforce these standards, and/or make judgments as to whether these standards have, or have not been met. This is a bit like having a speed limit but no speedometer and no police available to enforce it!

Another major problem is the lack of any meaningful voice for IMGs and other international health professionals in the current scheme. Almost without exception the current members of the Medical Board hold or have recently held senior positions in one of the other powerful medical political bodies (i.e. specialist colleges, AMC). This results in a lack of

independence of view as well as creates the potential for conflicts of interest. These concerns have been raised in the past in the Race to Qualify report.[i] In contrast, there is no IMG representative on the Medical Board. This is unacceptable given that IMGs are the group that is probably most affected by the decisions of the Board.

## Recommendations

There are a number of critical changes that need to be made to the system to improve it for IMGs and other international health professionals. For the purpose of this inquiry we would like to focus on two main recommendations:

1. **Establishment of an international health professional advisory and advocacy committee**. We would recommend that the committee start with the Medical profession and expand to the other professions as the committee becomes established. This committee could work closely with the AHPRA ombudsman. The primary mandate of this body would be to do the following:
    - Monitor the Professional Boards and other contracted accreditation authority's adherence to standards as outlined in the national law including potential breeches of anti-discrimination law
    - Gather data and provide information about the impact of Medical Board policies/decisions on IMGs as well as the potential impact on the Medical workforce particularly on rural communities. (i.e. percentage
    - Liaise with the Medical Board and other accreditation groups (AMC, colleges) regarding any new policies that could potentially impact on IMGs.
    - Provide recommendations as to how to better support IMGs in the Australian workplace
    - Provide information/advice/guidance to IMGs regarding registration/accreditation issues/problems.
    - Provide some form of legal assistance/advice to IMGs regarding appeals

**Reporting**

The Committee would report to the Ministerial committee

**Composition**

- The body would consist of representatives of IMG national groups and/or would have access to advice from legal, human rights, and medical education experts.

**Funding**

- Twenty percent of the registration fees for IMGs with any form of conditional registration would go towards funding the advocacy/advisory committee.

**2. IMG representation on Professional Boards** - Professional Boards like the Australian Medical Board need to have an international graduate representative on the Board. An IMG representative is not simply a member who is also an IMG but rather the member must represent one of the IMG groups and/or be endorsed by such groups. We recommend that AHPRA start with the Medical Board and gradually expand to the other boards as needed.

[i] The Race to Qualify – Report of the Committee for the Review of Practices for the Employment of Medical Practitioners in the NSW Health System Oct. 1998