16 November 2016

Senator Rachel Siewert
Chair
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

*Via email*: *community.affairs.sen@aph.gov.au*

Dear Senator

**Further response to the Senate Standing Committee on Community Affairs arising from the hearing of the inquiry into the medical complaints process in Australia**

Thank you for the opportunity to provide further information to the Senate Standing Committee on Community Affairs (the Committee) on key areas of interest arising from the hearing of 1 November 2016. I am pleased to provide a joint response from the Australian Health Practitioner Regulation Agency (AHPRA), the Medical Board of Australia and the Tasmanian Board of the Medical Board of Australia that covers both the questions on notice from the hearing as well as further relevant information to the inquiry.

Our response in Attachment A is broken into the following areas:

1. Progress on improving the complaints and notifications process
2. Selection and training of AHPRA investigators
3. Vexatious complaints
4. Further comments on bullying and harassment in the medical profession
5. Progress report of our work in response to *Lost in the Labyrinth: Report on the inquiry into the registration processes and support for overseas trained doctors*

We provide a response to matters concerning Dr Fettke from AHPRA and the Tasmanian Board of the Medical Board of Australia in Attachment B. [redacted]

We trust this information will assist the Committee with its work for the inquiry. Our contact is Nick Lord, Executive Officer, NRAS Review on [redacted]. If you have any queries, please do not hesitate to contact us.

Yours sincerely

**Martin Fletcher**
Chief Executive Officer, Australian Health Practitioner Regulation Agency

**Dr Joanna Flynn AM**
Chair, Medical Board of Australia

**Dr Andrew Mulcahy**
Chair, Tasmanian Board of the Medical Board of Australia

# Attachment A

## Responses to key issues of interest from the Medical Board of Australia and the Australian Health Practitioner Regulation Agency to the Community Affairs References Committee Inquiry into the medical complaints process in Australia

We provide this information and responses to questions taken on notice from the Community Affairs References Committee (the Committee) at the public hearing of 1 November 2016 into the medical complaints process in Australia.

### Progress on improving the complaints and notifications process

***Question:* 2** ***Hansard page reference:* 57**

***Hansard extract:***

> **Dr Flynn:** In general, and I will ask Ms Ayscough to comment, I think that most of those recommendations have been actioned [COAG 2015 independent review of the National Registration and Accreditation Scheme], but it would be easy for us to provide on notice a report against the table of the recommendations.
> **CHAIR:** That would be great.
> **Senator DASTYARI:** Okay. When you say that most of them have been actioned—again, I just want to get my head around this one point. I understand what you are saying: there are some that were legislative in nature, and ultimately that comes from your evidence that they are the ones that seem not to be actioned. But are there administrative ones that have not, as well as legislative ones? I could not quite understand—I am sorry; it might be a bad line. I thought you were saying there were both administrative and legislative ones that are still being worked through. Or are there just legislative ones that are being worked through?
> **Ms Ayscough:** I think it is appropriate if we provide a complete status update on the recommendations on notice. Some of the administrative recommendations certainly have had action taken, but in many ways they are continuous quality improvement activities, so whether we can complete them at any point in time is not entirely certain. But we have provided some examples of the outcomes of the action on some of these recommendations with our submission—for example, the processes by which we share information about complaints between AHPRA and the health complaints entities. We have done a lot of work with health complaints entities around the country to settle a tool, a matrix, to help us to make early decisions about which the right agency is to deal with a matter from the beginning. That level of certainty is something that certainly was made clear to the independent reviewer—something that both practitioners and notifiers were seeking from the complaints management system.
> We have further examples of those kinds of activities—introduction of new guidance tools and improvements, as Dr Flynn referenced, not only in our communications with practitioners but also with those who make notifications to us so that the information is more useful to them and in plain language and at a frequency that they would expect.
> **Senator DASTYARI:** Okay. You will take on notice, obviously, the specific status of the files. Your general overview is that some of the items, as you understand them—and, again, you will confirm this in the table—require legislative changes. I am recalling all of yours that went through. At this point they have not been presented to the parliament yet. Is that your understanding?

**Response**

A report on progress to implement Recommendation 9 of the Independent Review of the National Registration and Accreditation Scheme for Health Professions is at **Appendix 1A**. We believe the report demonstrates solid progress in both implementation of this recommendation and improvement of the complaints and notifications process, including:

- implementing a decision tool between National Boards and Health Complaints Entities (HCEs) of states and territories to ensure complaints are dealt with by the right body
- public reporting on timeliness of our performance against benchmark timeframes, and
- roll out of 'plain English' correspondence to ensure that notifiers and practitioners have clear information about the process for managing their notification and the work we have done in consulting with professional associations such as the Australian Medical Association to support this work.

We will continue our work to implement this recommendation and improve the complaints and notifications process.

***Question:* 6 *Hansard page reference:* 67**
***Hansard extract:***

> **CHAIR:** I have a couple of questions. I suspect there will be more on notice as well. And we are going to try and get Dr Fletcher on as well at some stage. In terms of the length of time for complaints to be resolved, you said the median time has come down to 135 days. What is the longest? We are getting complaints of a number of years. So what is the longest? They are the ones, obviously, we are going to hear about a lot.
> **Ms Ayscough:** Yes, as you say, I would need to take that on notice. I do not have the details of the longest investigation currently open.
> **CHAIR:** Could you take on notice, then, the longest, but also how many are taking over the median?

**Response**

As at 30 June 2016, there were 1,722 notifications which were open for longer than 137 days (the median age of open notifications).

The longest complaint was 280 weeks old. Given the confidentiality issues related to this notification, further information is provided in Attachment C.

### Selection and training of investigators employed by AHPRA

***Question:* 1 *Hansard page reference:* 54**
***Hansard extract:***

> **Senator DUNIAM:** You mentioned that some of your investigators are clinicians; do you have an idea of how many actually come from that background?
> **Ms Ayscough:** I am sorry but I do not have that information with me today.
> **CHAIR:** Could you take that on notice.
> **Ms Ayscough:** Yes.

***Question:* 5 *Hansard page reference:* 66**
***Hansard extract:***

> **Senator DUNIAM:** Thank you very much, Chair, and apologies for the technical problems. It was an adventure, I can tell you, while I was offline. The one question I had goes back to the qualifications of investigators. I wonder whether you might be able, on notice, to furnish the committee with the selection criteria by which the recruitment decisions are made around the investigators, if that is at all possible, please?
> **Ms Ayscough:** Certainly. Yes. We advertise those roles frequently, so we will be happy to provide the role description and selection criteria.

**Response**

AHPRA employs approximately 180 staff in our notifications division across Australia. There are 42 staff employed within our notifications division with a clinical background in a health profession, including nurses, midwives, psychologists, pharmacists, physiotherapists, occupational therapists, medical practitioners and chiropractors.

In addition, clinical advice is also available from a further 15 staff employed within the broader regulatory operations directorate who have clinical backgrounds in nursing, midwifery, psychology, pharmacy, physiotherapy, occupational therapy, dentistry and medicine. These staff are generally employed as professional officers to advise across our notification, registration, compliance and legal teams.

All decision-making Boards and Committees are also constituted of both practitioner and non-practitioner members.

The generic role description and selection criteria for an AHPRA notifications officer is at **Appendix 2A**. This includes a description of the purpose of the position, key requirements and result areas of the role.

To enhance the skills of our investigators, in 2014 we implemented a national training program. This is consistent with Recommendation 28 from the Independent Review of the National Registration and Accreditation Scheme for Health Professions. The training program was developed in partnership with the Council on Licensure, Enforcement and Regulation (CLEAR) based on a National Certified Investigator Training program which has been delivered in the USA and Canada for more than 30 years. More than 19,000 investigators have completed this program internationally.

**Appendix 3A** provides further detail on this work.

### Vexatious complaints

***Question:* 3** ***Hansard page reference:* 65**

***Hansard extract:***

> **Senator XENOPHON:** Sure. I will just wrap up, because of time. In terms of a vexatious complaint, something that the Senate committee back in 2011 reflected on and made recommendations on, we have heard from the College of Anaesthetists. They made a very interesting submission. At the bottom of page 3, they talked about one anaesthetist complaining about another and knocking one out from practicing and how that could have profound implications in a country town, for instance—in a regional community. I thought that was quite revealing. They said:
>
> ANZCA is unaware of any specific examples of individuals or institutions using the threat of reporting to AHPRA vexatiously to intimidate registrants. However there is some anecdotal evidence that suggests allegations against private specialists are being used to exclude them from being credentialed in private institutions. This has the impact of restricting their ability to practice which in small towns could be quite devastating.
>
> That is quite an open submission.
>
> I have to squeeze in a couple more questions so could you take on notice: how do you deal with those sorts of matters? How do you adequately deal with the consequences of vexatious complaints and whether it is appropriate? There needs to be a good faith declaration at the very least, to say, 'What I am saying is truthful', so, if it is found that you have falsely or recklessly made a statement, that ought to be taken into account.

**Response**

We recognise the potential for people to make a complaint on vexatious or frivolous grounds, and acknowledged that such complaints were potentially stressful and damaging to the subject of the complaint. Section 151 of the Health Practitioner Regulation National Law (the National Law) provides for a National Board not to take any further action in relation to a notification if the Board reasonably believes a complaint is frivolous, vexatious or lacking in substance.

While it is often possible to quickly conclude a matter which is lacking in substance, it is often difficult to determine if a matter is vexatious without investigation.

Our new notifications and complaints portal includes the requirement for notifiers and complainants to declare that the information they provide is true and accurate to the best of their belief. This will be implemented in early 2017.

Section 237 of the National Law only provides protection from liability to a person when making a notification or providing information when doing so in good faith.

### Further comments on bullying and harassment in the medical profession

The hearing of 1 November 2016 considered the issues of bullying and harassment within the medical profession in considerable depth, and the role of both the MBA and AHPRA in managing complaints regarding bullying and harassment in the profession.

The MBA and AHPRA recognise our leadership role in the medical profession. This is why we have worked and will continue to work with other professional leaders and stakeholders, such as the Royal

Australasian College of Surgeons, to eliminate bullying and harassment. Our role is to protect the public and uphold standards of practice and conduct in the medical profession.

Bullying is a serious problem across the health sector. Universities, employers, specialist medical colleges, regulators and governments all have a role in building a healthy culture in which bullying has no place. In the meantime, we need to work together to deal with it effectively now. Experience and published research makes it very clear that bullying is best dealt with quickly and locally.

Early intervention processes (such as the peer review system built at the Vanderbilt University) can demonstrably and substantially change practitioner behaviours (see Hickson: Changing Behaviour. MJA Insight 12 August 2013; available at www.mja.com.au/insight/2013/30/gerald-hickson-changing-behaviour).

The Board and AHPRA recognise bullying as a serious risk to patient safety and therefore as an appropriate focus for regulatory action. Regulators need to become involved when local interventions do not work or in cases that need to be escalated to be effectively addressed. We support evidence and risk-based interventions that protect patients.

### Progress report of our work in response to *Lost in the Labyrinth: Report on the inquiry into the registration processes and support for overseas trained doctors*

On 23 November 2010, the then Minister for Health and Ageing, Hon Nicola Roxon MP, asked the House of Representatives Standing Committee on Health and Ageing (the Committee) to inquire into and report on Registration Processes and Support for Overseas Trained Doctors. The inquiry was in response to concerns that the move to the National Scheme had caused significant problems for international medical graduates (IMGs), some of whom felt they had been significantly disadvantaged and even discriminated against. The Committee released its report of the inquiry that it titled *'Lost in the Labyrinth'* in March 2012. The Committee made 45 recommendations that aimed "to reduce red tape, duplication and administrative hurdles faced by international medical graduates whilst ensuring that the Australian standard continues to be rigorously applied."

Since the release of the report, the MBA and AHPRA have worked to implement many of the recommendations made in the report, in partnership with the Australian Medical Council and specialist medical colleges.

We provide a comprehensive progress report on our work in response to the Lost in the Labyrinth report in **Appendix 4A**.

# Appendix 1A. Progress report on Recommendation 9 of the Independent Review of the National Registration and Accreditation Scheme for Health Professions – responsiveness to consumers

Measures to be taken within the National Registration and Accreditation Scheme (the National Scheme) to ensure the following principles are met within the design and operation of the complaints and notifications process.

| # | Item | Response |
|---|---|---|
| A | Establish a process where complaints and notifications involve a shared assessment of the appropriate means of investigating and addressing the issues between the Australian Health Practitioner Regulation Agency (AHPRA) and Health Complaints Entities (HCEs). | • In February 2015, HCEs, National Boards and AHPRA established a HCE, National Board and AHPRA Working Group (joint working group).<br>• The purpose of the working group was to identify areas for change in handling notifications/complaints that will result in:<br>- streamlined, simplified and more timely processes<br>- greater consistency between jurisdictions regarding process<br>- more transparent decision-making<br>- increased clarity around processes and the roles of all organisations, and<br>- a more responsive system for practitioners and complainants/notifiers.<br>• The joint working group undertook a review of the joint consideration process in each jurisdiction used by National Boards, AHPRA and HCEs to decide the appropriate body to deal with issues raised in notifications and complaints.<br>• Based on the review, the working group developed a leading practice approach for joint consideration to trial in three jurisdictions (Vic, NT and WA).<br>• The working group developed and implemented a *HCE and National Board Matrix – joint consideration section 150 of the National Law* for use as a guiding tool by experienced senior AHPRA and HCE staff during the joint assessment of a:<br>- complaint about a registered health practitioner (received by a health complaints entity) |

| # | Item | Response |
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| | Complainants whose issue is referred to a National Board as a notification are to be interviewed to determine their expectation and be advised of the relevant processes. | - notification (that could also be made to a health complaints entity)<br>• At the local level, AHPRA state and territory offices meet with the relevant HCEs on a routine and ad hoc basis to discuss particular matters where necessary and to promote a strong working relationship between the two agencies.<br>• The working group has clarified the roles of all organisations involved, including:<br>- publishing a nationally consistent plain English brochure to describe the roles of each entity in NT, SA, Tas and WA including: "if the practitioner is a registered health practitioner, the HCE must talk with AHPRA and the National Board about your complaint to decide whether the Board or (name of HCE) will manage all or part of your complaint" and "the Board can decide to talk to the HCE about your complaint"<br>- planning of a version of the brochure for Victoria for completion in 2017 with the introduction of the Health Complaints Act, and<br>- approving an HCE and National Boards Referral Protocol detailing the roles and responsibilities of each entity.<br>• The working group has achieved a more responsive system for practitioners and those who made complaints about health practitioners, including:<br>- HCEs involved in the trial of the HCE and National Board matrix along with AHPRA reviewed their correspondence with the complainant and practitioner to ensure that all parties were aware of the entity handling the matter<br>- AHPRA and the National Boards removing 'double handling' of matters including reviewing and changing the levels at which delegations are held and decisions made<br>- applying the National Law to allow National Boards to wait until the HCE completes its handling of a matter in part or in full before the Board proceeds to take no further action or investigate the matter, and<br>- the development of a plain English brochure describing the roles of each entity will help anyone who wants to make a complaint about a health practitioner, to make their complaint directly to the entity most suited to respond to it.<br>• AHPRA has employed a Consumer Engagement Adviser (previously known as the Notifications Liaison Officer) to provide assistance to notifiers and third party witnesses (as well as their families) in understanding AHPRA's complaints processes.<br>• The Consumer Engagement Adviser will also provide support to AHPRA to keep notifiers and third parties informed throughout the notification process by:<br>- assessing support needs of individual notifiers and third party witnesses identified through notification processes |

| # | Item | Response |
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| | | - providing specialised responses (including assistance and progress information) to notifiers and third party witnesses involved in the notification process<br>- Assisting staff in managing and dealing with sensitive and complex complainant issues<br>- contributing to the development and delivery of education and training in relation to the experience of notifiers and third party witnesses involved in the notification process, and<br>- working with staff to foster a customer service culture with and towards notifiers and third party witnesses.<br><br>AHPRA has supplemented information on its website to provide more information about notification processes and outcomes. Further enhancements to the material available via the website have been progressed throughout 2016, including new information sheets and FAQs for complainants.<br><br>The layout and design of AHPRA's website has also been revised to be more user friendly, particularly for people wanting to make a complaint or raise a concern.<br><br>• AHPRA is also developing an online portal as an additional, quicker and more streamlined method for making a notification or raising a concern. |
| B | Investigations and reports to be shared between National Boards, AHPRA and HCEs as required. | • AHPRA and the many of the HCEs have now updated their processes to enable each organisation to share matters received by the HCE or a National Board more quickly, including:<br><br>- sharing matters earlier<br>- regular communication enabled better decision-making around which entity would handle matters in part or in full, and<br>- consideration whether a delegation under section 151(1)(e) of the National Law could be made to AHPRA in limited circumstances, to further streamline and simplify processes, leading to more timely outcomes for the complainant and practitioner.<br><br>• The working group has achieved more transparent decision-making, by:<br><br>- developing an HCE and National Boards matrix to help staff to identify the elements of the complaint or notification for discussion by a National Board and the HCE on receipt, and<br>- approving an HCE and National Board Information Exchange Protocol.<br><br>• The working group has clarified the roles of all organisations involved including:<br><br>- publishing a nationally consistent plain English brochure to describe the roles of each entity in NT, SA, Tas and WA including: "if the practitioner is a registered health practitioner, the HCE must talk with AHPRA and the National Board about your complaint to decide whether the Board or (name of HCE) will manage all or part of your complaint" and "the Board can decide to talk to the HCE about your complaint" |

| # | Item | Response |
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| | | - planning of a version of the brochure for Victoria for completion in 2017 with the introduction of the Health Complaints Act, and<br>- approving an HCE and National Boards Referral Protocol detailing the roles and responsibilities of each entity.<br>• The working group has achieved a more responsive system for practitioners and those who made complaints about health practitioners, including:<br>- HCEs involved in the trial of the HCE and National Board matrix along with AHPRA reviewed their correspondence with the complainant and practitioner to ensure that all parties were aware of the entity handling the matter<br>- by AHPRA and the National Boards removing 'double handling' of matters including reviewing and changing the levels at which delegations are held and decisions made<br>- applying the National Law to allow National Boards to wait until the HCE completes its handling of a matter in part or in full before the Board proceeds to take no further action or investigate the matter, and<br>- the development of a plain English brochure describing the roles of each entity will help anyone who wants to make a complaint about a health practitioner, to make their complaint directly to the entity most suited to respond to it. |
| C | Establish benchmark timeframes for completion of key aspects of notification management. | • During 2014, AHPRA introduced a series of benchmarks regarding notification process timeframes and regularly started reporting to National Boards about notification timeliness.<br>• The 2014 Inquiry into the performance of the Australian Health Practitioner Regulation Agency1 (the inquiry) found, in summary, that improving consistency across the operation of the National Scheme and the experience of the notifier should be priorities for the National Scheme as it moves into its fifth year. This finding was echoed within the 2014 NRAS review consultation.<br>• In May 2015, the Performance Committee[2] endorsed a new performance framework for performance reporting within AHPRA.<br>• In 2016, AHPRA began publishing performance data about notification timeliness on its |

[1] Parliament of Victoria (2014) 'Inquiry into the Performance of the Australian Health Practitioner Agency'

[2] The Performance Committee is a committee of the Agency Management Committee. It is responsible for making recommendations to the Agency Management Committee to strengthen the performance culture across the National Scheme, oversight and scrutiny of operational performance measures and data, and; providing assurance that any organisational performance related issues, including the consistency of data and statistics are being well managed.

| # | Item | Response |
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| | | website. |
| D | Rationale for deliberations and progress reports to be routinely and quarterly conveyed to notifiers and health practitioners in plain language. | • Section 161(3) of the National Law requires that notifiers receive written notice of the progress of an investigation at no less than 3 monthly intervals.<br>• The AHPRA commissioned Health Issues Centre report *Setting things right: improving the consumer experience of AHPRA* (June 2014) identified the need to develop more meaningful communication with notifiers throughout the life of a notification or complaint and in particular, highlighted the importance of improving the readability and usefulness of documentation.<br>• Significant work has been undertaken since 2014 to make improvements to all communication with notifiers, including progress reports, and this has involved consultation with AHPRA's Community Reference Group and with the former CEO of the Health Issues Centre.<br>• A revised suite of template correspondence sent to notifiers was introduced in 2015. AHPRA consulted with professional associations, including the Australian Medical Association about the content and language of correspondence to practitioners. AHPRA commenced using the updated templates in early 2016. |
| E | National Boards to be authorised to refer matters for Alternative Dispute Resolution to HCEs. | • National Boards are able to refer matters to the HCE under the National Law. On receipt of a notification that could also be handled under HCE legislation, section 150 of the National Law requires the National Board and the HCE to decide how the notification is to be dealt with.<br>• While it is possible for the National Board to refer a matter to the relevant HCE, the Boards do not have the power to specify that the referral is for the purposes of alternative dispute resolution.<br>• It is noted that the participation by the practitioner and the notifier in HCE processes (e.g. alternative dispute resolution) is voluntary. The willingness of the practitioner and notifier to engage in HCE processes is one of the factors included in the matrix. This information will be useful (not determinative in its own right) during the discussions between the HCE and AHPRA under section 150. |
| F | Any adverse findings and disciplinary decisions to include the timeframe for inclusion of the decision or finding on the registrants' record. These decisions should be supported by strengthened monitoring of practitioner compliance with restrictions on registration, | • We have strengthened our processes for monitoring compliance with restrictions on registration including the development of a national restrictions library, drug and alcohol screening protocol and compliance reporting.<br>• A single point of accountability for compliance is managed through a National Director, Compliance.<br>• Work has occurred to ensure clear differentiation on the AHPRA website between the register |

| # | Item | Response |
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| | including adequacy of supervision. | of cancelled health practitioners (containing the names of health practitioners whose registration has been cancelled since 2010) and the list of practitioners who not able to practise because, after an investigation, they have given an undertaking to not practise or because their registration has been prohibited, in accordance with Part 8 Proceedings of the National Law. |
| G | The *Health Practitioner Regulation National Law 2009* (the National Law) to be amended so that notifiers personally impacted by practitioner conduct can be informed in confidence by the National Board about the process, decision and rationale for the decision regarding their case. This complements the amendments to the National Law approved by Ministerial Council in 2011 as detailed in Appendix 11. | • This item would require legislative changes and States and Territories are progressing this work. |
| H | National Boards and AHPRA to review correspondence standards with notifiers to ensure improved clarity and sensitivity in communication. | • Since early 2015, all correspondence with notifiers has been revised with this in mind and will continue to be reviewed on a regular basis for the purpose of identifying continuous improvement in how AHPRA communicates with notifiers.<br>• AHPRA collaborated with a number of parties in the development of its revised suite of notifier-facing correspondence including community reference groups, professional associations and plain English experts. |
| I | HCEs to file complaints so practitioners can be searched according to their AHPRA registration number to allow authorised persons to access data for research into the predictability of professional misconduct. | • From the commencement of the National Scheme in 2010, each practitioner registered with a National Board is issued with a unique registration number that is publically available on the Register of Practitioners e.g. http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx<br>• AHPRA is unable to comment further on progress in terms of changes by the HCEs to the way complaints are recorded in their respective databases. |

# Appendix 2A. Role description – Notifications Officer, AHPRA

## Position data

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|---|---|---|---|
| ***Position no.*** | Multiple | ***Review Date*** | May 2017 |
| ***Work level*** | AHPRA Level 6 | ***Directorate/business unit*** | Regulatory Operations |
| ***Reports to (role)*** | Manager, Notifications | ***Operating budget*** | Notifications |
| ***Number of direct reports*** | Nil | ***Location*** | Various location across Australia |
| ***Positions reporting to this role*** | Nil | ***Status*** | Full time – ongoing and temporary |
| ***Number of indirect reports*** | Nil | ***Close Date*** | |

## Organisational context

The Australian Health Practitioner Regulation Agency (AHPRA) is a national organisation established to implement a modern national regulatory system for health professionals. AHPRA and 14 National Boards work in partnership to deliver the National Registration and Accreditation Scheme, which started in Australia on 1 July 2010 (18 October 2010 for Western Australia). The purpose of health practitioner regulation is to protect the public, by making sure that only health practitioners who have the skills, qualifications and knowledge to provide safe care are registered to do so.

AHPRA reports to the Australian Health Workforce Ministerial Council and is governed by an Agency Management Committee appointed by the Ministerial Council.

AHPRA has an office in each state and territory responsible for most operational matters and a national office in Melbourne. AHPRA supports the operations of the National Boards and their state and territory Boards and committees.

AHPRA and the National Boards each have a set of responsibilities and functions that are set out in the Health Practitioner Regulation National Law Act, as in force in each state and territory. AHPRA and the National Boards work in partnership to regulate the professions and implement the National Scheme. This includes maintaining a national public register of health practitioners, managing concerns about the health, performance or conduct of registered practitioners, and registering practitioners who meet the standards set by the Boards.

The health professions currently included in the National scheme are:

- Aboriginal and Torres Strait Islander Health Practice
- Chinese Medicine
- Chiropractic
- Dental
- Medical
- Medical Radiation Practice
- Nursing and Midwifery
- Occupational Therapy
- Optometry
- Osteopathy
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology

# Position purpose

A notification is a concern regarding the health, performance or conduct of a health practitioner or student who is registered with a National Board whose profession is regulated by the National Scheme. The notification process is one of two major regulatory functions of the National Boards, the other being the registration of practitioners. A notification regarding a practitioners conduct, performance or health may have serious implications for public safety and may require Board action impacting upon the practitioner's registration and scope of practice. Effective and efficient management of notifications is important both to the public and the professions themselves.

The purpose of the Notification Officer is to manage all incoming notifications that AHPRA receive about health practitioners from patients or their families, other health practitioners, employers or are received via the health complaint entities in each state and territory. This would include assessing and investigating concerns and contributing to the management of those that result in health and performance assessment.

## Key result areas

| Accountabilities | Key Activities |
|---|---|
| **File Management** | Planning and conducting assessments and investigations into notifications concerning health professionals' impairment, performance or conduct under the National Law.<br><br>Requesting, obtaining and analysing relevant information relating to the notification.<br><br>If required, interviewing relevant parties and drafting high quality witness statements relevant to investigations.<br><br>If required, conducting inspections including interviewing third parties and witnesses.<br><br>Documenting evidence and preparing high quality reports and recommendations in accordance with the National Law, incorporating findings for consideration by the relevant Board or committee.<br><br>Seeking approval on reports and recommendations prior to submitting an agenda paper for the relevant Board consideration.<br><br>Advising the relevant health entities of the decision of the Board.<br><br>If required, liaising with and assisting legal counsel in the preparation and conduct of matters to be dealt with by panels, tribunals and committees.<br><br>As directed, negotiating undertakings and other actions to effectively and appropriately deal with notifications about health practitioners with them, their insurers and legal representatives.<br><br>Preparing concise and accurate correspondence, to advise the notifier and registrant of Board outcomes and keep them informed during the notifications process.<br><br>Ensure briefing papers and reports are evidence based to enable effective decision-making across AHPRA and the Boards.<br><br>Ensuring compliance with AHPRA's nationally agreed notification processes. |
| **Administrative Support** | Effectively maintaining confidential records and filing systems.<br><br>Ensuring the Pivotal database is updated constantly throughout the notifications' process.<br><br>Contributing to the development, review and continuous improvement of procedures related to the management and reporting of notifications. |

| | |
|---|---|
| **Stakeholder engagement** | Developing and maintaining a positive rapport and effective working relationships with internal and external stakeholders.<br><br>Responding to stakeholder requests, collating and disseminating relevant information, resolving problems, escalating issues when required, and effectively prioritising responses to stakeholders. |
| **Other** | Undertaking other duties as directed by the Director or Manager Notifications. |
| **Mandatory Accountabilities for all Employees** | |
| **Our way of working** | Incorporate the AHPRA Way of Working into daily work practices.<br><br>Comply with the AHPRA Code of Conduct and all other AHPRA policies and procedures.<br><br>Adhere to and apply the information contained in any AHPRA mandatory or job related training. |
| **Workplace Health & Safety Management** | Adhere to AHPRA's workplace health and safety policies and procedures.<br><br>Take reasonable care for own and others' health and safety.<br><br>Identify and report any health and safety problem, hazard/risk or defect which may give rise to danger.<br><br>Report any health and safety incident immediately and implement measures to rectify cause.<br><br>Complete all mandatory or additional workplace health and safety training as required by AHPRA.<br><br>Follow any reasonable instruction by management in relation to workplace health and safety. |
| **Customer Service** | Deliver a professional, proactive, accurate, efficient, confidential and customer focused service to a wide range of internal and external stakeholders. |
| **Self Development** | Participate in periodic performance planning and review.<br><br>Complete agreed activities in performance improvement plans or development plans. |

## Key requirements

| Key stakeholders | Qualifications / experience | Personal attributes |
|---|---|---|
| **Internal**<br>State Manager<br>Director, Notifications<br>Notifications Team<br>Registration Team<br>Legal Team<br>Boards and Committees<br><br>**External**<br>General Public<br>Notifiers<br>Health Practitioners<br>Legal representatives / insurers<br>Health Complaints Entities<br>Other regulatory entities, government agencies and statutory authorities | **Required**<br>Previous experience in the conduct of professional standards investigations or case management in a sensitive and complex environment<br><br>Relevant tertiary qualification (for example lawyer, journalist or a health practitioner)<br><br>Ability to apply legislation, policies and procedures in a regulatory environment Intermediate to advance MS Office Skills<br><br>Experience operating in a virtual team and / or in a matrix management model<br><br>**Desirable**<br>Certificate IV in Government (Investigations)<br><br>Previous experience in the health sector | Strong problem-solving, analytical and conceptual skills together with a demonstrated ability to exercise sound judgment and resolve issues independently in a sensitive and complex environment<br><br>Well developed interpersonal and oral communication skills with the ability to build and maintain productive working relationships with a wide range of internal and external stakeholders<br><br>Strong written communication skills including experience in writing reports and recommendations, preparing correspondence and agenda items<br><br>Ability to work collaboratively and effectively as part of a team environment and also show initiative and work independently as required<br><br>Strong organisational skills, including the ability to effectively prioritise and manage multiple tasks and deadlines whilst ensuring attention to detail<br><br>Ability to exercise judgement and resolve issues independently |

# Appendix 3A. Investigator training and progress to implement Recommendation 28 of the Independent Review of the National Registration and Accreditation Scheme for Health Professions

Recognising that a consistent, national approach to investigator training is a significant contributor to ensuring good regulatory decision-making, a standard, baseline training package for AHPRA investigators was developed, commencing in mid 2014. The package was delivered in partnership with the Council on Licensure, Enforcement and Regulation (CLEAR) to all existing investigators (approximately 130 individuals). CLEAR has developed an internationally recognised training program for investigators which we adapted for the Australian context.

Following its evaluation, the in-house development and delivery of training for AHPRA investigators was endorsed by the Agency Management Committee as an ongoing priority in late 2014. This was complemented by Recommendation 28 of the Independent Review of the National Registration and Accreditation Scheme for Health Professions, which recommended that,

'*That the Australian Health Practitioner Regulation Agency conduct specific education and training programs for investigators. These should be designed in consultation with National Boards, Tribunals and Panel members to develop more consistent and appropriate investigative standards and approaches, consistent with the requirements of the Health Practitioner Regulation National Law 2009, including the primacy of public safety over other considerations within the matters*.'

AHPRA has now implemented a multi-stream approach to investigator training which includes:

a. A revision of the three day CLEAR training program for new investigators. This revised program takes into account the feedback from its earlier delivery and incorporates all new investigations policies that have been developed in collaboration with various stakeholder input, including National Boards such as the Notifications and Compliance Committee and the Performance Committee. A copy of the topics covered is at **Table 1.**

b. The three day package has continued to be refined to ensure sound understanding of key investigative concepts, including the need to ensure procedural fairness and the need to be impartial and transparent in our dealings with practitioners and notifiers. We continue to emphasise the importance of early, personal contact with practitioners and notifiers to enhance the experience of those parties to our notification processes.

c. Participants at the training also included representatives of the National Health Practitioner Ombudsman and Privacy Commissioner and other co-regulatory partners.

AHPRA is also implementing a process of ongoing review and quality improvement for its investigator training program.

AHPRA's commitment to investigator training also includes the development of a national Investigator's Manual to guide and direct investigators in the conduct of their investigations. Topics addressed in the Investigator Manual cover assessing risk, requesting an independent opinion and differential approaches to conducting health, performance and conduct investigations. The development of an ongoing program of training tailored to AHPRA's experienced investigators is continuing. This training is designed to be agile in approach and will target specific areas for development as the need arises and/or as identified by stakeholder committees.

AHPRA also meets regularly with the chairs of disciplinary tribunals, which provides a mechanism for ongoing discussion about investigator training and allows tribunals to inform any future development in this area. AHPRA has also consulted with various Australian and international regulatory bodies (such as

the Civil Aviation Safety Authority and UK health regulators) to examine the ways in which they train their investigators and develop and review their instructive material.

The training approach for investigators is consistent with our ongoing work for an integrated AHPRA Staff Competency Framework and Induction Manual.

### Table 1: Modules covered in investigator training

**Schedule of topics from CLEAR Investigation Training delivered for AHPRA**

| Module Name | |
|---|---|
| **National Scheme Introduction** | Including an introduction to the Regulatory Principles for Decision Making, codes and guidelines that apply in the national scheme and the purpose and importance of regulation. |
| **Overview of Inspections & Investigations** | Including discussion about the roles of investigators and inspectors, powers under the National Law with respect to investigations, reporting requirements under the National Law. |
| **Professional Conduct of an Investigator** | Including personal values and ethical considerations, expectations of an AHPRA investigator, the AHPRA Service Charter, Code of Conduct and ways of working and how to recognise and manage conflicts of interest. |
| **Investigation Tools and Techniques** | Including components of the investigation process, sources of investigations, notification analysis and risk assessment, investigation planning, conducting investigation activities, sources for obtaining investigation information, execution of investigation plans and personal safety during investigations. |
| **Principles of Evidence** | Including classification and forms of evidence, principles of evidence affecting investigators and sufficiency of evidence in administrative proceedings. |
| **Evidence Collection, Tagging and Storage** | Including obtaining evidence, using Schedule 5 of the National Law, warrant applications, executing site visits, maintaining evidence, exhibit management and practical exercises. |
| **Interviewing Techniques and Managing Conversations** | Including the attributes of successful interviewing, planning and preparation for interviews, practical steps in conducting interviews, questioning techniques and practical exercises to build interview skills. |
| **Principles of Administrative Law** | Including the purpose and function of administrative law, limits on administrative agencies, effective investigations, merits review proceedings, administrative actions under the National Law and practical exercises reviewing relevant tribunal decisions applying to the exercise of administrative powers in the national scheme. |
| **Report Writing – Investigation Report** | Including the goals of an investigation report, analysis and writing skills and practical exercises to strengthen reports. |

Medical Board of Australia | AHPRA

28 October 2016

Mr David Hallinan
First Assistant Secretary
Health Workforce Division
Department of Health
GPO Box 9848
CANBERRA ACT 2601

[redacted]

Dear Mr Hallinan

**House of Representatives Standing Committee on Health and Ageing *Report Lost in the Labyrinth: Report on the inquiry into the registration processes and support for overseas trained doctors***

I refer to your letter dated 4 October 2016.

Attached is an update from the Medical Board of Australia and the Australian Health Practitioner Regulation Agency on our work on the recommendations in the *Lost in the labyrinth report*.

We consent to you publishing this update as part of the Australian Government response on the parliamentary website.

Yours sincerely

**Dr Joanne Katsoris**
**Executive Officer, Medical**
**Australian Health Practitioner Regulation Agency**



**Australian Health Practitioner Regulation Agency**
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

# Update

27 October 2016

## House of Representative Standing Committee on Health and Ageing Report Lost in the Labyrinth on the inquiry into the registration processes and support for overseas trained doctors

This update is in response to correspondence dated 4 October 2016 from David Hallinan, First Assistant Secretary, Health Workforce Division, Department of Health.

The Department of Health is updating the Australian Government's response to the 'Lost in the Labyrinth' report and is seeking information on work undertaken since the Medical Board of Australia (Board), the Australian Health Practitioner Regulation Agency (AHPRA), the Australian Medical Council (AMC) and the Committee of Presidents of Medical Colleges reported to the Department of Health in 2012 on the recommendations in the report. This response will contribute to an update by the Department of Health to the House of Representatives Committee.

The Medical Board and AHPRA have implemented many of the recommendations in the *Lost in the labyrinth* report to improve assessment and registration processes for international medical graduates (IMGs). These are detailed at **Attachment A**. In this letter we also detail a number of other changes that we have made that were not included as recommendations in *Lost in the labyrinth* but that we believe have reduced unnecessary complexity, duplication and cost for IMGs. These are primarily the result of a review of the pathways to registration.

We continue to review and revise registration processes for all practitioners, including for IMGs, work with our stakeholders and invite feedback about how to improve registration processes while maintaining professional standards. However, we acknowledge that registration for IMGs can be complex and confusing. IMGs are a heterogeneous group and should be assessed as individuals. While a 'one size fits all' model would simplify the registration process, it would also reduce flexibility and have potentially serious workforce consequences.

### Background

On 23 November 2010 the Minister for Health and Ageing, Hon Nicola Roxon MP, asked the House of Representatives Standing Committee on Health and Ageing (the Committee) to inquire into and report on Registration Processes and Support for Overseas Trained Doctors. The inquiry was in response to concerns that the move to the National Registration and Accreditation Scheme had caused significant problems for international medical graduates (IMGs), some of whom felt they had been significantly disadvantaged and even discriminated against.

The Committee released its report of the inquiry that it titled *'Lost in the labyrinth'* in March 2012. The Committee made 45 recommendations that aimed "to reduce red tape, duplication and administrative hurdles faced by IMGs whilst ensuring that the Australian standard continues to be rigorously applied."[1]

[1] 'Lost in the Labyrinth', Report on the inquiry into registration processes and support for overseas trained doctors, *House* of Representatives Standing Committee on Health and Ageing, March 2012

After the release of the *Lost in the labyrinth* report, the Board and AHPRA worked with the AMC and the specialist medical colleges, through the Committee of Presidents of Medical Colleges, to respond to each of the recommendations that were relevant to them. The response dated 7 June 2012 was provided to the Commonwealth Department of Health.

Since then, the Medical Board and AHPRA have worked to implement many of the recommendations in the *Lost in the labyrinth* report. A detailed report on the progress of implementing each recommendation is at **Attachment A**.

In addition to the recommendations in the *Lost in the labyrinth* report, the Medical Board and AHPRA have reviewed other aspects of the assessment, registration and supervision of international medical graduates. More information about this is outlined below.

## The introduction of the National Registration and Accreditation Scheme

The Committee inquiry was announced early in the establishment of the National Registration and Accreditation Scheme (the Scheme). The early issues in establishing the Scheme have been well documented. For example, by the Finance and Public Administration References Committee inquiry into 'The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA) – June 2011. See http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/report/index

Since the release of that report, we have done a great deal of work on our systems. We now have much more mature and streamlined processes to support practitioner registration.

## Workforce considerations and numbers of IMGs

The Committee inquiry was held at a time of significant workforce shortages, when there were government initiatives in place to recruit IMGs to live and work in Australia, particularly in areas of workforce shortage. While there continue to be some workforce shortages, as evidenced by the ongoing need to register international medical practitioners to work in areas of need, there appears to be a reducing reliance on IMGs in the Australian health workforce.

Registration data confirms that there were 6,221 medical practitioners holding limited registration in June 2011, comprising around 7.25% of the total register of medical practitioners[2]. As at June 2016, there were 2,705 medical practitioners with limited registration and 1,329 medical practitioners on the competent authority pathway with provisional registration. The June 2016 total of IMGs represents approximately 3.9% of the register of medical practitioners[3]. Since 2011, there has been a gradual reduction in the number of practitioners with limited registration year on year, across the categories of limited registration for postgraduate training or supervised practice and for area of need.

**Table 1:** Total number of practitioners with limited registration (all types)

| Type of limited registration | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| Postgraduate training or supervised practice | | 3295 | 2991 | 2742 | 2162 | 1651 |
| Area of need | | 2335 | 2006 | 1566 | 1261 | 1021 |
| Public interest | | 14 | 9 | 10 | 6 | 3 |
| Teaching or research | | 24 | 22 | 29 | 26 | 30 |
| **TOTAL** | **6221** | **5668** | **5028** | **4347** | **3455** | **2705** |

Changes to the competent authority pathway on 1 July 2014 have resulted in a number of medical practitioners being granted provisional registration in 2015 and 2016 who would previously have been

[2] Excluding medical practitioners with non-practising registration

[3] Excluding medical practitioners with non-practising registration

granted limited registration. The following table takes into consideration the number of practitioners in the competent authority in 2015 and 2016:

**Table 2**: Number of practitioners with limited registration from 2011 to 2014 and number of practitioners with limited and provisional registration in the competent authority pathway for 2015 to 2016

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| **TOTAL** | **6221** | **5668** | **5028** | **4347** | **4100** | **4034** |

Notes:
2015 – 645 IMGs in the competent authority pathway who hold provisional registration
2016 – 1329 IMGs in the competent authority pathway who hold provisional registration

A breakdown of the number of medical practitioners with limited registration by category and by state and territory is at **Attachment B**.

These data suggest that the Australian health care system is becoming less reliant on IMGs with limited registration to meet our healthcare needs. This is likely to be related to a range of factors including:

- the increasing number of local medical graduates who are practising in positions that were previously held by IMGs
- the changes to the competent authority pathway (see below) have made it easier for medical practitioners from competent authorities to apply for registration in Australia
- medical practitioners with limited registration are being actively encouraged to meet the requirements of general or specialist registration and therefore progress from limited registration. Between 1 July 2015 and 30 June 2016, there were 510 practitioners with limited registration who were granted general registration and 289 practitioners with limited registration who were granted specialist registration.

While there may be a reducing reliance on practitioners with limited registration to meet Australian workforce needs, we are committed to continuing to streamline assessment and registration processes for IMGs, so these are transparent, effective, efficient and fair, while maintaining high standards to protect the community.

## Changes to registration pathways

While the *Lost in the labyrinth* recommendations went some way to reducing red tape, duplication and administrative hurdles faced by IMGs, the Medical Board of Australia and AHPRA have reviewed registration processes for IMGs and made more extensive changes than were recommended. These changes, summarised below, have only been possible with the cooperation and support of a number of other agencies including the AMC, specialist medical colleges and the jurisdictions.

### Streamlining the competent authority pathway

The competent authority pathway was introduced in July 2007 as part of the Council of Australian Governments (COAG) commitment "to a national assessment process for overseas-qualified doctors to ensure appropriate standards in qualifications and training as well as increase the efficiency of the assessment process."[4]

The competent authority pathway allows IMGs who have completed specified examinations or accredited training and assessment in countries that have both a similar health care system and

[4] http://archive.coag.gov.au/coag_meeting_outcomes/2006-02-10/index.cfm

similar training, assessment and registration systems to those in Australia, to be 'fast tracked' through the assessment and registration process.

Changes to the competent authority pathway were possible because of the flexibility in the National Law.

Changes include:

- IMGs now apply for provisional registration rather than limited registration, reducing the registration obligations imposed on individuals, supervisors and employers.
- Applicants who perform satisfactorily are granted general registration after 12 months supervised practice.
- The AMC is no longer involved in determining eligibility for the competent authority pathway. This reduces the number of organisations that individual IMGs have to deal with, improving accountability, reducing paperwork and reducing costs. To illustrate, the entire process from application through to general registration was reduced from $3,770 to $2,056 in 2014/15.

**Streamlining the specialist pathway**

The specialist pathway is for IMGs who have overseas specialist qualifications. They can be assessed by the relevant specialist medical college and if they are found to be comparable to an Australian qualified specialist, can work towards specialist registration by meeting the requirements of the colleges. These requirements are customised to the individual practitioner's circumstances and may include peer review, supervised practice and/or assessments.

The MBA has worked with the AMC and the specialist medical colleges to make administrative changes to streamline the specialist pathway and make accountabilities clearer. IMGs previously applied for the specialist pathway through the AMC. They now apply directly to the specialist medical colleges and communicate directly with colleges.

The AMC no longer acts as a clearing house and intermediary for the specialist medical colleges. Data from the specialist medical colleges indicate that the number of incomplete applications received has reduced, compared to when IMGs applied through the AMC. Accountabilities are also much clearer.

The revised pathway relies on a purpose built secure portal. This is a repository of information including the results of primary source verification, qualifications, AMC results and college assessments. Access is tightly controlled and the portal is accessed by authorised AHPRA, college and AMC staff to obtain information necessary for assessment and registration. The use of the portal has reduced the need for multiple written communications and the need for IMGs to present the same documents to multiple agencies.

As part of the review of the specialist pathway, the definitions of comparability were also revised. Over time, some specialist medical colleges had modified the comparability definitions. This had led to divergent approaches to the assessment of specialist IMGs. The definitions of comparability have now been standardised for all specialist medical colleges, so they are clearer. The definitions are now explicit and specialist medical colleges must consider previous training, assessment, recent specialist practice and continuing professional development. They must also confirm the maximum time for assessment and peer review.

The AMC previously collected a range of data on specialist pathway applications. As the AMC no longer collect pathway data, colleges now report their data directly to the Board and AHPRA. The Board has published the data from the colleges covering the period 1 January – 31 December 2015. **See Attachment C).**

All colleges report against the same metrics. The data for 2015 includes:

- number and type of applications received in 2015 (application for specialist recognition, area of need or combined (specialist recognition and area of need))
- applicant's (IMG) country of training (for applications received in 2015)
- number of applications received which were incomplete on first submission
- number of applications withdrawn by the applicant (IMG)
- outcome of college's interim comparability assessment (IMG found to be not comparable, partially comparable or substantially comparable)
- outcome of college's area of need assessment (IMG found to be suitable or not suitable for the area of need position)
- outcome of final assessment for specialist recognition (IMG recommended for specialist recognition or not recommended for specialist recognition)
- time to first available assessment interview (from the date a complete application is received to the date of first available interview that is offered)
- time taken by college to assess IMG's application - interim assessment and/or area of need assessment (from the date a complete application is received to the date that decision of interim assessment is made by college)
- time from interim assessment to final assessment (from the date of decision of interim assessment, to the date that decision of final assessment is made by college)
- number of fellowships awarded to IMGs
- number of appeals of college decision by IMGs.

The MBA has also implemented *'Good practice guidelines for the international medical graduate assessment process*' (Good practice guidelines). These aim to help specialist medical colleges to assess IMGs more consistently. The guidelines were developed in consultation with the specialist medical colleges and are published on the MBA's website. The guidelines came into effect on 2 November 2015. They are at **Attachment D**.

**Specialist college performance benchmarks**

Following a recommendation made in the Snowball review of the National Registration and Accreditation Scheme, the Medical Board is now required 'to evaluate and report on the performance of specialist colleges in applying standard assessments of international medical graduate applications and apply benchmarks for timeframes for completion of assessments'.

The Board consulted with colleges about how performance could be measured and in June 2016 the Board advised colleges of the finalised benchmarks and compliance measures. Colleges will report against these in the next specialist pathway data report which will cover the 2016 period.

The Board will also commission an independent review of each college's specialist assessment process and performance, looking at the time taken to complete assessments and how the college's processes comply with the *Good practice guidelines for the specialist international medical graduate assessment process*. This review will start in 2017, acknowledging that the performance benchmarks were finalised midway through the 2016 reporting period.

**Improvements in the standard pathway**

The AMC, with the financial assistance of Health Workforce Australia and the Commonwealth, has built a world-class assessment centre that has significantly reduced waiting times for IMGs to sit the clinical examination. For example, 58% of candidates who have been examined in the clinical examination since the beginning of 2015 waited 12 months or less for a clinical examination place and 26% waited six months or less.

**Review and clarification of the 'short-term training' pathway**

This pathway is for IMGs who are overseas-trained specialists or specialists-in-training, who wish to undertake a short period of specialist or advanced training in Australia. While the pathway has been in place since the COAG-led introduction of the pathways to registration, there was little information published and stakeholders reported that the pathway was confusing.

After consulting with stakeholders, the MBA published guidance on the short-term training pathway. This clearly explains the operation of the pathway and the responsibilities of specialist medical colleges and IMGs. The guidelines also introduced additional flexibility to deal with issues that had arisen in the past. The guidance is at **Attachment E**.

## Other changes that relate to recommendations in the *Lost in the labyrinth* report:

A response to each recommendation in the *Lost in labyrinth* has been provided at **Attachment A**. The overview below outlines some of the related work undertaken by the MBA, AHPRA and the AMC.

**Primary source verification – streamlining processes**

The AMC has collaborated with the Educational Commission for Foreign Medical Graduates (ECFMG) to streamline the primary source verification (PSV) process for IMGs. IMGs now apply directly to the ECFMG's online service, the Electronic Portfolio of International Credentials (EPIC) to have their medical qualifications verified.

EPIC enables applicants to upload their qualifications for verification electronically and stores their qualifications and the results of PSV. Medical practitioners can build a digital portfolio of verified qualifications that can be accessed by authorised organisations around the world. It eliminates the multiple paper-based processes under the previous EICS verification system and allows practitioners to arrange for PSV before they apply for registration.

Medical practitioners are able to track the progress of their PSV online through the ECFMG and/or through an AMC online service. Qualifications and results of PSV are sent from the ECFMG directly to the AMC electronically and uploaded to the AMC secure portal. The AMC secure portal is used by AHPRA and the specialist medical colleges for registration and assessment purposes respectively.

The EPIC system removes multiple steps required under the previous EICS verification system and reduces processing times from 90 – 100 days to 8 – 10 days.

**Review of the Pre-employment structured clinical interview (PESCI)**

Pre-employment structured clinical interviews (PESCIs) are an objective assessment of IMGs' knowledge, skills, clinical experience and attributes to determine whether they are suitable to practise in a specific position. IMGs are required to have a PESCI when they are seeking to work in higher risk positions, such as general practice and senior non-specialist positions. The PESCI consists of a structured clinical interview using scenarios and the results of the PESCI provide valuable information to the MBA when deciding whether to register a practitioner to work in a high risk position.

At the request of the MBA, the AMC reviewed the guidelines for PESCIs. The AMC consulted widely about the guidelines and the approved AMC and MBA *Pre-employment Structured Clinical Interview Guidelines and Criteria for AMC approval of PESCI providers* came into effect from 1 March 2015.

The PESCI guidelines are published on the MBA and AMC websites. They provide information about PESCIs, including when a PESCI is required and what a PESCI involves. The guidelines describe the

roles and responsibilities of stakeholders and AMC approved providers and define the criteria for the AMC approval of PESCI providers.

The MBA has also published additional information about PESCIs on its website.

**Revised English language skills registration standard**

The MBA, with 12 other National Boards, reviewed their English language skills registration standards in 2013. An approved common revised English language skills registration standard came into effect from 1 July 2015 and was informed by wide-ranging consultation and independent research commissioned by AHPRA.

AHPRA has published a consultation report that provides the rationale for the content of the final revised registration standards of 13 National Boards. See **Attachment F**.

In summary, the main issues identified by stakeholders were:

- the requirement for obtaining test results in one sitting for two prescribed tests (IELTS and OET) was too onerous and should be relaxed
- the list of recognised countries was limited and did not reflect that there are other countries where English is the primary language, and
- there was a need for more flexibility.

The MBA and the other National Boards have retained the list of recognised countries, as there was little objective evidence to support the addition of other countries. With the exception of South Africa, the list of recognised countries is consistent with the countries recognised by the Department of Immigration and Border Protection for English language assessment purposes.

The revised standards increase flexibility by:

- extending the validity period of tests when the applicant has been practising or studying in English in a recognised country
- accepting test results from two sittings, within defined parameters, and
- adding two other test options and providing for the addition of other tests if they become available.

The revised standard has been approved by the Australian Health Workforce Ministerial Council and has been successfully implemented.

**Transparent, clear information for IMGs**

The MBA has been improving the information it publishes for IMGs on its website. The MBA has a dedicated webpage for IMGs that describes the available assessment pathways and registration types.

The website contains detailed information and flowcharts to help IMGs easily identify which pathway is relevant to them and what to expect from the different assessment processes.

The MBA has also collaborated with the AMC and the specialist medical colleges and developed guides on the specialist pathway for use by each organisation that ensure IMGs have access to consistent information.

**Revised supervision guidelines for IMGs**

All IMGs with limited or provisional registration must have supervision. This supports individual IMGs and promotes patient safety.

The MBA has revised its supervision guidelines to make the responsibilities of supervisors, IMGs and employers more explicit. See Attachment F. The MBA has also introduced a compulsory training and assessment module for supervisors to provide assurance that they understand their obligations.

The revised guidelines provide more detail about the requirements of each level of supervision and provide more flexibility for practice in other contexts, such as hospitals that have existing supervision structures in place.

## Concluding remarks

The early days of the National Registration and Accreditation Scheme were challenging. Practitioners from a range of professions and a range of registration categories found the registration process to be difficult to navigate. In the past six years AHPRA's registration systems have become much more mature and robust and there has been significant streamlining.

As well as improving registration processes for all practitioners, the MBA and AHPRA have implemented most of the recommendations in the *Lost in the labyrinth* report to improve assessment and registration processes for IMGs. We have worked also with other organisations such as the AMC and specialist medical colleges to improve information for IMGs and to reduce unnecessary complexity, duplication and cost.

While Australia's reliance on IMGs appears to be reducing, we are committed to continuing to streamline assessment and registration processes for IMGs, so these are transparent, effective, efficient and fair, while maintaining high standards to protect the community. We invite feedback from our stakeholders about how to improve registration processes.

However, we acknowledge that registration for IMGs is complex. The complexity has developed over time to deal with IMGs as individuals. While the simplest way to reduce the complexity would be to design a single pathway for all IMGs, this would reduce flexibility, would not allow for the need for different skills and experience in different contexts and may have serious workforce consequences.

# Summary of actions arising from the 'Lost in the Labyrinth' report

The following table provides a status report on the recommendations in 'Lost in the Labyrinth' that refer to responsibilities and functions of the Medical Board of Australia (the MBA), the Australian Health Practitioner Regulation Agency (AHPRA) and the Australian Medical Council (AMC).

| Recommendations | Status |
|---|---|
| **Recommendation 1**<br><br>The Committee recommends that the Australian Medical Council (AMC), in consultation with the Medical Board of Australia (MBA) and international medical graduates (IMGs), take steps to assist IMGs experiencing difficulties and delays with primary source verification, including but not limited to:<br><br>• continuing to assist IMGs who have passed all requirements of a pathway towards registration as a medical practitioner, excepting primary source verification;<br><br>• liaising with the Educational Commission for Foreign Medical Graduates to ascertain and address any barriers to achieving timely primary source verification; and<br><br>• providing IMGs with up-to-date information relevant to their application, including the anticipated timeframe for response based on | This recommendation has been implemented.<br><br>The current and revised registration standards for limited registration require that a practitioner has submitted their qualifications for primary source verification (PSV) when they apply for limited registration. They do not need to have completed the PSV. This policy decision was made because the Board recognises there are delays in PSV that are beyond the control of the applicant. There are safeguards in place to detect potentially fraudulent documents, even before PSV.<br><br>The AMC collaborated with the Educational Commission for Foreign Medical Graduates (ECFMG) to streamline the PSV process for IMGs. IMGs now apply directly to the ECFMG's online service, the Electronic Portfolio of International Credentials (EPIC) to have their medical qualifications verified.<br><br>EPIC enables applicants to upload their qualifications for verification electronically and stores their qualifications and the results of PSV. Medical practitioners can build a digital portfolio of verified qualifications that can be accessed by authorised organisations around the world. It eliminates the multiple paper-based processes under the previous EICS verification system and allows practitioners to arrange for PSV before they apply for registration.<br><br>Medical practitioners are able to track the progress of their PSV online through the ECFMG and/or through an AMC online service. Qualifications and results of PSV are sent from the ECFMG directly to the AMC electronically and uploaded to the AMC secure portal. The AMC secure portal is used by AHPRA and the specialist medical colleges for registration and assessment purposes respectively. |

| Recommendations | Status |
|---|---|
| their application, or options on how they might hasten the process, such as contacting the institution directly. | The EPIC system removes multiple steps required under the previous EICS verification system and reduces processing times from 90 – 100 days to 8 – 10 days.<br><br>The AMC continues to be in regular contact with the ECFMG on issues arising from the primary source verification of medical qualifications and individual IMG cases. Based on the information provided by the ECFMG, the AMC continues to list individual institutions that are slow to respond to verification requests on the AMC website. |
| **Recommendation 2**<br><br>The Committee recommends that the Australian Medical Council take action to increase the availability of the Australian Medical Council Structured Clinical Examination (SCE) so that those making a first attempt at the examination be accommodated within six months of their initial application. | Implementation of this recommendation is progressing well.<br><br>With financial support from the Commonwealth Government and Health Workforce Australia, the AMC has established a dedicated clinical exam centre in Melbourne to allow exams to be administered on a rolling basis. The AMC has eliminated wait times for candidates to sit the clinical exams and IMGs can book to sit scheduled exams through an online booking system.<br><br>Before commissioning the National Test Centre, the waiting times for IMGs who had passed the MCQ examination to sit a clinical examination was between 24 to 36 months. Since the NTC became operational, the AMC has been clearing the backlog of candidates who were waiting for the clinical examination. Although the AMC is still clearing candidates who qualified at the MCQ examination in 2010, 2011 and 2012, 58% of candidates who have been examined in the clinical examination since the beginning of 2015 waited 12 months or less for a clinical examination place and 26% waited six months or less. |
| **Recommendation 3**<br><br>The Committee recommends that the Australian Medical Council publish detailed information on its website outlining the processes for determining the allocation of places for the Structured Clinical Examination (SCE). The information should explain prioritisation, the purpose and operation of the standby list and provide up-to-date information on waiting times for undertaking the SCE. | This recommendation is no longer relevant.<br><br>The prioritisation of applications for places in the clinical examination has been overtaken by the implementation of the National Testing Centre with expanded capacity for clinical examinations.<br><br>It is no longer necessary to prioritise applications for AMC examinations. The AMC has implemented a new and improved online exam scheduling system. IMGs now view online when exams are scheduled and what places are available. They can then book to sit the exam online.<br><br>There is a great deal of information about the clinical exam, the process, exam dates and how to apply published on the AMC website. |

| Recommendations | Status |
|---|---|
| **Recommendation 4**<br><br>The Committee recommends that the Australian Medical Council provides a detailed level of constructive written feedback for candidates who have undertaken the Australian Medical Council's Structured Clinical Examination. | There has been work done to provide additional feedback to candidates who have undertaken the AMC's Structured Clinical Exam.<br><br>The Board and the AMC support in principle the concept of providing improved feedback to candidates, but it is a challenge with any 'high stakes' examination, including the SCE to provide enough feedback to assist candidates to improve their performance without compromising the integrity/confidentiality (and therefore the validity) of the examination. This remains a careful balance.<br><br>In May 2014, the AMC implemented a new scoring system for clinical examinations. Candidates are now provided individual station level feedback showing performance by the Key Steps, the numeric scoring of the levels of performance observed and the global rating. This provides additional feedback to candidates without compromising the validity of the examination.<br><br>In addition to the improved feedback, in 2014 the AMC implemented a new appeals procedure which includes provision for candidates to have access to the video recordings of clinical examination stations where the result of the station is disputed. An independent Appeals Panel can hen review the recording and any submissions made by the candidate Unlike AMC clinical examinations prior to the establishment of the NTC, the appeals can now be decided on the basis of the actual performance of the candidate as recorded, thereby engancing the transparency of the assessment process. |
| **Recommendation 5**<br><br>The Committee recommends that the Council of Australian Governments include workplace-based assessment (WBA) pathway for international medical graduates on its health workforce agenda in order to extend endorsement from state and territory governments and increase the availability of host sites nationally. | This recommendation is outside the scope of the MBA or AHPRA. |
| **Recommendation 6**<br><br>The Committee recommends that the Medical Board of Australia in conjunction with the Australian | Following the 'Lost in the Labyrinth' report, the AMC, with the Australian Department of Health and Ageing, hosted a workshop with stakeholders and interested parties to promote the work place based assessment (WBA) and exchange views about them. |

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| Medical Council, commission an independent evaluation of the workplace-based assessment (WBA) model. The evaluation should incorporate a cost benefit analysis of WBA, and encompass the views of all stakeholders, including international medical graduates, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public. | There has been a cost analysis of the WBA program of Newcastle University that was reported in the Medical Journal of Australia (MJA 2014; 200:41-44). The analysis found that the WBA was a cost effective program that helped to offset the cost of recruiting doctors for health services.<br><br>While there has been some expansion of WBA providers, it remains a 'boutique' form of assessment. The AMC continues to support and promote WBA but further expansion can only be achieved if institutions agree to run the program. |
| **Recommendation 7**<br><br>The Committee recommends that the Australian Government Department of Health and Ageing and Australian Medical Council, in consultation with the Joint Standing Committee on Overseas Trained Specialists and the specialist medical colleges:<br><br>a) publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration;<br><br>b) develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability<br><br>c) develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are taken into account when determining the length of time an IMG needs to spend under peer review; and<br><br>d) develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs' | These recommendations have either been achieved or are in progress.<br><br>The role of the Joint Standing Committee on Overseas Trained Specialists has been taken over by the Medical Board's National Specialist International Medical Graduate (IMG) Committee.<br><br>A response to each recommendation is provided:<br><br>a) As part of the work to streamline the specialist pathway process, the MBA reviewed the definitions of comparability. After consultation, revised comparability definitions came into effect on 1 July 2014 and are published.<br><br>The Board was aware that over time, some colleges had modified comparability definitions and assessment practice was becoming divergent between colleges.<br><br>The current revised comparability definitions clarify that specialist medical colleges must take into consideration an IMG's previous training, assessment, recent specialist practice and continuing professional development to determine comparability to an Australian trained specialist. The revised comparability definitions also define the maximum length of oversight or training that can be imposed.<br><br>b) As well as revising the comparability definitions, the MBA has developed and published *Good practice guidelines for the specialist international medical graduate assessment process* (Good practice guidelines) that provide additional guidance to colleges on how the comparability definitions are to be applied.<br><br>The guidance requires colleges to consider an applicant's previous training, assessment, recent specialist practice and continuing professional development. However, it avoids being prescriptive about how colleges should use these to determine comparability. The Board has preferred to maintain flexibility and avoid introducing unintended consequences, such as excluding individuals who do not |

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| professional qualifications and rates of success. | fit the guidelines.<br>c) The comparability definitions define the maximum period an IMG assessed as 'substantially comparable' may spend under peer review i.e. up to 12 months. IMGs assessed as 'partially comparable' are required to complete up to 24 months of upskilling or other associated assessment (which may include formal exams). The revised comparability definitions make clear that the period of peer review or upskilling/other assessment must not exceed the maximum period defined for the associated level of comparability.<br>d) With the implementation of the changes to the specialist pathway from 1 July 2014, the specialist medical colleges are collecting data on the specialist pathway processes for the MBA. Before this, the AMC collected this information for stakeholders including the Medical Training Review Panel (MTRP). The MBA has published the data covering the 2015 calendar year. The Board will continue to provide data for the MTRP reports. The MBA data will include de-identified data on IMGs' country of origin and the outcome of the comparability assessment. |
| **Recommendation 8**<br>The Committee recommends that specialist medical colleges adopt the practice of using workplace-based assessment (WBA) during the period of peer review to assess the clinical competence of specialist international medical graduates (IMGs) in cases where applicants can demonstrate that they have accumulated substantial prior specialist experience overseas. As part of the WBA process the specialist medical colleges should make available the criteria used to select WBA assessors.<br>Specialist medical college examinations should only be used as an assessment tool where specialist IMGs are recent graduates, or where deficiencies or concerns have been identified during WBA. | The actions outlined in this recommendation have been in place for some time.<br>Some of the concerns raised about this issue may stem from a possible misunderstanding of the distinction between the assessment outcomes of 'substantially comparable' and 'partially comparable'. It is important to understand that the 'peer review' or 'working under oversight' provision in the assessment of specialist IMGs is intended for specialist IMGs who have been assessed as 'substantially comparable'. Specialist medical colleges are using workplace-based performance assessment for this purpose.<br>Specialist IMGs who have been assessed as 'partially comparable' are required to complete further training or up skilling to achieve the standard required for a 'substantially comparable' assessment. As such, they may reasonably be required to complete formal assessment of their competence in identified areas of additional training or up skilling.<br>To eliminate misunderstandings between the different levels of comparability, the MBA made the following changes to the definition for 'substantially comparable':<br>a) incorporated the use of WBAs in the definition, and<br>b) confirmed that IMGs who successfully complete the period of peer review are eligible for Fellowship without formal examination. |

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| | The *Good practice guidelines* developed for the specialist medical colleges reiterate this advice.<br><br>Many Colleges publish their criteria to select WBA/peer review assessors. |
| **Recommendation 9**<br><br>The Committee recommends that all specialist medical colleges consult with the Australian Medical Council to ensure each college undertakes a consistent three-stage appeals process, incorporating the following:<br><br>• an automatic right for an international medical graduate (IMG) to undertake the next stage of appeal, following completion of each preceding appeal;<br><br>• the option for the IMG to retain an advocate for the duration of any appeal process to an Appeals Committee, including permission for that advocate to appear on the IMG's behalf at the appeal itself; and<br><br>• the capacity to expand membership of the Appeals Committee to include an IMG who holds full membership of the relevant specialist college, but has no involvement with the decision under review. | The actions outlined in this recommendation are in place.<br><br>The National Scheme's objective of facilitating the provision of high quality education and training of health practitioners is enabled through the accreditation function.<br><br>The AMC accreditation standards for specialist medical education, approved by the MBA, define the standards specialist medical colleges must meet to become an accredited education provider. The standards require colleges to have reconsideration, review and appeals processes that are transparent, timely and credible, and which afford procedural fairness. The colleges are also required to publish information about the appeals processes.<br><br>The AMC regularly reviews and monitors accredited education providers to ensure they continue to meet the accreditation standards, including the standards that refer to appeals processes.<br><br>The MBA's *Good practice guidelines* also require specialist medical colleges to have a documented and published appeals process consistent with the AMC accreditation standards. The specialist medical colleges have published information about reconsideration, review and appeals mechanisms. |
| **Recommendation 10**<br><br>The Committee recommends that the specialist medical colleges undertake the following steps to ensure international medical graduates (IMGs) are aware of their right of appeal regarding their | The actions outlined in this recommendation are in place.<br><br>Appeals processes are published and communicated to IMGs.<br><br>The AMC Accreditation Standards include standards that relate to appeals for trainees and IMGs. Colleges have to provide specific information to the AMC that address these standards, including the |

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| application for specialisation:<br>• publish information regarding their appeals process in a prominent place on their website, including information regarding each stage of the appeals process, timelines for lodging appeals and the composition of Appeals Committee membership; and<br>• ensure that IMGs are informed of their right to appeal when any decision is made regarding their application, with information regarding their right to appeal a particular decision provided in writing on the same document advising the IMG of the decision made regarding their application. | number of appeals and outcomes, their appeals policy, and evidence that information on the policy is accessible to trainees and IMGs.<br>The AMC asks trainees and IMGs (in meetings and surveys) about their experience of dispute resolution processes, and confidential feedback mechanisms. All AMC accreditation reports comment specifically on appeals processes. The AMC monitors changes in these processes through progress reports.<br>Colleges also report to the Medical Board and AHPRA the number of appeals each year. The Board publishes these data. |
| **Recommendation 11**<br>The Committee recommends that the Australian Health Ministers Advisory Council, in conjunction with the Australian Government Department of Health and Ageing and the National Health Practitioner Ombudsman, develop and institute an overarching, independent appeals mechanism to review decisions relating to the assessment of clinical competence to be constituted following an unsuccessful appeal by an international medical graduate to the Appeals Committee of a specialist medical college. | While this is not for a response by the MBA or AHPRA, it is evident from the responses to recommendations 9 and 10 that there are already appeals processes in place in the specialist medical colleges, which are subject to regular external monitoring by the AMC.<br>There are significant risks associated with adding a further appeals mechanism to review decisions relating to the assessment of clinical competence, particularly if the assessment is undertaken by individuals who are not expert in the relevant field of specialist practice. |
| **Recommendation 12**<br>The Committee recommends that Health Workforce Australia, in consultation with state and territory | As far as the Board and AHPRA are aware, there has not been progress on this recommendation.<br>While the Recommendation has merit, it may be difficult to implement because of the competition for |

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| health departments, the Medical Board of Australia, specialist medical colleges and other key stakeholders, investigate options to ensure equitable and fair access to clinical supervision places for international medical graduates. Consideration should include establishing designated supervised placements for international medical graduates in teaching hospitals or similar settings. | positions for local health students as well as positions for the increasing number of medical graduates.<br><br>The increased number of local graduates and the consequent reduction in reliance on IMGs to meet workforce needs, may reduce the need for clinical supervision places for IMGs. The MBA's revised supervision guidelines, in conjunction with the revised Registration Standard for limited registration for area of need (which requires that IMGs have considerable general practice experience before they can be registered to practise in general practice) may also reduce the need for the recommendation. |
| **Recommendation 13**<br><br>The Committee recommends that the Australian Medical Council, the Medical Board of Australia and specialist medical colleges collaborate to develop a process which will allow semi or recently retired medical practitioners and specialist practitioners to maintain a category of registration which will enable them to work in the role of a clinical supervisor. | The intention of this recommendation appears to be to free up potential supervisors for IMGs.<br><br>The Board expects that clinical supervisors have current experience and knowledge to support them to fulfil this important and highly responsible role. The Board's registration standard for recency of practice mandates a minimum amount of practice necessary as a requirement of registration.<br><br>Semi-retired practitioners who complete the requirements for registration can supervise IMGs if they meet all the other requirements.<br><br>The registration categories available under the National Law allow semi-retired doctors to be registered so they can be involved in teaching.<br><br>The National Law imposes certain obligations on all registered medical practitioners (excluding those with non-practising registration). These obligations include the requirement to have recency of practice (recency can be achieved through the teaching roles), participation in continuing professional development (CPD) activities and holding professional indemnity insurance (PII).<br><br>Registration requirements are not onerous and have been developed to support safe practice. They are consistent with community expectations that medical practitioners who are registered will keep their skills and knowledge up to date in the areas in which they are involved. |
| **Recommendation 14**<br><br>The Committee recommends that Health Workforce Australia provide support under the Clinical | This recommendation is outside the scope of the MBA or AHPRA. |

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| Supervision Support Program to promote the innovative use of new technologies to increase clinical supervision capacity, particularly for medical practitioners who are employed in situations where they have little or no access to direct supervision. | |
| **Recommendation 15**<br><br>The Committee recommends that prior to undertaking practice in an area of need position or regional, rural, remote position with indirect or limited access to clinical supervision, international medical graduates (IMGs) be placed in a teaching hospital, base hospital or similar setting. Within this setting IMGs could be provided appropriate supervision for a defined period to further establish their clinical competency and assist with their orientation to the Australian health care system. | This recommendation is outside the scope of the MBA or AHPRA.<br><br>The recommendation has merit but may be difficult to achieve in the context of competition for supervised positions by Australian graduates as well as issues of funding the positions and finding supervisors.<br><br>As the number of local graduates increases and there is reduced reliance on IMGs, it would not be unreasonable to expect that the IMGs who are offered positions in areas of need are better qualified and have less need for the additional assessment.<br><br>A further safeguard is that the recently approved registration standard for limited registration for area of need advises that applicants should have three years experience in general practice or primary care before they are granted limited registration for area of need to work in general practice. |
| **Recommendation 16**<br><br>The Committee recommends that Health Workforce Australia ensure aspects of cross cultural awareness and communication issues are key components in any guidelines, educational materials or training programs that are developed to support enhanced competency of clinical supervisors. | While AHPRA and the MBA support this recommendation, it is outside our scope.<br><br>However, the MBA has approved revised guidelines for the supervision of IMGs. The guidelines require supervisors to successfully complete a compulsory online education module to demonstrate that they are aware of the MBA's supervision requirements. Among other things, supervisors have to ensure that IMGs have orientation on cultural diversity and the Australian social context of care. |
| **Recommendation 17**<br><br>The Committee recommends that the Medical Board of Australia/Australian Health Practitioners | This recommendation has been implemented.<br><br>The Board has published a great deal of information about PESCIs on its website that is easy to locate in the section on IMGs. The information includes: |

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| Registration Agency provide more information on the Pre-Employment Structured Clinical Interview (PESCI).<br><br>At a minimum this information should outline:<br><br>• the criteria used to determine the need for an IMG to undertake a PESCI assessment; and<br><br>• criteria for accreditation of PESCI providers.<br><br>• details of the PESCI assessment process including:<br><br>o the composition of the interview panel, the criteria used for selecting panel members and their roles and responsibilities;<br><br>o the format of the interview and the aspects of skills, knowledge and experience that will be assessed;<br><br>o criteria for assessment and mechanisms for receiving feedback; and<br><br>o the process for lodging and determining an appeal against the findings of a PESCI assessment.<br><br>This information should be easily located on the MBA/AHPRA website and provide links to relevant information on PESCIs that is available on the websites of Australian Medical Council accredited PESCI providers. | • what a PESCI is and what it involves<br><br>• who needs a PESCI<br><br>• what the recommendations of the PESCI panel mean<br><br>• who are accredited PESCI providers and how are they accredited<br><br>• what does it mean if a PESCI finds that an applicant is not suitable for a position.<br><br>PESCIs were also reviewed and revised Pre-employment Structured Clinical Interview Guidelines and Criteria for AMC approval of PESCI providers were published on the AMC and MBA websites. The<br><br>The revised guidelines include:<br><br>• when a PESCI is required and what a PESCI involves<br><br>• the roles and responsibilities of stakeholders and AMC approved providers<br><br>• the criteria for the AMC approval of PESCI providers.<br><br>There are also links from the MBA website to the websites of the accredited PESCI providers and the AMC. |

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| **Recommendation 18**<br><br>The Committee recommends that all Pre-Employment Structured Clinical Interview (PESCI) assessments be video-recorded and a copy of the video-recording be provided to the applicant for the purpose of providing appropriate feedback on the assessment and as a record should an international medical graduate wish to appeal the outcome of a PESCI. | While PESCI providers are not prevented from video-recording PESCIs, they are not required to do so. The Board and AHPRA have concerns about implementing this recommendation.<br><br>The MBA and AHPRA agree that it is helpful and appropriate for applicants to have feedback on their performance in the PESCI. The review of the PESCIs included the development of nationally consistent templates for reporting a PESCI outcome to the MBA and to the applicant. The templates require PESCI providers to give reasons for their recommendation about whether an applicant is suitable or not suitable for a specific position. The applicant is therefore provided with written feedback on their performance.<br><br>However, the recommendation to video-record PESCIs has not been implemented because the PESCI is an assessment of fitness for task. It is intended to inform the MBA and AHPRA of the suitability of the IMG for a specific area of need or limited registration position. The assessment is part of a risk management strategy and is used to determine the conditions that need to be placed on the registration of the IMG to ensure the safety of the public. It is not structured or intended to be a formal assessment of qualifications or relevant experience for the purposes of general registration.<br><br>The proposal to introduce video recording of the PESCI process would introduce a level of technical complexity and cost to the process that does not appear to be justified, given the purpose of this assessment and the number of candidates to whom the video would be of any benefit. |
| **Recommendation 19**<br><br>The Committee recommends that the Medical Board of Australia, as part of its current review of the utility and portability of Pre-Employment Structured Clinical Interview, include broader consideration of its utility as an assessment tool, particularly its application to international medical graduates who have already practised in Australia for a significant period of time under Limited Registration. | The MBA and AHPRA, with the AMC, considered this recommendation during the review of PESCIs and the associated guidelines. We concluded that the portability of PESCI results is limited, as a PESCI assesses an applicant against the requirements of a specific position.<br><br>The Board takes into consideration feedback and supervision reports about IMGs who have already practised in Australia with limited registration. Longitudinal assessment is probably more valid than a point in time assessment that is designed for a particular position. |
| **Recommendation 20**<br><br>The Committee recommends that the Medical Board | This PESCI review has been completed and the recommendation was largely actioned.<br><br>The AMC publicly consulted on the revised PESCI. The MBA referred to the consultation and invited |

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| of Australia provide an opportunity for interested parties, including international medical graduates, to provide input into its current review of the utility and portability of Pre-Employment Structured Clinical Interviews.<br><br>To promote transparency, the Medical Board of Australia should also provide regular updates on the review on its website, and at the conclusion of the review publish its findings. | feedback on it in its April 2014 edition of its electronic newsletter, the Medical Board Update, that is sent to more than 95% of all registered medical practitioners.<br><br>The Board also published an article in the February 2015 edition of the Medical Board Update, announcing the revised guidelines.<br><br>The approved revised guidelines are published on the websites of the Board and the AMC. |
| **Recommendation 21**<br><br>The Committee recommends that the Medical Board of Australia review whether the current English Language Skills Registration Standard is appropriate for international medical graduates.<br><br>The review should include consideration of:<br><br>• whether the International English Language Testing System and Occupational English Test scores required to meet the English Language Skills Registration Standard is appropriate; and<br><br>• the basis for requiring a pass in all four components in a single sitting. | This recommendation has been actioned.<br><br>In 2013, 13 National Boards including the Medical Board, reviewed their English language skills registration standards.<br><br>The review of the English language standard was informed by the National Boards' experience with their standards in the first three years of operation of the National Scheme. AHPRA also commissioned independent research and the Boards consulted with stakeholders.<br><br>After Ministerial Council approval, 13 National Boards, including the MBA, implemented a revised largely common English language standard from 1 July 2015.<br><br>The revised English language registration standard is more flexible and provides additional pathways for IMGs to demonstrate English language competence without comprising standards for safe practice.<br><br>Stakeholder feedback on the minimum test scores was varied and inconclusive. However the commissioned research indicated the MBA's minimum IELTS and OET scores were appropriate in the context of health profession regulation. In the absence of contradicting evidence, the MBA maintained the previous minimum scores in the revised standard. It should be noted that research commissioned by the General Medical Council (UK) found that the MBA's current minimum overall score of 7 for IELTS and a minimum of 7 for each component is not adequate for screening English language competency and recommended the overall score be increased to 8 with a minimum of 8 in two components and a minimum of 7.5 in the other two components. The GMC has decided to increase its minimum overall score to 7.5 for IELTS with a minimum score of 7 for each component.<br><br>Based on stakeholder feedback and the commissioned research, which did not provide a conclusive |

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| | answer on whether to accept test results from multiple sittings, the MBA revised standard accepts results from a maximum of two sittings within defined parameters. This approach provides some flexibility and balances the need to ensure test results indicate an applicant's true language ability.<br><br>A consultation outcome report on the review of the English language registration standard, which includes a summary of the independent research, has been published and is at Attachment E. |
| **Recommendation 22**<br><br>The Committee recommends that the Medical Board of Australia negotiate with providers of the International English Language Testing System and Occupational English Test with a view to requiring that detailed, qualitative written feedback on each component of the English Language test be provided in writing to international medical graduates to enable identification of areas of deficiency which may be rectified. | This recommendation has not been actioned. The providers of English language testing are independent companies. They provide English language testing that is used by a range of organisations, for a range of purposes around the world. |
| **Recommendation 23**<br><br>The Committee recommends that the Medical Board of Australia extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a minimum period of four years. | A comprehensive review of the English language standard has been conducted by 13 Boards and AHPRA. After receiving feedback from test providers and language experts on English language attrition, together with research confirming that a two-year validity period is the norm in comparable countries, the MBA has retained the validity period of two years, but has made some changes to increase flexibility.<br><br>The English language skills registration standard allows the two-year validity period to be extended when an applicant has maintained their English language skills through continued use of English language, either through study or work in English in one of the recognised countries. |
| **Recommendations 24**<br><br>The Committee recommends that the Medical Board of Australia/Australian Health Practitioners Registration Agency provide the Australian | We have not received any recent feedback that the Department of Immigration and Border Protection is having difficulty sourcing information from the MBA or AHPRA for the purposes of determining whether to grant a visa to an IMG. Meetings held after the introduction of the National Scheme confirmed that the process, in which the Board approves an application for registration 'in principle' to enable the DIBP to |

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| Government Department of Immigration and Citizenship with direct access to information on its registration database as necessary to determine granting of a visa for employment purposes. | issue a visa, is working well.<br><br>However, the MBA and AHPRA are happy to work with the Department on ways to improve the provision of registration information if required. |
| **Recommendation 25**<br><br>The Committee recommends that the Australian Government Department of Health and Ageing produce and publish on its website a comprehensive guide detailing how District of Workforce Shortage (DWS) status is determined and how it operates to address issues of medical practitioner workforce shortages. The guide should include detailed information on the following:<br><br>• the methodology of DWS determination;<br><br>• frequency of DWS status review; and<br><br>• criteria for benchmarking of appropriate workforce levels. | This recommendation is outside the scope of the MBA and AHPRA. |
| **Recommendation 26**<br><br>The Committee recommends that the Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining Area of Need (AoN) status based on agreed criteria. Consideration should also be given to improving the alignment between the AoN and Districts of Workforce Shortage. | While this recommendation is supported, it is outside the scope of the MBA and AHPRA. |

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| **Recommendation 27**<br><br>The Committee recommends that the Department of Health and Ageing, in association with Health Workforce Australia, examine options for a planned, scaled reduction in the length of the 10 year moratorium so that it is consistent with the average duration of return of service obligations that apply to Australian graduates of Bonded Medical Places. Workforce modelling should be used to determine the implications for workforce preparation, transition, training and distribution. The outcomes should be made publicly available. | This recommendation is outside the scope of the MBA and AHPRA. |
| **Recommendation 28**<br><br>The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes. Information published on websites should be updated on a quarterly basis. | The MBA and AHPRA support transparency through the reporting and publication of data.<br><br>The MBA has established key performance indicators with AHPRA, which are contained in the Health Profession Agreement between the two entities. The MBA and AHPRA regularly monitor their performance on many parameters, including the time taken to assess applications for registration. The MBA and AHPRA report publicly on performance in the annual report. The 2014/15 annual report stated that it takes on average 27 calendar days to finalise a complete application for limited registration.<br><br>Specialist colleges are now required to report to the Board annually on a range of parameters that are relevant to the assessment of specialist IMGs. These parameters include measures of timeliness, volume and quality (as evidenced through appeals). The Board has publish the 2015 data on its website. The data collected for 1 January 2015 to 31 December 2015 is published and included at Attachment F for information.<br><br>During 2016, the Board developed benchmarks that specialist colleges have to report against for the 2016 calendar year and beyond. These benchmarks include measures of compliance with Good Practice Guidelines and are included at Attachment G.<br><br>The MBA and AHPRA will monitor trends and issues highlighted by the data that are collected and will continue to work with stakeholders to improve performance when required.<br><br>Annual reporting is preferred as the publication of quarterly data is not meaningful and will result in |

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| | considerable administrative burden. |
| **Recommendation 29**<br><br>The Committee recommends that AHPRA's annual report, with respect to the functions carried out by the MBA must also include a number of other key performance indicators providing further information to IMGs. In the Committee's view, these indicators must include (but should not be limited to):<br><br>• the country of initial qualification for each IMG applying for Limited Registration;<br><br>• the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and specialist medical colleges; and<br><br>• the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:<br><br>o Australian Medical Council Multiple Choice Question Examination;<br><br>o Australian Medical Council Structured Clinical Examination;<br><br>o AHPRA's Pre-Employment Structured Clinical Interview (PESCI);<br><br>o the MBA's English Language Skills Registration Standard;<br><br>o other MBA Registration Standards | The MBA and AHPRA are committed to transparency and publish a great deal of data on notification and registration performance in our annual reports. Quarterly registration data are also published on the MBA's website.<br><br>Many of the KPIs in the recommendations are currently collected by the MBA/AHPRA, the AMC and the colleges and are provided for publishing in the annual Medical Training Review Panel report (MTRP).<br><br>From 1 July 2014, colleges have been reporting to the MBA on a range of parameters related to the specialist pathway. The MBA and AHPRA publish this information.<br><br>The AMC routinely publishes the following information in its annual report:<br><br>• AMC CAT MCQ Examination: passes by country of training and number of attempts<br><br>• AMC Clinical Examination, passes by country of training and number of attempts<br><br>• Workplace-based assessment, all candidates, by country of training<br><br>Some of the reporting parameters cannot be reported on. For example, an individual who has not attained the necessary level in the English language proficiency test is unlikely to apply for registration and is therefore unlikely to be known.<br><br>It is questionable whether there is a public interest in publishing certain information that is suggested in the recommendation. For example, AHPRA publishes data when there has been regulatory action taken in relation to the Criminal History Registration Standard. However, it might appear discriminatory to distinguish IMGs when there are no other sub-groups reported on.<br><br>PESCI providers are required to provide an annual report that:<br><br>• reports against each approval criteria, noting any changes in the provider's circumstances<br><br>• includes data on how many PESCIs have been conducted, and whether face to face, teleconference or videoconference, how many applicants were found suitable or not suitable, and the support or supervision required for those found suitable |

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| including Criminal History Registration Standard; and<br>o processes of specialist medical colleges including college interviews, examinations and peer review assessments. | • reports on the number of scenarios the provider has and how often each is used<br>• reports on the number of assessors in the assessor pool and how many have been used in the past twelve months<br>• provides a self-analysis of the quality of assessors and quality of scenarios<br>• reports on any appeals considered and the outcomes of those<br>• details any changes to its capacity to deliver, or plans for any changes in the coming year<br>The AMC will monitor PESCI providers as part of its accreditation function. |
| **Recommendation 30**<br>The Committee recommends that where an international medical graduate considers that the processes prescribed under the National Registration and Accreditation System have placed them at a significant disadvantage compared to their circumstances under the processes of former state and territory medical boards, that the Medical Board of Australia investigate the circumstances, and if necessary rectify any registration requirements to reduce disadvantage. The process and procedure for review should be clearly outlined. Any review should be conducted in a timely and transparent manner. | This recommendation is more than five years old and is probably no longer relevant.<br>Since this recommendation was made, IMGs who have not progressed to general or specialist registration will have had to make a new application for limited registration and meet the registration standards of the day.<br>As a principle, it would be a retrograde step to approve registration if an applicant did not comply with the relevant registration standards. Having said that, the MBA considers every application for registration on its individual merits and may grant registration with conditions to a practitioner who does not meet an element of the standards, if it is appropriate and safe to do so.<br>When the Board refuses an application for registration, the applicant has a right to appeal the decision to the independent Tribunal under the National Law.<br>Looking forward at any future changes to standards, we have processes in place to ensure that stakeholders are informed early about changes. We have comprehensive implementation and transitional arrangements to support the smooth implementation of new standards. A recent example of this is the introduction of the revised English language registration standard. |
| **Recommendation 31**<br>The Committee recommends that the Australian Medical Council and the Medical Board of | AHPRA and the AMC have robust information systems that contain up-to-date information about IMGs in relation to their respective functions.<br>AHPRA and AMC staff can access the necessary information, and have the knowledge to provide timely |

| Recommendations | Status |
|---|---|
| Australia/Australian Health Practitioner Regulation Agency ensure that computer-based information management systems contain up-to-date information regarding requirements and progress of individual international medical graduate's assessment, accreditation and registration status to enable timely provision of advice. | advice to IMGs in relation to their respective functions.<br><br>AHPRA staff can also access the AMC secure portal to obtain information required for registration purposes such as the results of primary source verification, AMC exam results and the outcome of college assessments of IMGs. This sharing of information, done with strict privacy controls, helps AHPRA to provide accurate and helpful information to applicants, to guide them through the assessment and registration processes.<br><br>From 1 October 2015, the AMC introduced the AMC Portfolio system to support the ECFMG electronic primary source verification process (EPIC). See response to recommendation 1. IMGs can now track the progress of their primary source verification applications online through the ECFMG or the AMC Portfolio system. |
| **Recommendation 32**<br><br>The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency implement appropriate induction and ongoing training for all employees responsible for dealing with inquiries. This training should include among other things, an understanding of the overall system of accreditation and registration so that referrals to other organisations can be made where necessary. | This recommendation has been actioned.<br><br>AHPRA conducts mandatory induction programs for all new staff as well as additional specific training for customer service, notification and registration staff.<br><br>To support face-to-face induction and training programs, AHPRA publishes on the intranet up-to-date National Board and AHPRA policies and procedures and training materials that staff to access at anytime.<br><br>Before changes are introduced, AHPRA staff are notified and specific training is provided as relevant.<br><br>AHPRA also has a dedicated national customer service team that receives additional training on AHPRA information systems and notification and registration requirements for all professions |
| **Recommendation 33**<br><br>The Committee recommends that the Medical Board of Australia, in conjunction with the Australian Medical Council and specialist medical colleges, develop a centralised repository of documentation supplied by international medical graduates (IMGs) for the purposes of medical accreditation and | The AMC has developed an electronic information repository that can be accessed by AHPRA and specialist colleges. Access is strictly controlled and monitored.<br><br>The electronic repository or 'AMC portal' as it is known includes:<br><br>• AMC information – examination outcomes, AMC certificates awarded, primary source verification information<br><br>• Specialist college information – results of assessments of comparability. Colleges can also upload |

| Recommendations | Status |
|---|---|
| registration.<br><br>The central document repository should have the capacity to:<br><br>• be accessed by relevant organisations to view certified copies of documentation provided by IMGs;<br><br>• be accessed by relevant organisations to fulfil any future documentary needs for IMGs without the need for them to resubmit non time-limited documentation multiple times;<br><br>• form a permanent record of supporting documentation provided by IMGs; and<br><br>• comply with the Australian Government's Information Privacy Principles and *Privacy Act 1988* (Cth). | IMG qualifications.<br><br>Both AHPRA and the colleges actively use the AMC secure portal to assess and register respectively.<br><br>The AMC secure portal helps streamline IMG assessment and registration processes by eliminating a number of paper-based processes. For example, rather than requiring colleges or the applicant to provide AHPRA with documents relevant to a specialist assessment, AHPRA simply views the documents from the AMC portal.<br><br>However, the full recommendation has not been implemented and it is unlikely that it is feasible to do so.<br><br>It is relatively straight-forward to upload registration-related documents such as qualifications, results of assessments and primary source verification documents. However, it is prohibitively resource intensive to upload all the documentation that a college might rely on to assess comparability, as it can be thousands of pages, particularly for procedural specialties that might rely on log books. It would also require a system upgrade and ongoing resources to maintain the system that on balance, are difficult to justify. Much of the extensive information that may be required by colleges is not required by the AMC or the Medical Board. Uploading the information is therefore not necessary given the costs involved. |
| **Recommendation 34**<br><br>The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, the Australian Medical Council, and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible. These requirements should be developed with a view to further reducing duplication by preventing the need for international medical graduates (IMGs) to lodge the information more than once and in different forms and formats.<br><br>This documentation should form part of an IMG's | The MBA and AHPRA, AMC and specialist colleges have worked towards requiring consistent requirements for supporting documentation. This principle has been put into practice through guidelines and through routine processes:<br><br>• The MBA *Good practice guidelines* require colleges to use MBA/AHPRA format for documentary evidence wherever possible (e.g. certifying documents, format of curriculum vitae).<br><br>• The specialist medical colleges return documents to IMGs once they have been scanned so that IMGs can re-use them if necessary.<br><br>• The AMC has returned documents to IMGs since 2013 so they can re-use them if necessary.<br><br>• Since 1 October 2015 with the introduction of the new online application processing system and the EPIC process for primary source verification of qualifications, IMGs no longer submit documentation to the AMC. |

| Recommendations | Status |
|---|---|
| permanent record on a central document repository. | We will continue to work to streamline documentation requirements where possible. |
| **Recommendation 35**<br><br>The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Registration Agency amend requirements so that Certificates of Good Standing provided by past employers remain valid for a period of 12 months, noting the following:<br><br>• where there is a period of greater that three months since the last Certificate was issued, applicants must certify that they have not been employed in medical practice during that period; or<br><br>• where applicants have been employed in medical practice since issuing of the last Certificate, additional Certificate(s) of Good Standing must be provided.<br><br>Certificates of Good Standing should also be available on a central document repository. | A *Certificate of Good Standing (COSGS)* is a statement from an overseas regulatory authority that provides information to the MBA about whether an applicant for registration has any outstanding matters that may impact on a decision to grant registration. An outdated COGS is problematic and cannot be supported, as there may have been serious conduct, health or performance issues about an applicant that the Board would not be able to consider before granting registration to practise in Australia.<br><br>It is important to clarify that COGS are provided by overseas regulatory authorities and not by employers. The period of validity of the COGS is determined by the overseas regulatory authorities, not by the MBA/AHPRA. |
| **Recommendation 36**<br><br>The Committee recommends that specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to international medical graduates (IMGs) seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the | The changes to the specialist pathway introduced from 1 July 2014 define the points of assessment at which colleges can charge fees. The MBA's *Good practice guidelines* state that Colleges will publish fees on their websites and set fees in accordance with the principles of the National Law, including that fees are to be reasonable having regard to the efficient and effective operation of the scheme.<br><br>While the MBA and AHPRA support the current uniformity in approach towards fees, a uniform assessment fee is not feasible. The costs of assessing applicants for comparability differ between colleges, reflecting different approaches. For example, there are significant differences in the approach, and therefore cost implications to assess a specialist IMG in a procedural compared with a non- |

| Recommendations | Status |
|---|---|
| Australian Medical Council and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should be informed about possible penalties which may be applied throughout the assessment process. | procedural specialty.<br><br>It is worth noting that the fees charged for assessment do not reflect the true cost of assessment, as much of this work is done pro-bono. |
| **Recommendation 37**<br><br>The Committee recommends that the Medical Board of Australia/ Australian Health Practitioner Registration Agency, the Australian Medical Council and specialist medical colleges review the administrative fees and penalties applied throughout the accreditation and assessment processes to ensure that these fees can be fully justified in a cost recovery based system. | The MBA reviews its fees on an annual basis. It does not have any penalties that are specific to IMGs.<br><br>As a result of the changes to the specialist pathway and the implementation of *Good practice guidelines*, Colleges have reviewed their administrative fees and penalties.<br><br>Penalties for incomplete applications are not unreasonable and reflect the additional work that has to be done to assess applications. Despite the provision of detailed information and checklists of documents and processes to be followed for certification, some applications remain incomplete. These applications often require multiple follow ups, and repeat correspondence with applicants and re-checking of documentation. This adds considerably to the administrative costs of the assessment process.<br><br>There is evidence that the number of incomplete applications is reducing. We believe this is because applicants are dealing directly with the specialist colleges, rather than working through the AMC. |
| **Recommendation 38**<br><br>The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency increase awareness of administrative complaints handling and appeal processes available to international medical graduates (IMGs) by:<br><br>• prominently displaying on their websites information on complaints handling policies, appeals processes and associated costs; and<br><br>• ensuring when IMGs are advised of adverse outcomes of any review, that the advice contains | Appeals processes against decisions made by the MBA are defined in National Law. Appeals are heard by an external Tribunal.<br><br>If the Board proposes to refuse to grant registration, applicants are invited to make a submission about that proposal. Applicants who are refused registration are provided with information about their right to appeal when the decision to refuse is communicated to them. Information on appeals is also published on the AHPRA website.<br><br>There is information on the AHPRA website about how to make a 'complaint' about administrative processes, including the right to make a complaint to the National Health Practitioner Ombudsman.<br><br>There is information on the AMC website about how to appeal AMC decisions.<br><br>In 2013, the AMC reviewed its appeal procedures in line with access to advanced technology at the National Test Centre. A three-stage appeal procedure has been established, consisting of a first stage |

| Recommendations | Status |
|---|---|
| information on the next step in the appeal process. | administrative review, a second stage review by an independent panel of examiners and third stage review by an external appeal committee. A unique feature of the new appeals procedures is the ability of both the candidate and the second stage panel to review the actual footage of an examination station. This means that the second stage panel is able to alter a result from a Fail to a Pass based on the performance of the candidate in the examination.<br><br>To November 2015, some 109 applications have been considered at the first stage – one resulting in a re-examination. 26 applications have proceeded to the second stage appeal involving 65 test stations. 45 test stations have been reviewed and confirmed as a Fail and 6 stations have been confirmed as a Pass. 14 stations are still under review.<br><br>The AMC specialist accreditation processes (and associated annual reporting provisions) confirm that all specialist medical colleges must have detailed information about their appeals processes available on their websites. |
| **Recommendation 39**<br><br>The Committee recommends that the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies. | The importance of appropriate standards of professional behaviour is clearly identified in the MBA Code of Conduct *Good Medical Practice* which applies to all medical practitioners. The Code contains information about bullying. In Section 4.4.6, the Code states that *"When working in a team, good medical practice involves understanding the nature and consequences of bullying and harassment, and seeking to eliminate such behaviour in the workplace"* and in Section 1.2, the Code states *"... if your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration".*<br><br>The MBA and AHPRA have endorsed the call for action across the health sector to end discrimination, bullying and sexual harassment, after the publication of the report of the Expert Advisory Group (EAG) established by the Royal Australasian College of Surgeons.<br><br>The MBA and AHPRA identified three core areas to consider what more they could do to help end discrimination, bullying and sexual harassment:<br><br>• Accreditation of specialist training: In partnership with the Australian Medical Council, review the standards for specialist education and training to ensure they are explicit and clear about what processes are required to support trainee wellbeing.<br><br>• Specialist IMG assessment: Work with specialist medical colleges to ensure there is enough |

| Recommendations | Status |
| --- | --- |
| | transparency and accountability in their assessment of international medical graduates and that these processes are free from discrimination, bullying and sexual harassment.<br>• Complaints management: While the best place to manage most complaints about discrimination, bullying and sexual harassment is in the workplace in partnership with other relevant agencies, some of the most serious cases may breach the Board's professional standards and require regulatory action to manage risk to patients. |
| **Recommendation 40**<br>The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop and implement a program of orientation to be made available to all international medical graduates (IMGs) and their families to assist them with adjusting to living and working in Australia. In addition to detailed information on immigration, accreditation and registration processes, the program should include:<br>• accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare benefits and services, and information about ongoing support programs for IMGs and their families;<br>• information on Australia's social, cultural, political and religious diversity; and<br>• an introduction to the Australian healthcare system including accreditation and registration processes for IMGs, state and territory health departments and systems along with Medicare.<br>An integral part of the orientation program should be | This recommendation is outside scope for the MBA and AHPRA. |

| Recommendations | Status |
| --- | --- |
| the development of a comprehensive package of information which can be accessed by IMGs and their families prior to their arrival in Australia. | |
| **Recommendation 41**<br><br>The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a nationally consistent and streamlined system of education and training supports for international medical graduates.<br><br>The consultation should include specific consideration of the following:<br><br>• strategies for facilitating access for IMGs working in regional, remote and rural locations, including:<br>- the potential for the innovative use of new technologies including tele/video-conferencing and internet;<br>- the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and<br>- the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.<br>• strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and<br>• the financial and resource implications | This recommendation is outside scope for the MBA and AHPRA. |

| Recommendations | Status |
|---|---|
| associated with providing wider access to educational and training supports. | |
| **Recommendation 42**<br><br>The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment. Such a system should include at a minimum, a particular emphasis on the educational needs of children, along with support and employment prospects for spouses. | This recommendation is outside scope for the MBA and AHPRA. |
| **Recommendation 43**<br><br>The Committee recommends that Health Workforce Australia (HWA), as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for international medical graduates (IMGs) seeking registration in Australia. Serious consideration should be given to the feasibility of providing an individualised case management service for IMGs.<br><br>In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing. | This recommendation is outside scope for the MBA and AHPRA. |
| **Recommendation 44** | This recommendation is outside scope for the MBA and AHPRA. |

| Recommendations | Status |
| --- | --- |
| The Committee recommends that the Australian Government Department of Health and Ageing expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including information on:<br>• details of location;<br>• eligibility;<br>• duration and timing;<br>• cost; and<br>• whether the program is available electronically/remotely | |
| **Recommendation 45**<br>The Committee recommends that the Australian Government Department of Health and Ageing provide a telephone help line to answers questions and provide clarification on information provided on the DoctorConnect website. | This recommendation is outside scope for the MBA and AHPRA. |

Medical Board of Australia | AHPRA

## Data report

# Medical practitioners with limited registration between 2011 and 2015

**Table 1: Total number of medical practitioners with limited registration (all types)**

| Type of limited registration | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| Postgraduate training or supervised practice | | 3295 | 2991 | 2742 | 2162 | 1651 |
| Area of need | | 2335 | 2006 | 1566 | 1261 | 1021 |
| Public interest | | 14 | 9 | 10 | 6 | 3 |
| Teaching or research | | 24 | 22 | 29 | 26 | 30 |
| **TOTAL** | **6221** | **5668** | **5028** | **4347** | **3455*** | **2705#** |

Changes to the competent authority pathway on 1 July 2014 have resulted in a number of medical practitioners being granted provisional registration in 2015 and 2016 who would previously have been granted limited registration. The following table takes into consideration the number of practitioners in the competent authority in 2015 and 2016:

**Table 2: Number of practitioners with limited registration from 2011 to 2014 and number of practitioners with limited and provisional registration in the competent authority pathway for 2015 to 2016**

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| **TOTAL** | **6221** | **5668** | **5028** | **4347** | **4100** | **4034** |

Notes:

2015 – 645 IMGs in the competent authority pathway who hold provisional registration
2016 – 1329 IMGs in the competent authority pathway who hold provisional registration

### Table 3: Number of medical practitioners with limited registration for postgraduate training or supervised practice by state or territory

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| ACT | | 79 | 69 | 85 | 37 | 24 |
| NSW | | 1370 | 1257 | 1140 | 797 | 573 |
| NT | | 11 | 12 | 9 | 12 | 8 |
| QLD | | 238 | 269 | 352 | 319 | 243 |
| SA | | 389 | 346 | 296 | 207 | 144 |
| TAS | | 77 | 55 | 47 | 48 | 43 |
| VIC | | 947 | 810 | 644 | 555 | 408 |
| WA | | 168 | 168 | 161 | 168 | 186 |
| No PPP | | 16 | 5 | 8 | 19 | 22 |
| **TOTAL** | | **3295** | **2991** | **2742** | **2162** | **1651** |

### Table 4: Number of medical practitioners with limited registration for area of need by state or territory

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| ACT | | 19 | 22 | 25 | 18 | 16 |
| NSW | | 169 | 155 | 127 | 119 | 103 |
| NT | | 110 | 77 | 80 | 58 | 42 |
| QLD | | 871 | 585 | 276 | 224 | 184 |
| SA | | 113 | 105 | 94 | 88 | 74 |
| TAS | | 76 | 65 | 60 | 53 | 44 |
| VIC | | 281 | 353 | 384 | 397 | 378 |
| WA | | 689 | 638 | 519 | 301 | 179 |
| No PPP | | 7 | 6 | 1 | 3 | 1 |
| **TOTAL** | | **2335** | **2006** | **1566** | **1261** | **1021** |

### Table 5: Number of medical practitioners with limited registration in the public interest by state or territory

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| ACT | | 1 | 1 | 1 | 1 | |
| NSW | | 3 | - | 1 | 1 | |
| NT | | - | 1 | 2 | 2 | 1 |
| QLD | | - | 1 | 4 | - | |
| SA | | 1 | - | 1 | - | |
| TAS | | 1 | - | - | - | |
| VIC | | 2 | 1 | 1 | 1 | 1 |
| WA | | 6 | 5 | - | - | |
| No PPP | | - | - | - | 1 | 1 |
| **TOTAL** | | **14** | **9** | **10** | **6** | |

**Table 6: Number of medical practitioners with limited registration for teaching or research by state or territory**

| | June 2011 | June 2012 | June 2013 | June 2014 | June 2015 | June 2016 |
|---|---|---|---|---|---|---|
| ACT | | 1 | 1 | - | - | - |
| NSW | | 6 | 8 | 11 | 8 | 6 |
| NT | | - | - | - | 1 | 1 |
| QLD | | 6 | 3 | 4 | 5 | 4 |
| SA | | 1 | 3 | 3 | 3 | 2 |
| TAS | | 1 | - | - | - | - |
| VIC | | 6 | 3 | 3 | 4 | 8 |
| WA | | 3 | 4 | 8 | 5 | 9 |
| No PPP | | - | - | - | - | - |
| **TOTAL** | | **24** | **22** | **29** | **26** | **30** |

Attachment C

Medical Board of Australia

# Report on specialist medical colleges' specialist pathway data

Reporting period: 1 January 2015 – 31 December 2015

Medical Board of Australia | AHPRA

## Introduction

The specialist pathway is for international medical graduates (IMGs) who are overseas-trained specialists seeking specialist registration in Australia (specialist recognition) or who are applying for an area of need specialist level position in Australia. Information about the specialist pathway is available on the Board's website.

On 1 July 2014 changes were made to the specialist pathway for IMGs. IMGs now apply directly to the relevant specialist medical college for assessment rather than through the Australian Medical Council (AMC). The AMC previously collected a range of data on specialist pathway applications. As the AMC no longer collect pathway data, colleges now report their data directly to the Medical Board of Australia (the Board).

Reporting is annual by calendar year. The first report covered the initial six month period 1 July – 1 December 2014. The second report covered 1 January – 31 December 2015. The Board is publishing the data from the first full calendar year of reporting.

All colleges report against the same metrics. The data requested for 2015 includes:

- number and type of applications received in 2015 (application for specialist recognition, area of need or combined (specialist recognition and area of need))
- applicant's (IMG) country of training (for applications received in 2015)
- number of applications received which were incomplete on first submission
- number of applications withdrawn by the applicant (IMG)
- outcome of college's interim comparability assessment (IMG found to be not comparable, partially comparable or substantially comparable)
- outcome of college's area of need assessment (IMG found to be suitable or not suitable for the area of need position)
- outcome of final assessment for specialist recognition (IMG recommended for specialist recognition or not recommended for specialist recognition)
- time to first available assessment interview (from the date a complete application is received to the date of first available interview that is offered)
- time taken by college to assess IMG's application - interim assessment and/or area of need assessment (from the date a complete application is received to the date that decision of interim assessment is made by college)
- time from interim assessment to final assessment (from the date of decision of interim assessment, to the date that decision of final assessment is made by college)
- number of fellowships awarded to IMGs
- number of appeals of college decision by IMGs.

## How to interpret the data

The specialist college data report is a report of all college 'activities' during the period and reflects point in time reporting as IMGs are unlikely to complete all the processes within one reporting period. Therefore, denominators are unable to be defined and percentages cannot be calculated. A college may have more assessment outcomes than applications received for the period.

Delays can occur during the assessment process which are outside the control of the college, for example, an IMG may choose to defer their interview.

Data has been collated and summarised in graphs and tables. Highlights from the 2015 data include:

1. IMGs have gained their specialist qualifications in a range of countries with highest numbers of applications from United Kingdom, India, South Africa, United States of America and Ireland

2. the colleges with the highest number of applications in the twelve month period were the Royal Australian College of General Practitioners (RACGP) (257 applications) and the Royal Australasian College of Physicians (RACP) (151 applications).

3. the colleges with the lowest number of applications in the twelve month period were the Royal Australasian College of Medical Administrators (RACMA) (three applications) and the Australasian College of Sport and Exercise Physicians (ACSEP) (two applications)

4. most colleges were able to offer the majority of their IMGs an interview within 3 months of receiving a complete application (note that some IMGs do not elect to have the interview on the first available date)

5. most colleges were able to complete their area of need assessments within three months

6. across all colleges, over 70% of IMGs from the UK and Ireland were assessed as 'substantially comparable'

7. across all colleges, 99% of IMGs from the UK and Ireland who were assessed as partially comparable or substantially comparable fulfilled the college requirements and were recommended for specialist recognition

8. the majority of applicants for the specialist pathway - area of need were found suitable for the position (note these data exclude applications where the IMG applied for both specialist recognition and area of need assessment)

9. the majority of IMGs were 'recommended for specialist recognition' at their final assessment (after their period of up to 12 months peer review (substantially comparable) or a up to 24 months of upskilling or other assessment/examination (partially comparable))

10. the majority of appeals relate to the interim assessment of comparability (i.e. IMG appealing assessment outcome 'not comparable' or 'partially comparable')

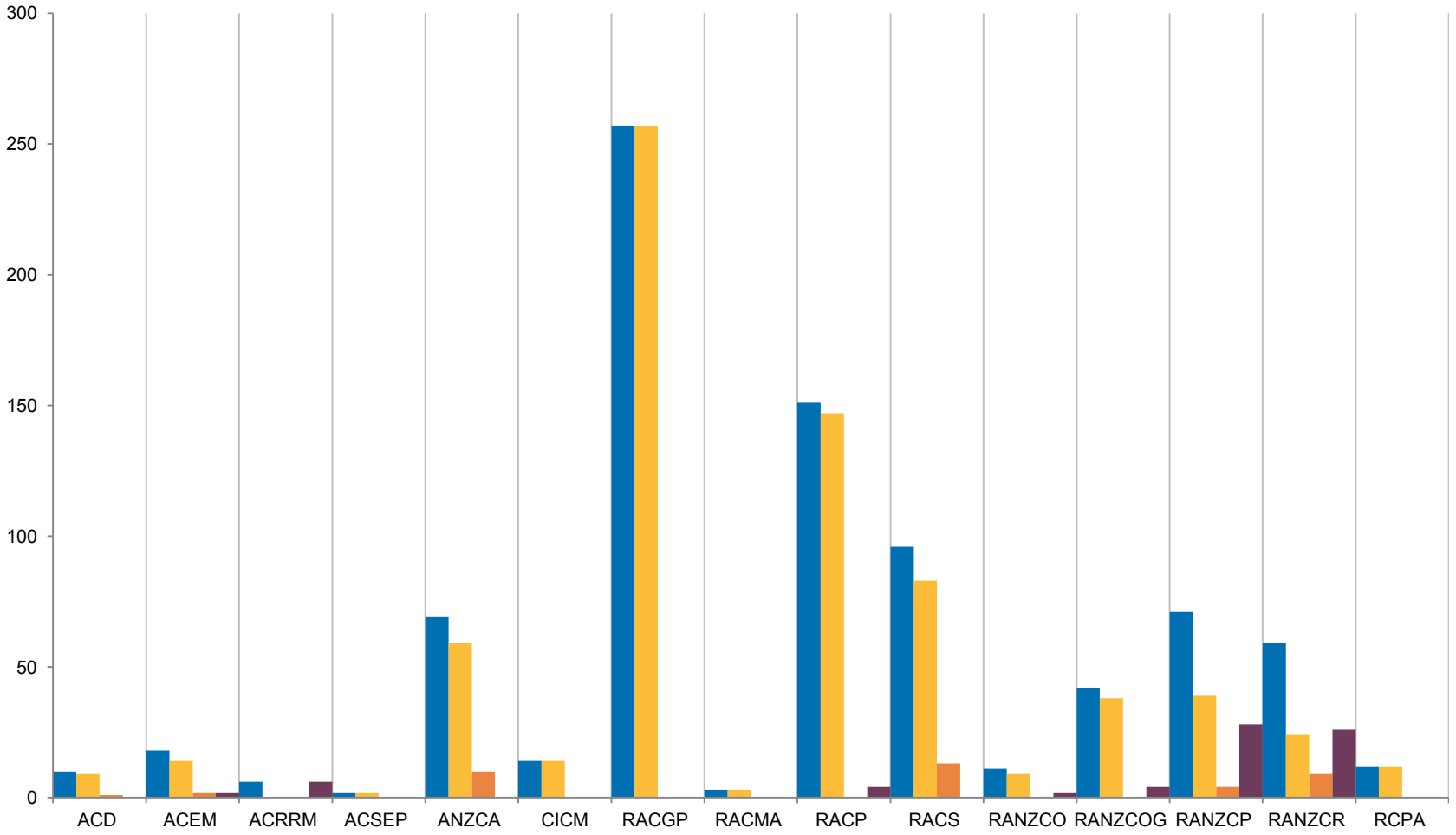
The Royal Australasian College of Dental Surgeons (RACDS) did not receive any applications in the reporting period.

## List of college abbreviations

| | |
|---|---|
| ACD | Australasian College of Dermatologists |
| ACEM | Australasian College for Emergency Medicine |
| ACSEP | Australasian College of Sport and Exercise Physicians |
| ANZCA | Australian and New Zealand College of Anaesthetists |
| ACRRM | Australian College of Rural and Remote Medicine |
| CICM | College of Intensive Care Medicine of Australia and New Zealand |
| RACDS | Royal Australasian College of Dental Surgeons |
| RACS | Royal Australasian College of Surgeons |
| RACGP | The Royal Australian College of General Practitioners |
| RACMA | The Royal Australasian College of Medical Administrators |
| RACP | The Royal Australasian College of Physicians |
| RANZCP | The Royal Australian and New Zealand College of Psychiatrists |
| RANZCOG | The Royal Australian and New Zealand College of Obstetricians and Gynaecologists |
| RANZCO | The Royal Australian and New Zealand College of Ophthalmologists |
| RANZCR | The Royal Australian and New Zealand College of Radiologists |
| RCPA | The Royal College of Pathologists of Australasia |

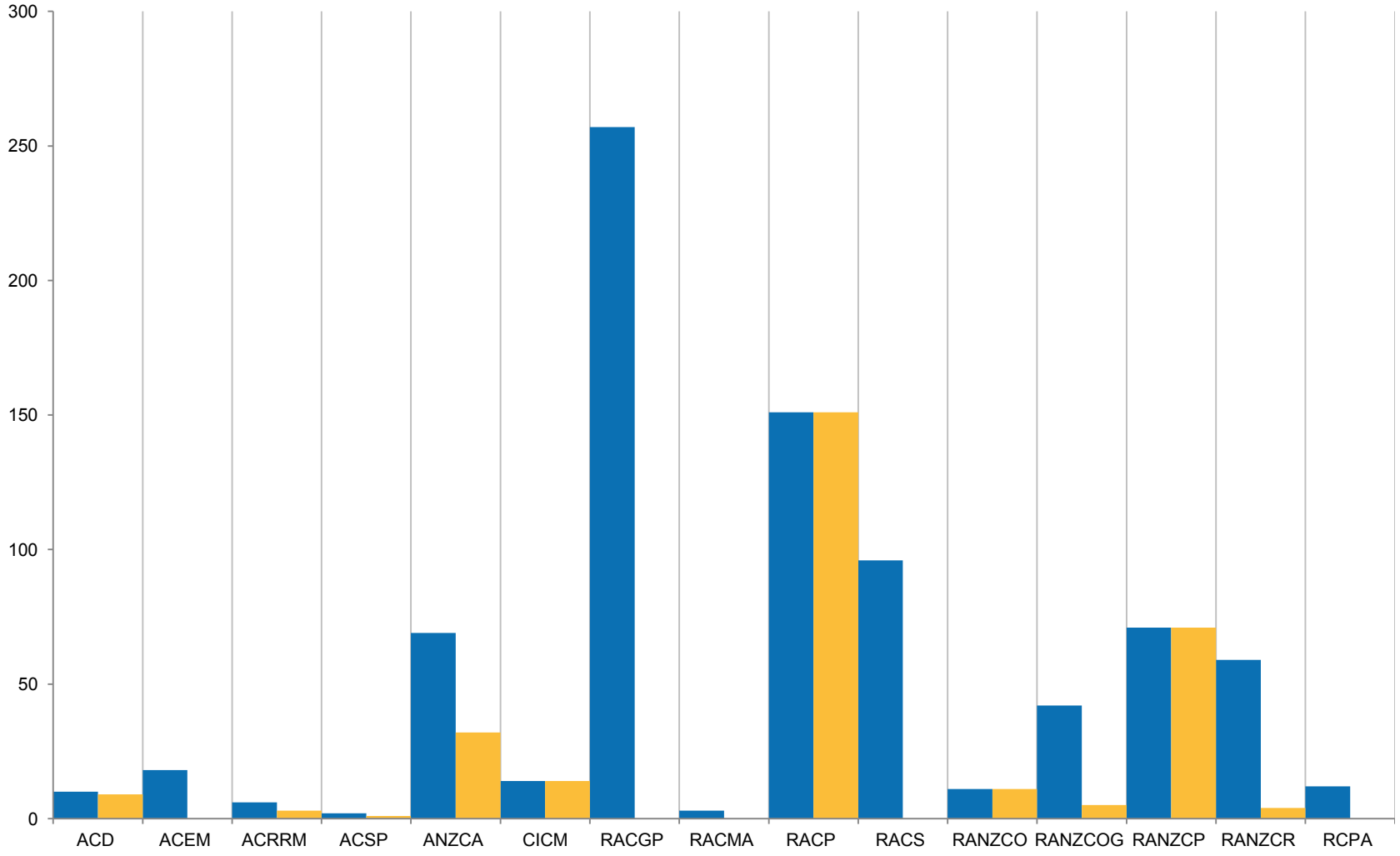
## List of graphs and tables

## 1. Number of applications received




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| Application for specialist recognition | 9 | 14 | 0 | 2 | 59 | 14 | 257 | 3 | 147 | 83 | 9 | 38 | 39 | 24 | 12 |
| Application for area of need | 1 | 2 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 13 | 0 | 0 | 4 | 9 | 0 |
| Combined application – specialist recognition and area of need | 0 | 2 | 6 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 2 | 4 | 28 | 26 | 0 |

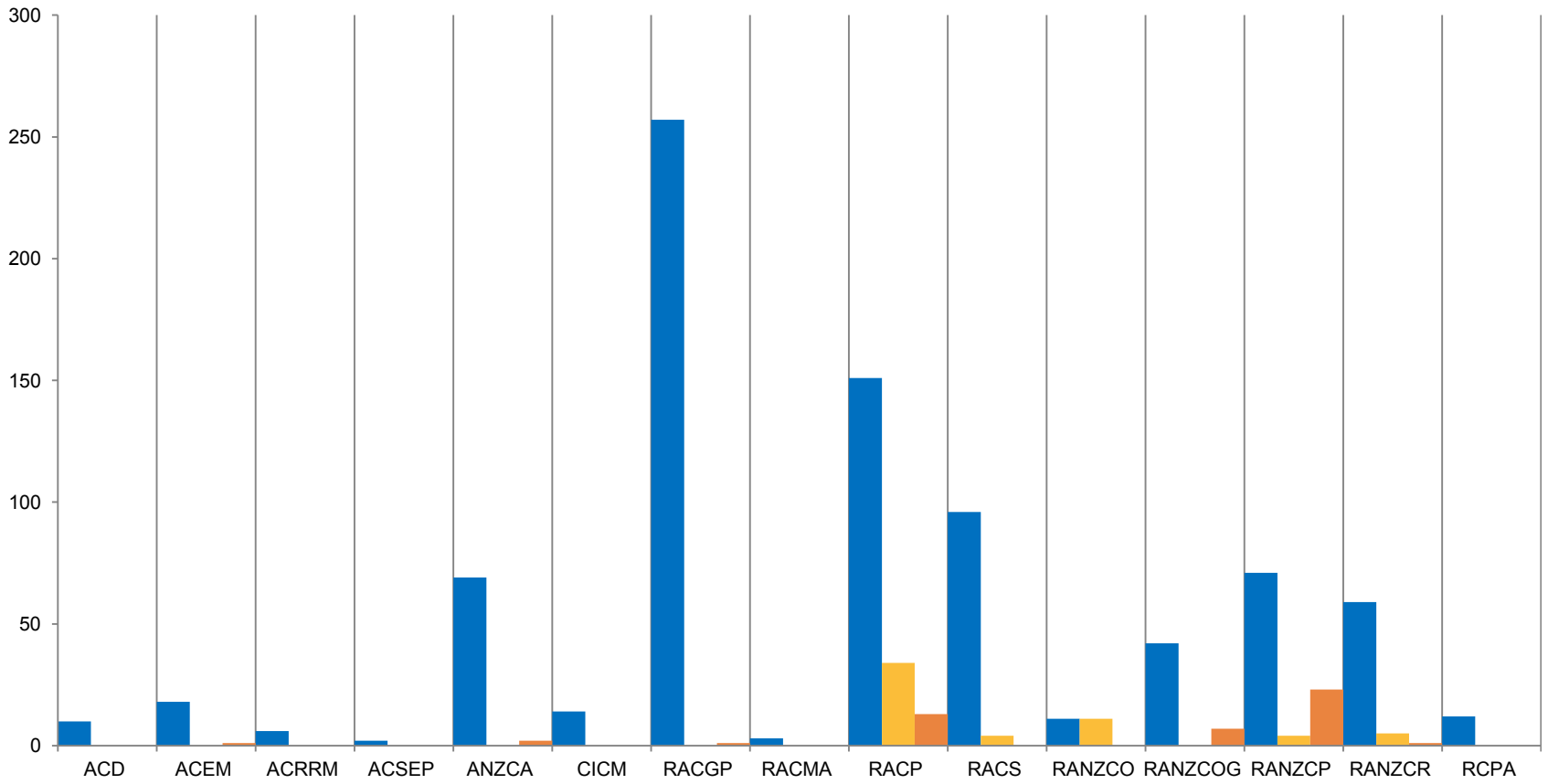
## 2. Number of applications incomplete on first submission




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| | Incomplete on first submission | 9 | 0 | 3 | 1 | 32 | 14 | | 0 | 151 | | 11 | 5 | 71 | 4 | 0 |

Note: RACGP and RACS data not collected. Some colleges require documentation from a third party for applications to be complete.

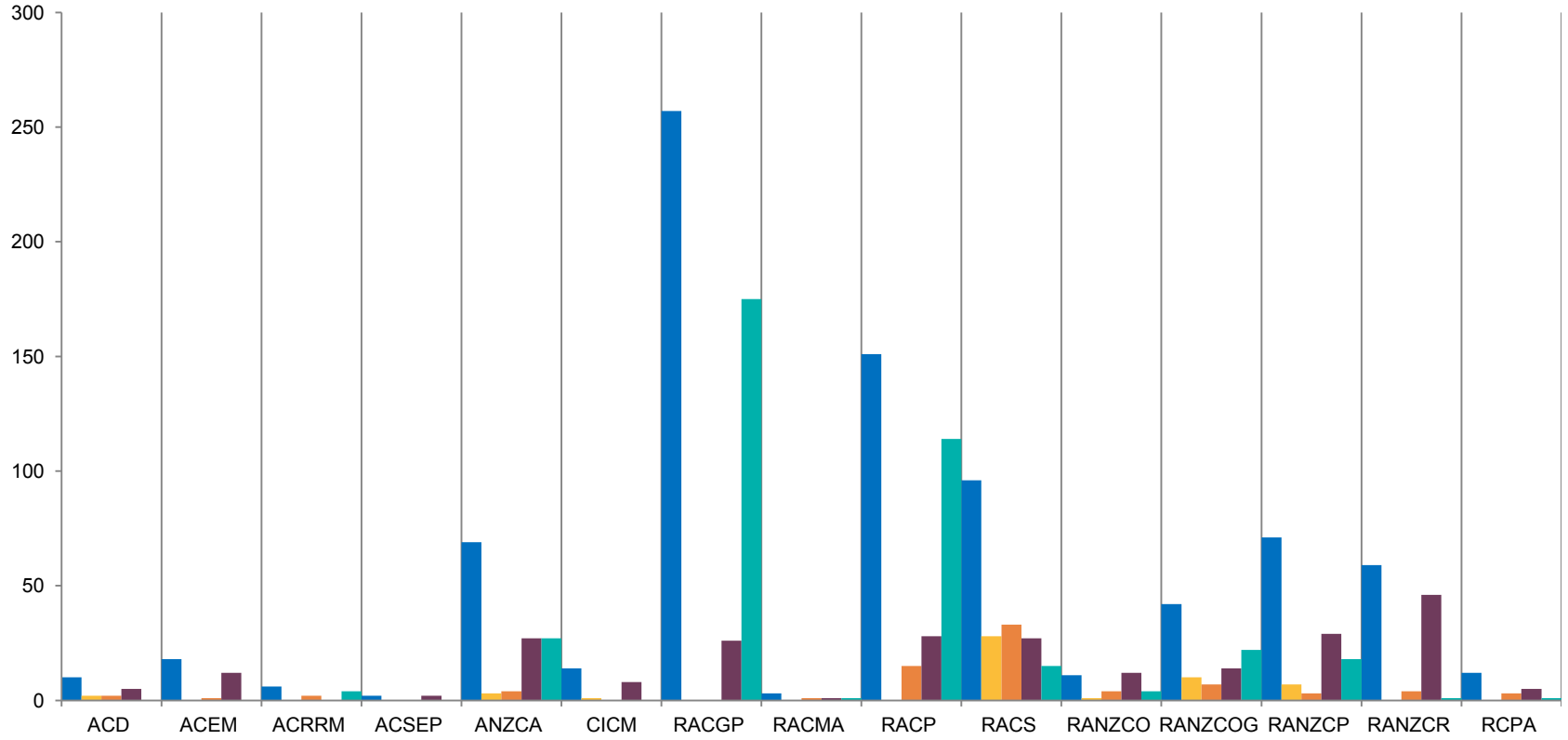
### 3. Number of applications withdrawn by the IMG




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| Number withdrawn before interim assessment | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 34 | 4 | 11 | 0 | 4 | 5 | 0 |
| Number withdrawn between interim assessment and final assessment | 0 | 1 | 0 | 0 | 2 | 0 | 1 | 0 | 13 | | 0 | 7 | 23 | 1 | 0 |

Note: Some RACGP and RACS data not collected. Some withdrawls relate to applications received before 2015

## 4. Specialist recognition – outcome of interim assessment of comparability




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| | Initial paper based review – not comparable | 2 | 0 | 0 | 0 | 3 | 1 | 0 | 0 | | 28 | 1 | 10 | 7 | 0 | 0 |
| | Interim assessment – not comparable | 2 | 1 | 2 | 0 | 4 | 0 | 0 | 1 | 15 | 33 | 4 | 7 | 3 | 4 | 3 |
| | Interim assessment – partially comparable | 5 | 12 | 0 | 2 | 27 | 8 | 26 | 1 | 28 | 27 | 12 | 14 | 29 | 46 | 5 |
| | Interim assessment – substantially comparable | 0 | 0 | 4 | 0 | 27 | 0 | 175 | 1 | 114 | 15 | 4 | 22 | 18 | 1 | 1 |

Note: Outcomes of assessment may not total 'Total number of applications received' as some assessments were still in progress. The RACP initial paper based review is not a final decision. RANZCR do not do an initial paper based assessment.

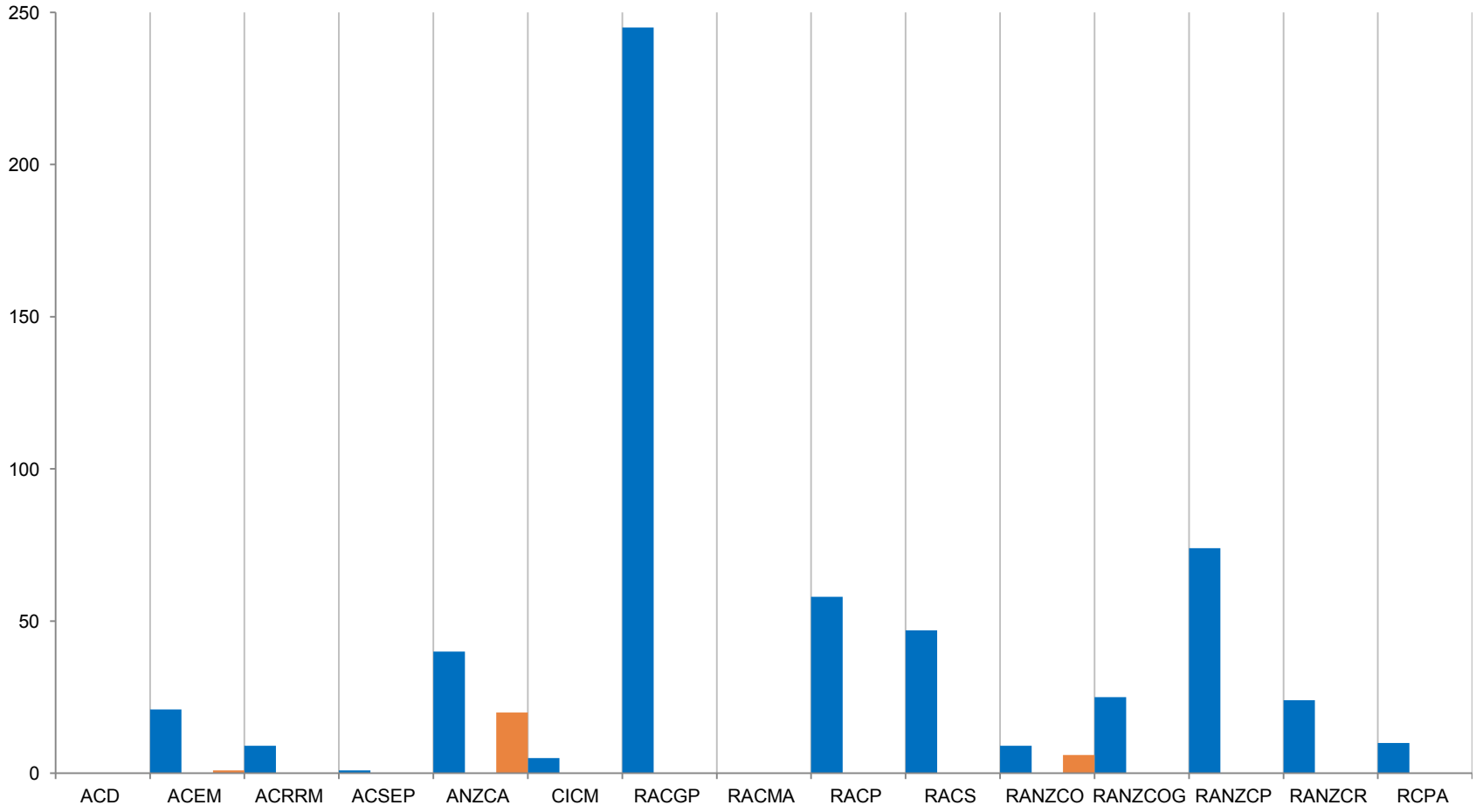
## 5. Specialist recognition - outcome of interim assessment by country of highest specialist qualification – all colleges

| Country | Not comparable | Partially comparable | Substantially comparable |
|---|---|---|---|
| Argentina | 0 | 2 | 0 |
| Austria | 0 | 1 | 0 |
| Bangladesh | 2 | 1 | 0 |
| Belgium | 1 | 2 | 1 |
| Brazil | 2 | 6 | 0 |
| Canada | 2 | 5 | 7 |
| Czech Republic | 1 | 0 | 0 |
| Chile | 1 | 2 | 0 |
| China | 4 | 2 | 3 |
| Colombia | 1 | 1 | 0 |
| Denmark | 1 | 1 | 1 |
| Egypt | 8 | 6 | 0 |
| Fiji | 0 | 1 | 0 |
| France | 0 | 1 | 2 |
| Germany | 2 | 2 | 0 |
| India | 32 | 47 | 14 |
| Iran | 4 | 6 | 5 |
| Iraq | 2 | 4 | 1 |
| Ireland | 2 | 6 | 23 |
| Israel | 0 | 2 | 0 |
| Italy | 1 | 0 | 4 |
| Jamaica | 1 | 1 | 0 |
| Japan | 0 | 3 | 0 |
| Jordan | 0 | 2 | 1 |

| Country | Not comparable | Partially comparable | Substantially comparable |
|---|---|---|---|
| Kazakhstan | 1 | 0 | 0 |
| Malaysia | 0 | 4 | 1 |
| Mexico | 0 | 1 | 0 |
| Netherlands | 0 | 6 | 2 |
| New Zealand | 0 | 0 | 4 |
| Nigeria | 0 | 1 | 0 |
| Norway | 0 | 1 | 1 |
| Pakistan | 5 | 7 | 1 |
| Philippines | 1 | 0 | 0 |
| Poland | 0 | 1 | 0 |
| Portugal | 0 | 0 | 1 |
| Qatar | 0 | 1 | 0 |
| Romania | 0 | 1 | 0 |
| Russia | 2 | 0 | 0 |
| Saudi Arabia | 0 | 1 | 0 |
| Singapore | 0 | 1 | 4 |
| South Africa | 0 | 18 | 6 |
| South Korea | 0 | 0 | 1 |
| Spain | 2 | 0 | 1 |
| Sri Lanka | 0 | 11 | 6 |
| Sweden | 1 | 2 | 0 |
| Switzerland | 0 | 2 | 2 |
| Syria | 3 | 3 | 0 |
| Taiwan | 1 | 0 | 0 |

| Country | Not comparable | Partially comparable | Substantially comparable |
|---|---|---|---|
| Trinidad and Tobago | 1 | 0 | 0 |
| Turkey | 2 | 1 | 0 |
| UK | 11 | 70 | 267 |
| United Arab Emirates | 0 | 1 | 0 |
| USA | 2 | 13 | 16 |
| Venezuela | 0 | 1 | 0 |
| Unknown | 0 | 5 | 0 |

## 6. Specialist recognition - Outcome of final assessment for specialist recognition




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Recommended for specialist | 0 | 21 | 9 | 1 | 40 | 5 | 245 | 0 | 58 | 47 | 9 | 25 | 74 | 24 | 10 |
| | Recommended for specialist – limited scope | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Not recommended for specialist | 0 | 1 | 0 | 0 | 20 | 0 | 0 | 0 | 0 | 0 | 6 | 0 | 0 | 0 | 0 |

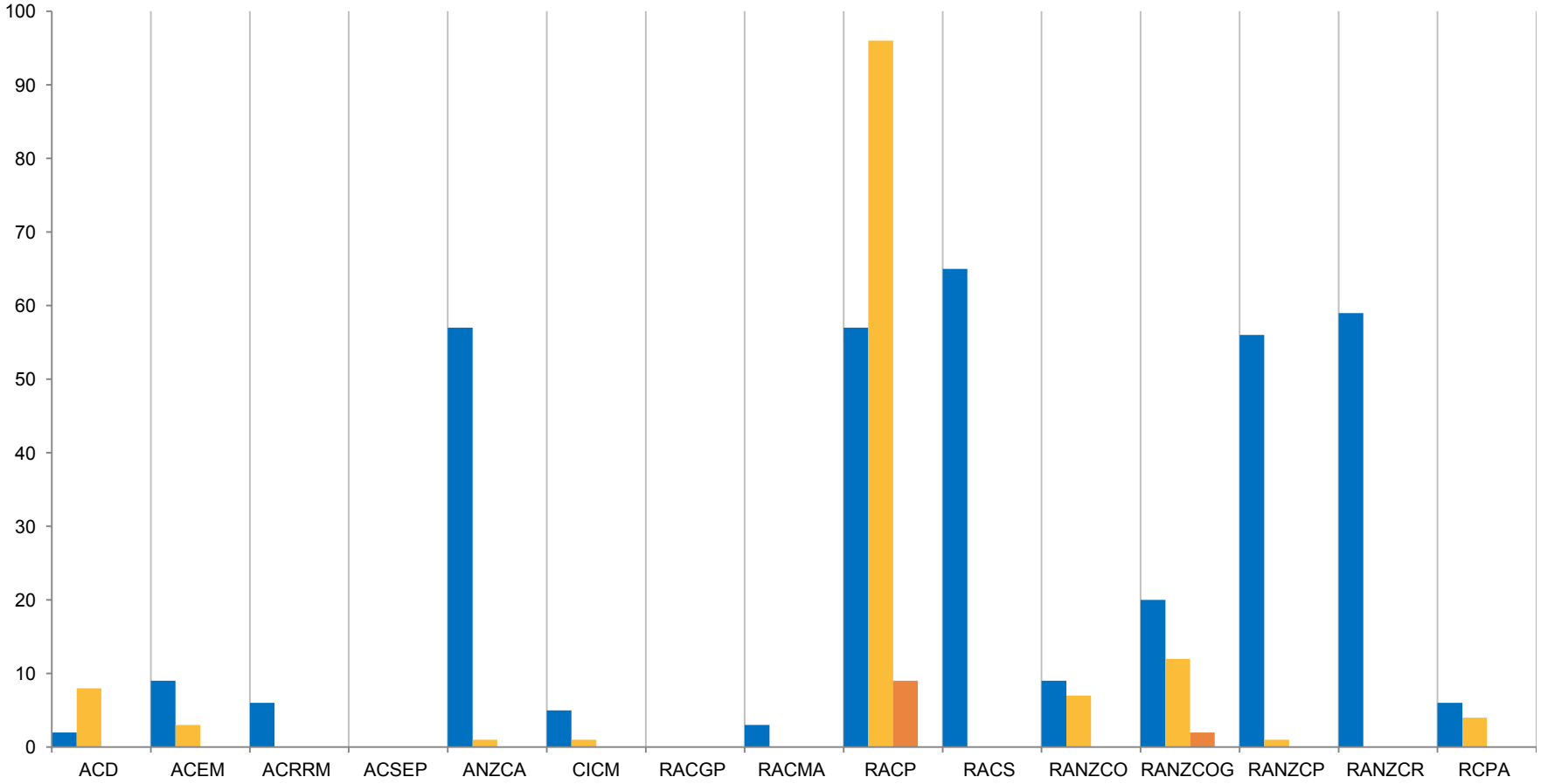
Note: ANZCA data includes a number of applicants who had exceeded the maximum timeframe.

## 7. Specialist recognition - outcome of final assessment by country of highest specialist qualification – all colleges

| Country | Partially comparable | | Substantially comparable | |
|---|---|---|---|---|
| | Recommended | Not recommended | Recommended | Not recommended |
| Austria | 0 | 0 | 1 | 0 |
| Belgium | 1 | 0 | 0 | 0 |
| Brazil | 2 | 0 | 1 | 0 |
| Bulgaria | 1 | 0 | 0 | 0 |
| Canada | 5 | 2 | 0 | 0 |
| Croatia | 1 | 0 | 0 | 0 |
| China | 0 | 0 | 1 | 0 |
| Denmark | 1 | 0 | 0 | 0 |
| Egypt | 3 | 3 | 0 | 0 |
| Germany | 5 | 3 | 1 | 0 |
| Greece | 2 | 0 | 0 | 0 |
| India | 51 | 4 | 13 | 0 |
| Iran | 5 | 2 | 1 | 0 |
| Iraq | 1 | 0 | 0 | 0 |
| Ireland | 6 | 0 | 21 | 0 |
| Israel | 0 | 1 | 1 | 0 |
| Italy | 1 | 1 | 0 | 0 |
| Jordan | 0 | 0 | 1 | 0 |
| Malaysia | 5 | 0 | 0 | 0 |
| Mexico | 2 | 0 | 0 | 0 |
| Myanmar | 1 | 0 | 0 | 0 |
| Netherlands | 6 | 0 | 3 | 0 |

| Country | Partially comparable | | Substantially comparable | |
|---|---|---|---|---|
| | Recommended | Not recommended | Recommended | Not recommended |
| New Zealand | 0 | 0 | 4 | 0 |
| Nigeria | 2 | 0 | 0 | 0 |
| Norway | 0 | 0 | 0 | 1 |
| Pakistan | 0 | 1 | 0 | 0 |
| Papua New Guinea | 1 | 0 | 0 | 0 |
| Poland | 1 | 0 | 0 | 0 |
| Portugal | 1 | 0 | 0 | 0 |
| Romania | 0 | 0 | 1 | 0 |
| Russia | 0 | 1 | 0 | 0 |
| Singapore | 1 | 0 | 1 | 0 |
| South Africa | 13 | 0 | 9 | 0 |
| Sri Lanka | 16 | 3 | 3 | 0 |
| Sweden | 3 | 1 | 0 | 0 |
| Switzerland | 2 | 0 | 1 | 0 |
| Syria | 2 | 0 | 0 | 0 |
| Trinidad and Tobago | 1 | 0 | 0 | 0 |
| UK | 42 | 2 | 277 | 0 |
| Ukraine | 0 | 1 | 0 | 0 |
| USA | 13 | 0 | 4 | 0 |

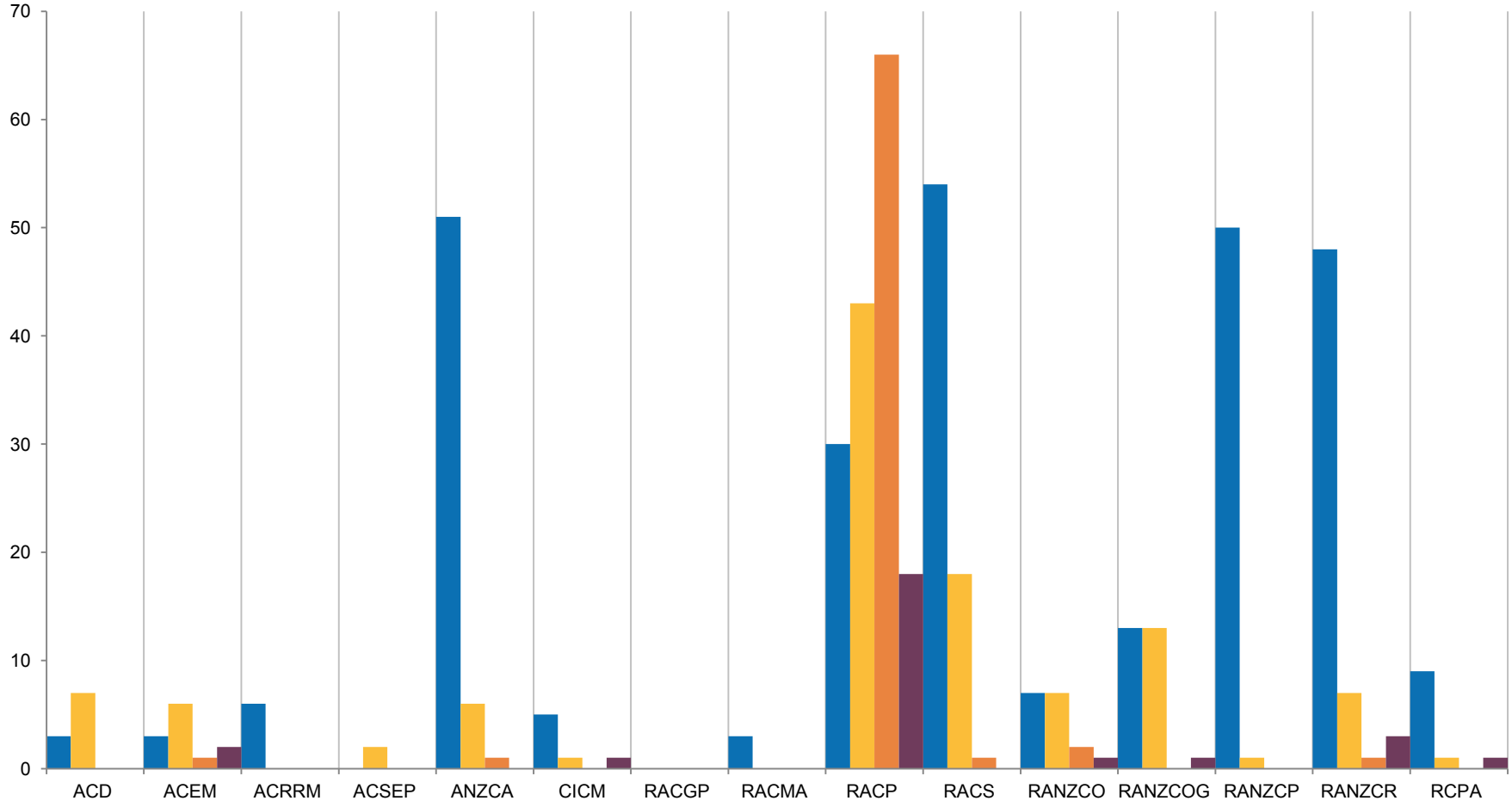
## 8. Specialist recognition - time to first available assessment interview




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 – 3 months | 2 | 9 | 6 | 0 | 57 | 5 | | 3 | 57 | 65 | 9 | 20 | 56 | 59 | 6 |
| 4 – 6 months | 8 | 3 | 0 | 0 | 1 | 1 | | 0 | 96 | 0 | 7 | 12 | 1 | 0 | 4 |
| 7 – 9 months | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 9 | 0 | 0 | 2 | 0 | 0 | 0 |
| 9 months + | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Note: RACGP do not interview to assess comparability.

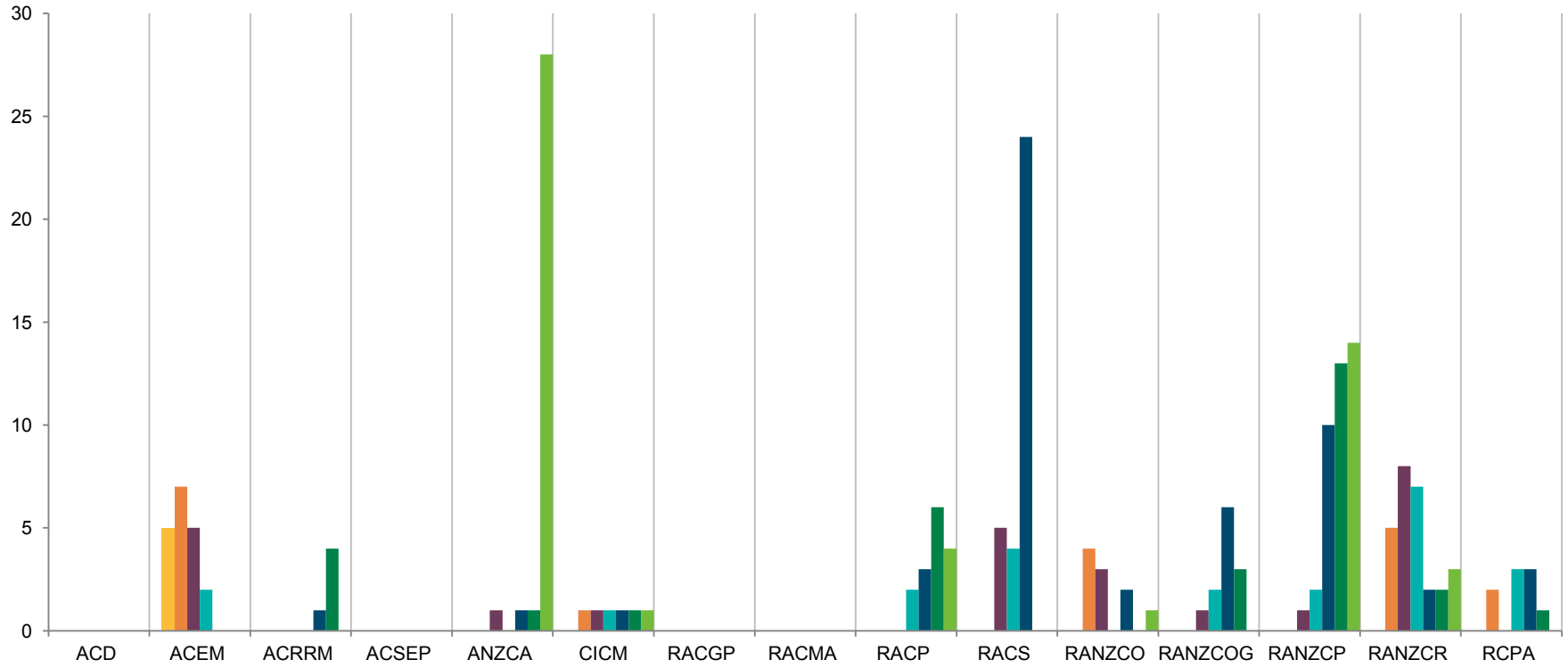
## 9. Specialist recognition - time for interim assessment of comparability




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 – 3 months | 3 | 3 | 6 | 0 | 51 | 5 | | 3 | 30 | 54 | 7 | 13 | 50 | 48 | 9 |
| 4 – 6 months | 7 | 6 | 0 | 2 | 6 | 1 | | 0 | 43 | 18 | 7 | 13 | 1 | 7 | 1 |
| 7 – 9 months | 0 | 1 | 0 | 0 | 1 | 0 | | 0 | 66 | 1 | 2 | 0 | 0 | 1 | 0 |
| 9 months + | 0 | 2 | 0 | 0 | 0 | 1 | | 0 | 18 | 0 | 1 | 1 | 0 | 3 | 1 |

Note: RACGP data not collected.

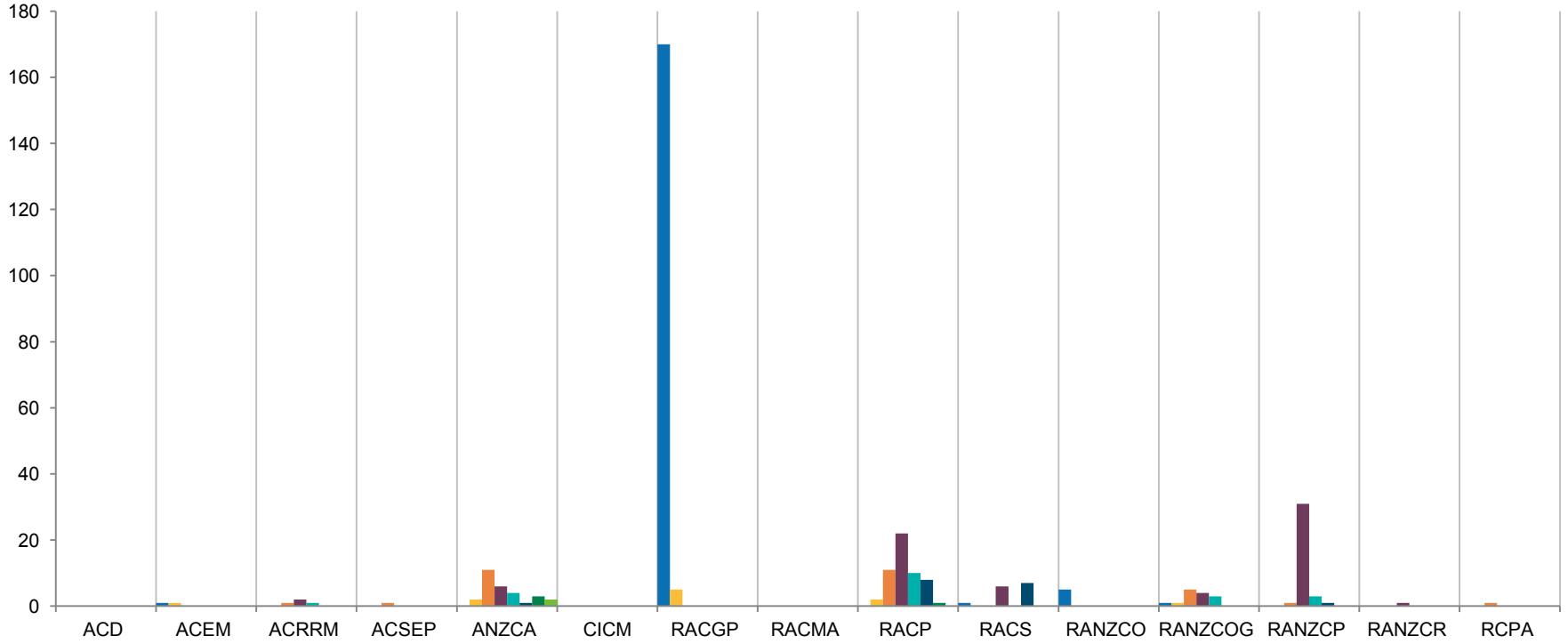
### 10. Time for final assessment – partially comparable IMGs




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 – 3 months | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 – 6 months | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 – 12 months | 0 | 7 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 5 | 2 |
| 13 – 18 months | 0 | 5 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 5 | 3 | 1 | 1 | 8 | 0 |
| 19 – 24 months | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 4 | 0 | 2 | 2 | 7 | 3 |
| 25 – 36 months | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 3 | 24 | 2 | 6 | 10 | 2 | 3 |
| 37 – 48 months | 0 | 0 | 4 | 0 | 1 | 1 | 0 | 0 | 6 | | 0 | 3 | 13 | 2 | 1 |
| 48+ months | 0 | 0 | 0 | 0 | 28 | 1 | 0 | 0 | 4 | | 1 | 0 | 14 | 3 | 0 |

Note: Some RACS data not collected.

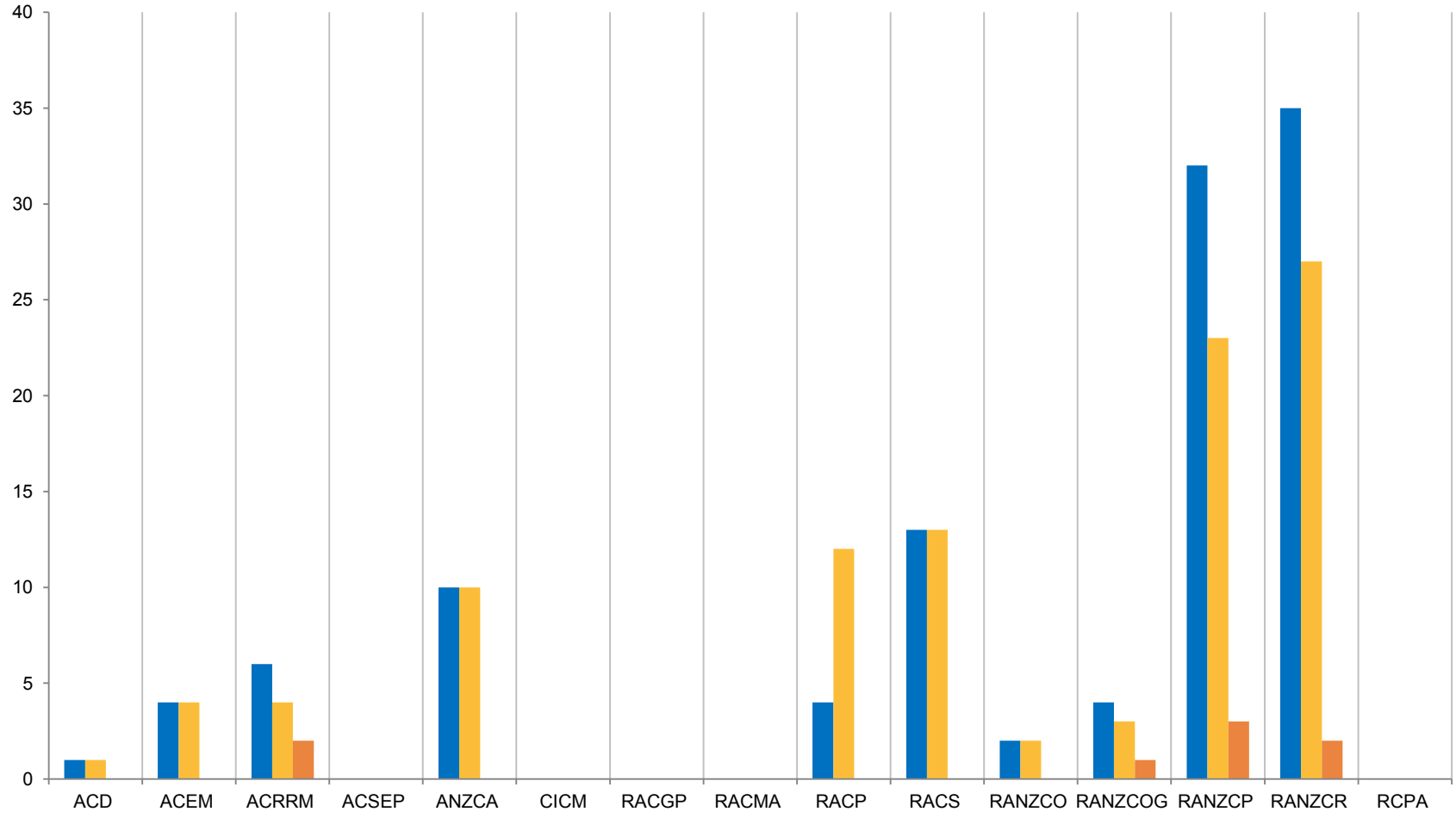
## 11. Time for final assessment – substantially comparable IMGs




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 – 3 months | 0 | 1 | 0 | 0 | 0 | 0 | 170 | 0 | 0 | 1 | 5 | 1 | 0 | 0 | 0 |
| 4 – 6 months | 0 | 1 | 0 | 0 | 2 | 0 | 5 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 |
| 7 – 12 months | 0 | 0 | 1 | 1 | 11 | 0 | 0 | 0 | 11 | 0 | 0 | 5 | 1 | 0 | 1 |
| 13 – 18 months | 0 | 0 | 2 | 0 | 6 | 0 | 0 | 0 | 22 | 6 | 0 | 4 | 31 | 1 | 0 |
| 19 – 24 months | 0 | 0 | 1 | 0 | 4 | 0 | 0 | 0 | 10 | 0 | 0 | 3 | 3 | 0 | 0 |
| 25 – 36 months | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 8 | 7 | 0 | 0 | 1 | 0 | 0 |
| 37 – 48 months | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 1 | | 0 | 0 | 0 | 0 | 0 |
| 48+ months | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 |

Note: Some RACS data not collected.

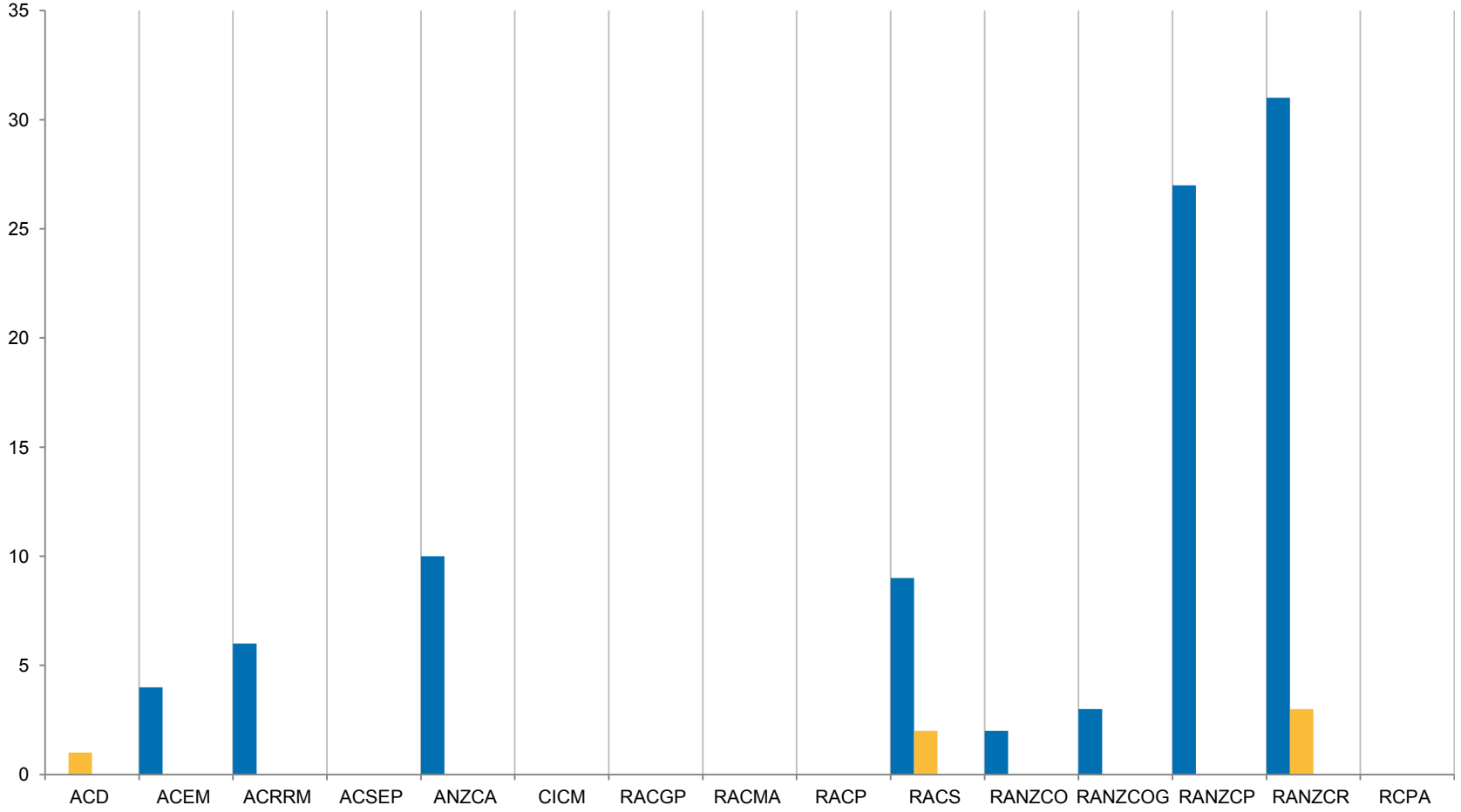
## 12. Area of need – outcome of assessment




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total number of area of need applications received | 1 | 4 | 6 | 0 | 10 | 0 | 0 | 0 | 4 | 13 | 2 | 4 | 32 | 35 | 0 |
| | Suitable for area of need | 1 | 4 | 4 | 0 | 10 | 0 | 0 | 0 | 12 | 13 | 2 | 3 | 23 | 27 | 0 |
| | Not suitable for area of need | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 2 | 0 |

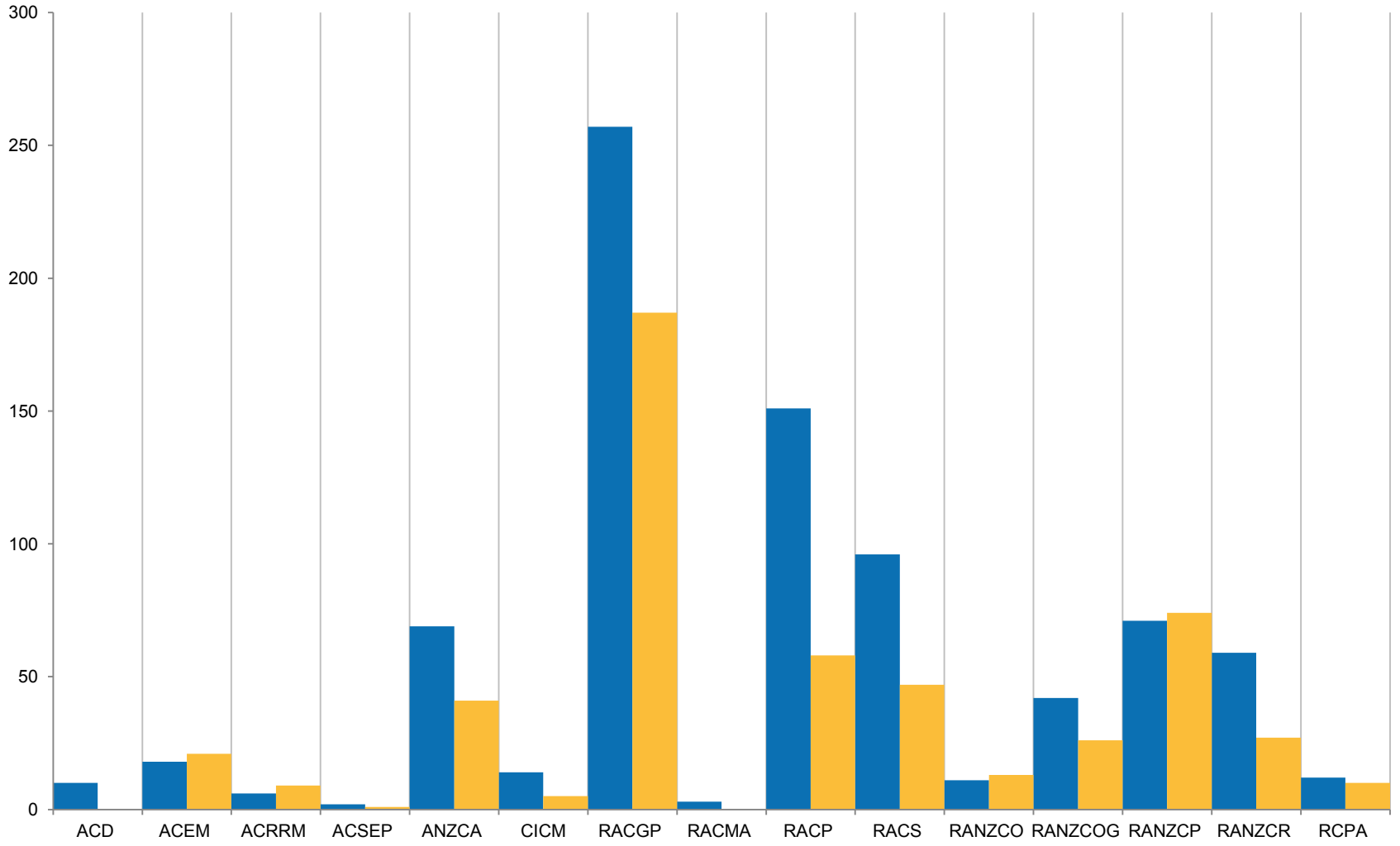
Note: Outcomes of assessment may not total 'Total number of applications received'; some assessments were still in progress and some relate to applications received before 2015

### 13. Time for area of need assessment




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 – 3 months | 0 | 4 | 6 | 0 | 10 | 0 | 0 | 0 | 0 | 9 | 2 | 3 | 27 | 31 | 0 |
| 4 – 6 months | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 3 | 0 |
| 7 – 9 months | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9+ months | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

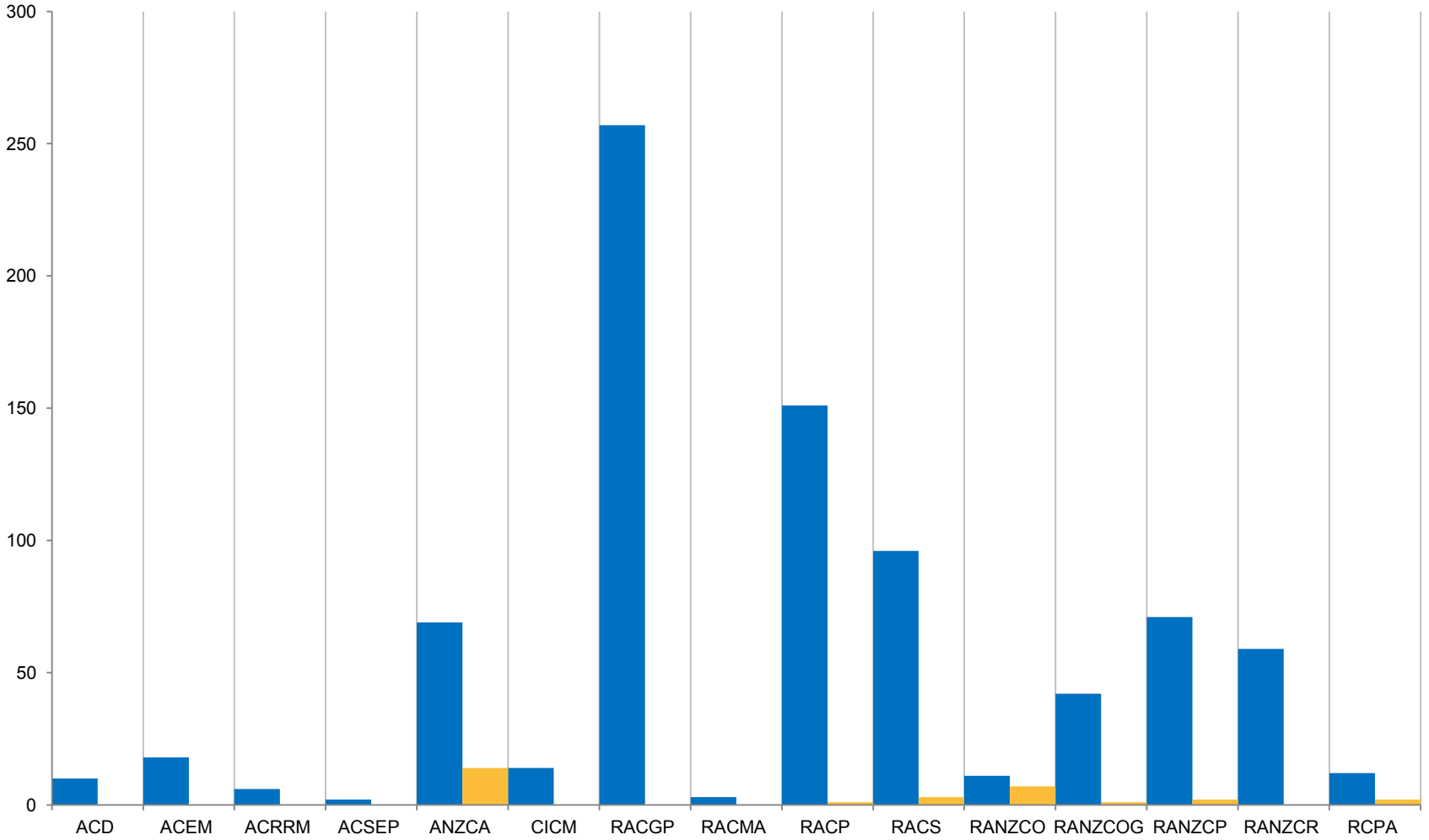
### 14. Number of fellowships awarded to IMGs




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| Number of fellowships awarded to IMGs | 0 | 21 | 9 | 1 | 41 | 5 | 187 | 0 | 58 | 47 | 13 | 26 | 74 | 27 | 10 |

Note: The number of applications is provided as an indication of application volume; data includes IMGs who applied before 2015 and does not include IMGs who applied in 2015 period and are still in progress.

## 15. Number of appeals




| | ACD | ACEM | ACRRM | ACSEP | ANZCA | CICM | RACGP | RACMA | RACP | RACS | RANZCO | RANZCOG | RANZCP | RANZCR | RCPA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of applications received | 10 | 18 | 6 | 2 | 69 | 14 | 257 | 3 | 151 | 96 | 11 | 42 | 71 | 59 | 12 |
| Number of appeals | 0 | 0 | 0 | 0 | 14 | 0 | 0 | 0 | 1 | 3 | 7 | 1 | 2 | 0 | 2 |

Note: Colleges have different appeals process and classification of ‘appeals’ varies. The number of applications is provided as an indication of volume, appeals may relate to IMGs who applied in 2015 or before 2015.

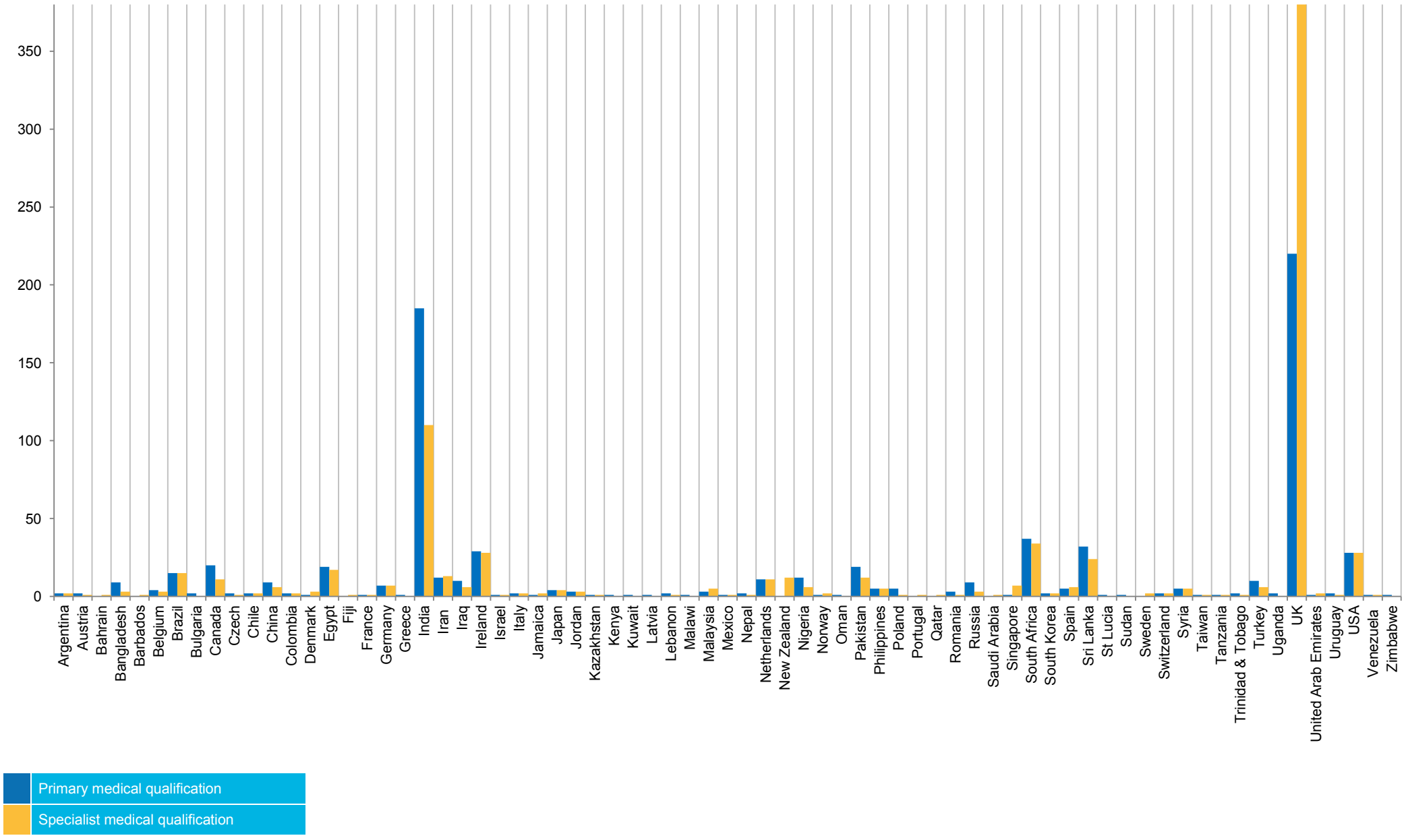
## 16. IMG's country of qualification – primary medical degree and specialist qualification – all colleges

| Country | All colleges - primary | All colleges - specialist |
|---|---|---|
| Argentina | 2 | 2 |
| Austria | 2 | 1 |
| Bahrain | 0 | 1 |
| Bangladesh | 9 | 3 |
| Barbados | 0 | 1 |
| Belgium | 4 | 3 |
| Brazil | 15 | 15 |
| Bulgaria | 2 | 0 |
| Canada | 20 | 11 |
| Czech | 2 | 1 |
| Chile | 2 | 2 |
| China | 9 | 6 |
| Colombia | 2 | 2 |
| Denmark | 1 | 3 |
| Egypt | 19 | 17 |
| Fiji | 0 | 1 |
| France | 1 | 1 |
| Germany | 7 | 7 |
| Greece | 1 | 0 |
| India | 185 | 110 |
| Iran | 12 | 13 |
| Iraq | 10 | 6 |
| Ireland | 29 | 28 |
| Israel | 1 | 1 |

| Country | All colleges - primary | All colleges - specialist |
|---|---|---|
| Italy | 2 | 2 |
| Jamaica | 1 | 2 |
| Japan | 4 | 4 |
| Jordan | 3 | 3 |
| Kazakhstan | 1 | 1 |
| Kenya | 1 | 0 |
| Kuwait | 1 | 0 |
| Latvia | 1 | 0 |
| Lebanon | 2 | 1 |
| Malawi | 1 | 0 |
| Malaysia | 3 | 5 |
| Mexico | 1 | 1 |
| Nepal | 2 | 1 |
| Netherlands | 11 | 11 |
| New Zealand | 0 | 12 |
| Nigeria | 12 | 6 |
| Norway | 1 | 2 |
| Oman | 1 | 0 |
| Pakistan | 19 | 12 |
| Philippines | 5 | 5 |
| Poland | 5 | 1 |
| Portugal | 0 | 1 |
| Qatar | 0 | 1 |
| Romania | 3 | 1 |

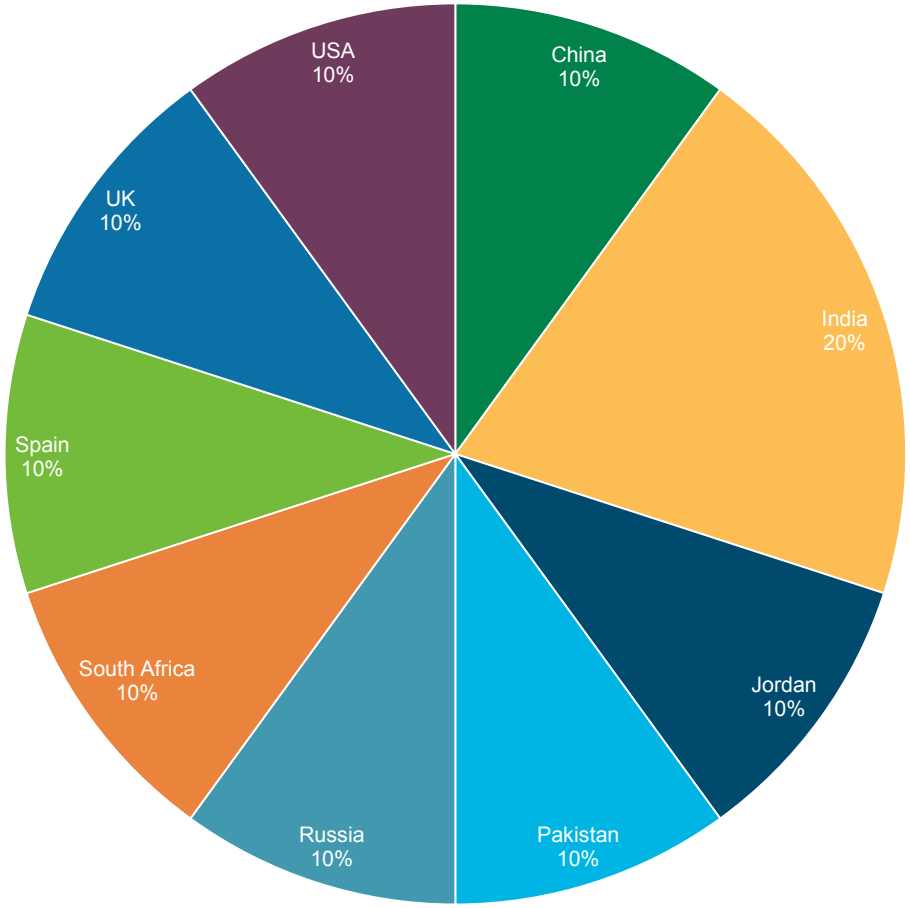
| Country | All colleges - primary | All colleges - specialist |
|---|---|---|
| Russia | 9 | 3 |
| Saudi Arabia | 0 | 1 |
| Singapore | 1 | 7 |
| South Africa | 37 | 34 |
| South Korea | 2 | 2 |
| Spain | 5 | 6 |
| Sri Lanka | 32 | 24 |
| St Lucia | 1 | 0 |
| Sudan | 1 | 0 |
| Sweden | 0 | 2 |
| Switzerland | 2 | 2 |
| Syria | 5 | 5 |
| Taiwan | 1 | 1 |
| Tanzania | 1 | 1 |
| Trinidad and Tobago | 2 | 1 |
| Turkey | 10 | 6 |
| Uganda | 2 | 0 |
| UK | 220 | 380 |
| United Arab Emirates | 1 | 2 |
| Uruguay | 2 | 1 |
| USA | 28 | 28 |
| Venezuela | 1 | 1 |
| Zimbabwe | 1 | 0 |
| Unknown | 0 | 5 |

## 17. IMG's country of qualification – all colleges

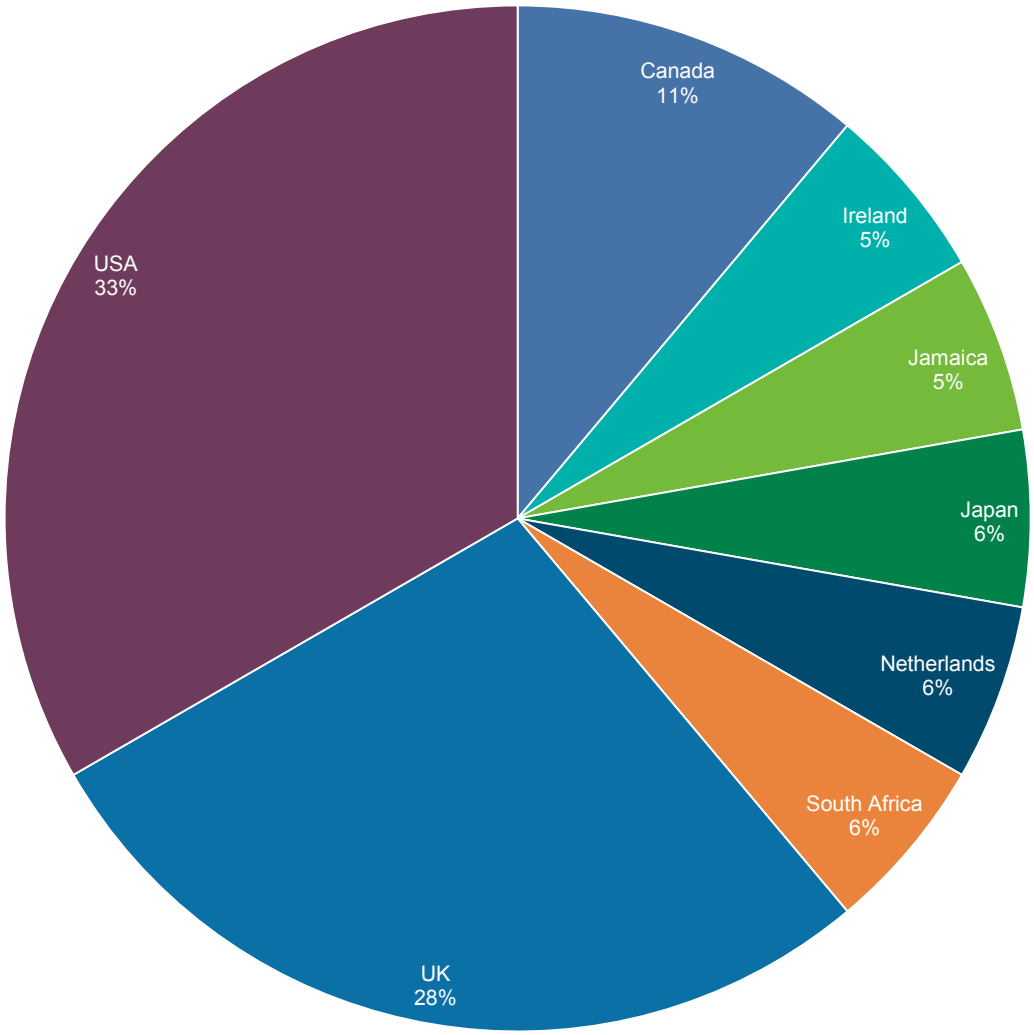


## 17. IMG's country of qualification – specialist qualification

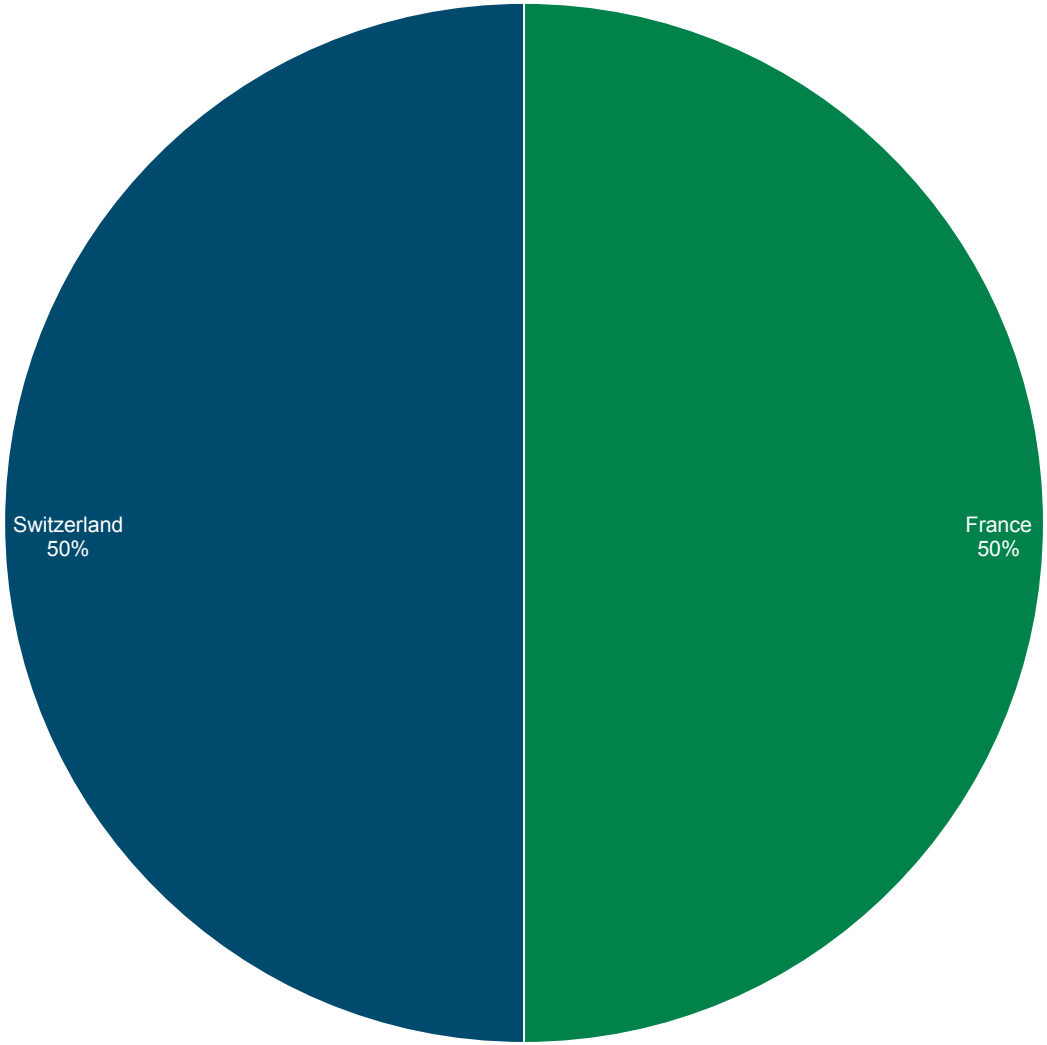
**Australasian College of Dermatologists**



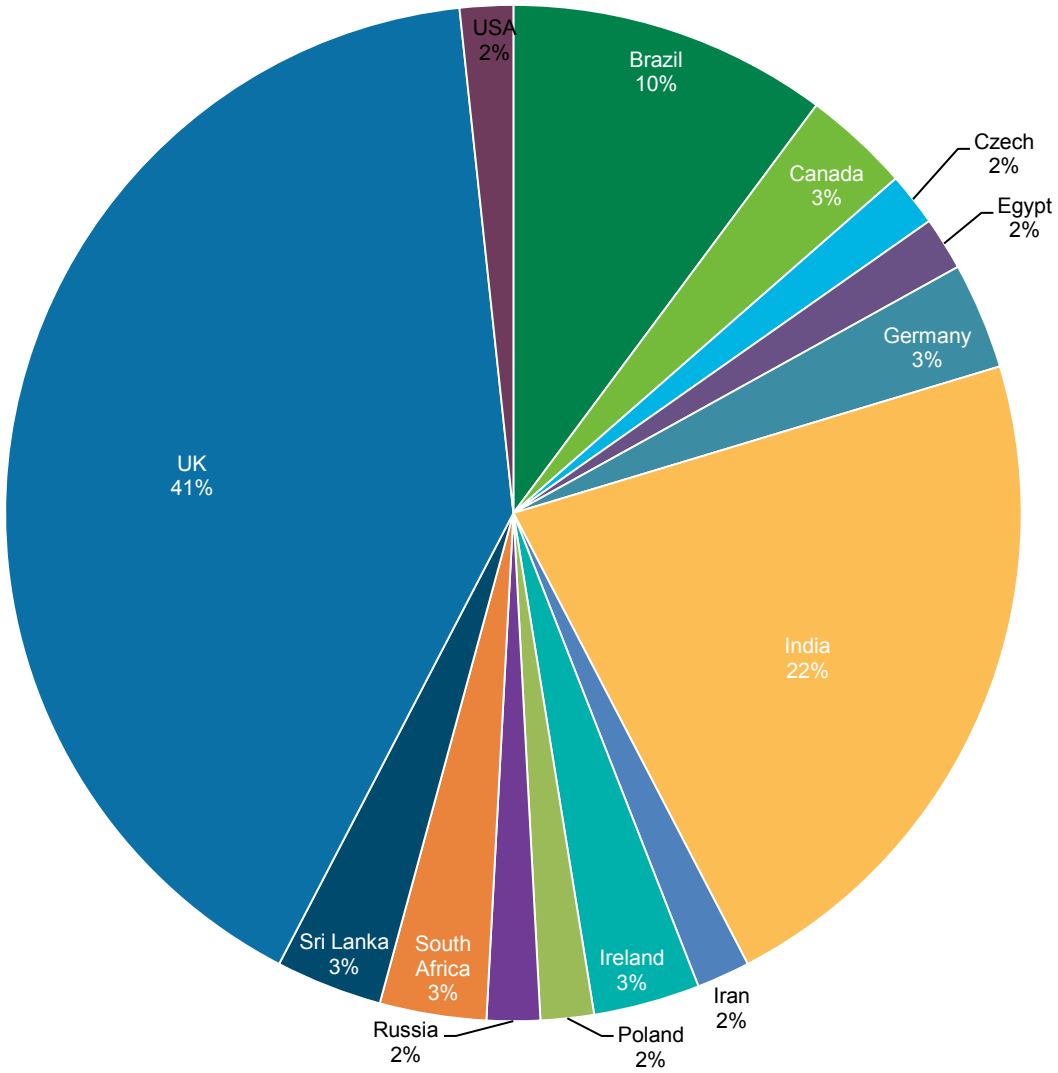
**Australasian College for Emergency Medicine**



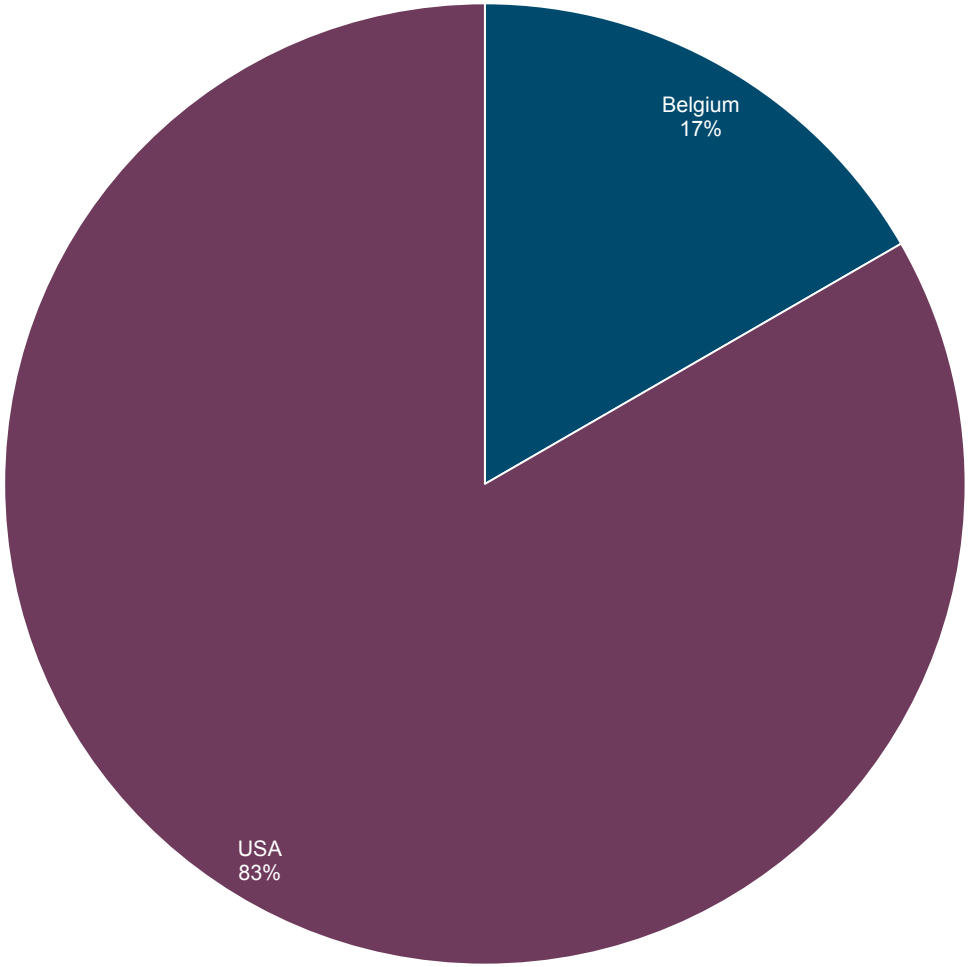
**Australasian College of Sports and Exercise Physicians**



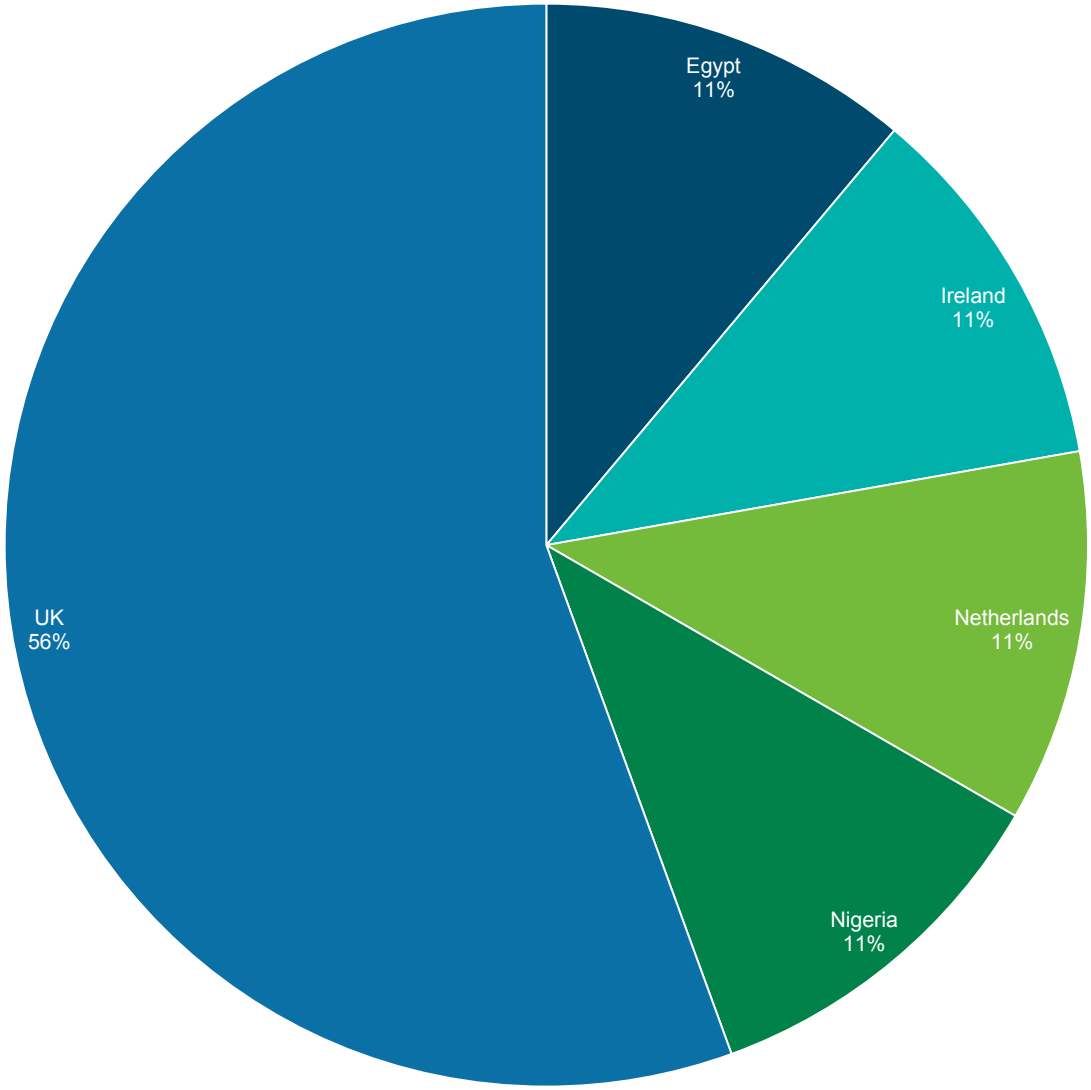
**Australia and New Zealand College of Anaesthetists**



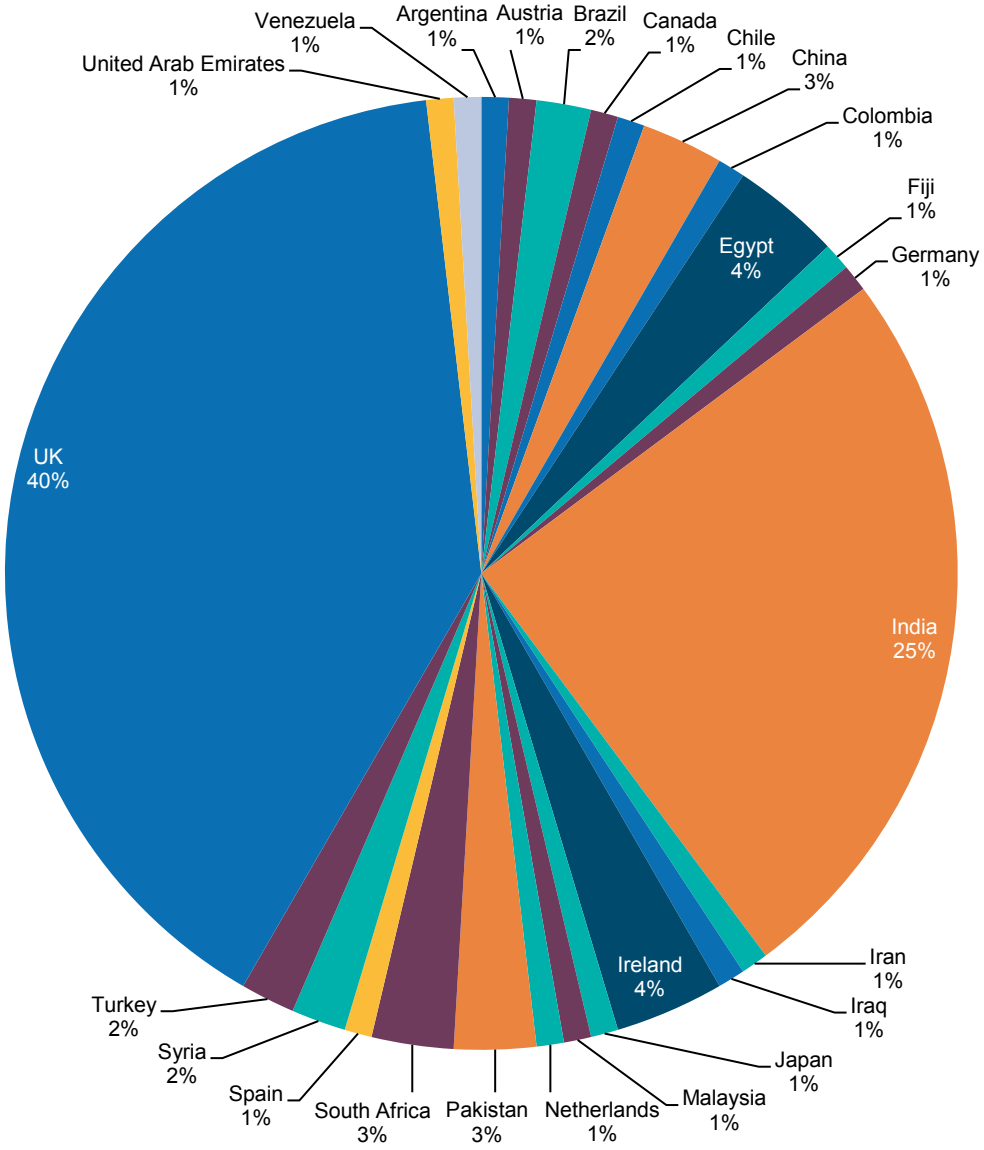
**Australian College of Rural and Remote Medicine**



**College of Intensive Care Medicine**

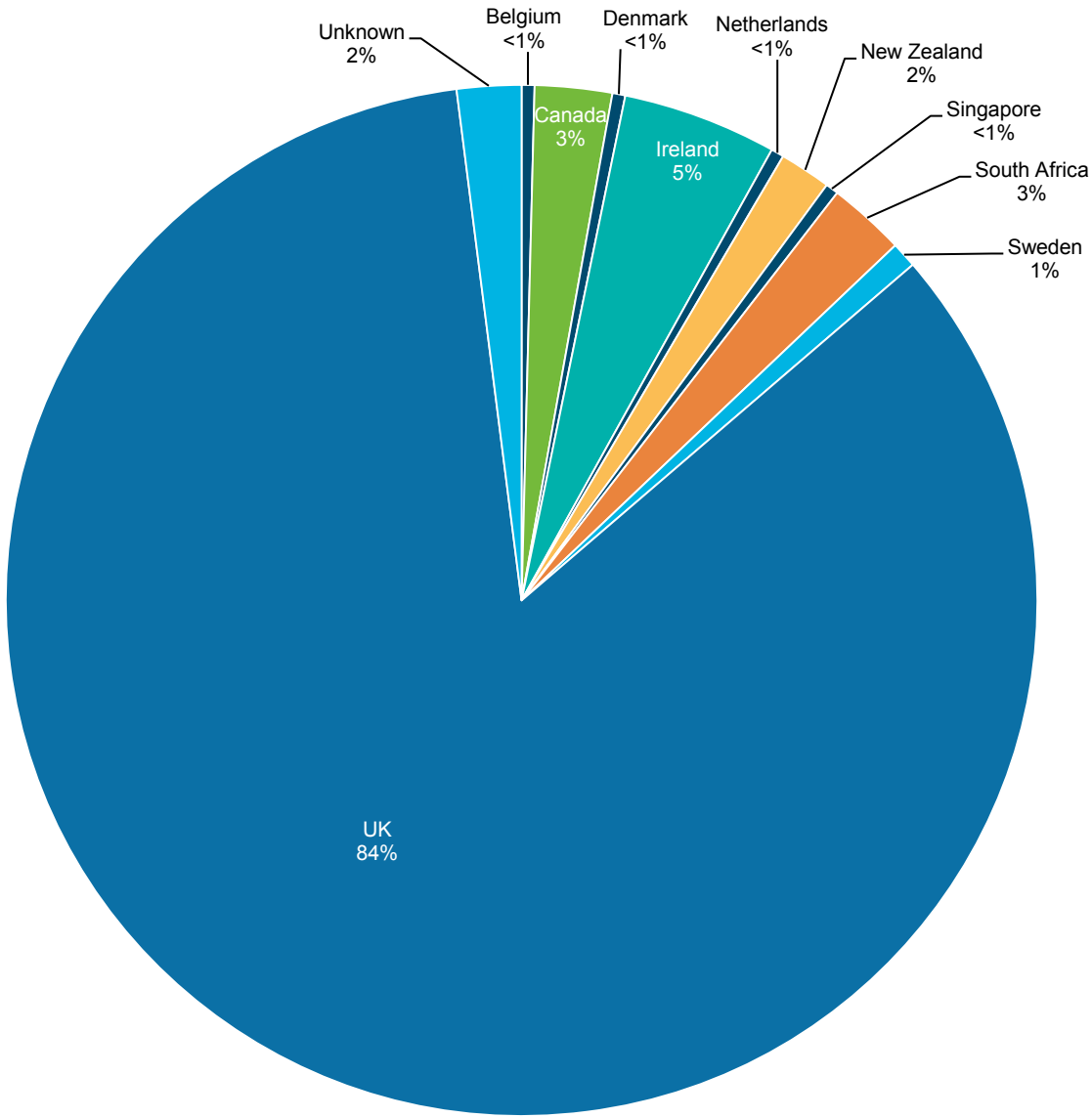


**Royal Australasian College of Surgeons**

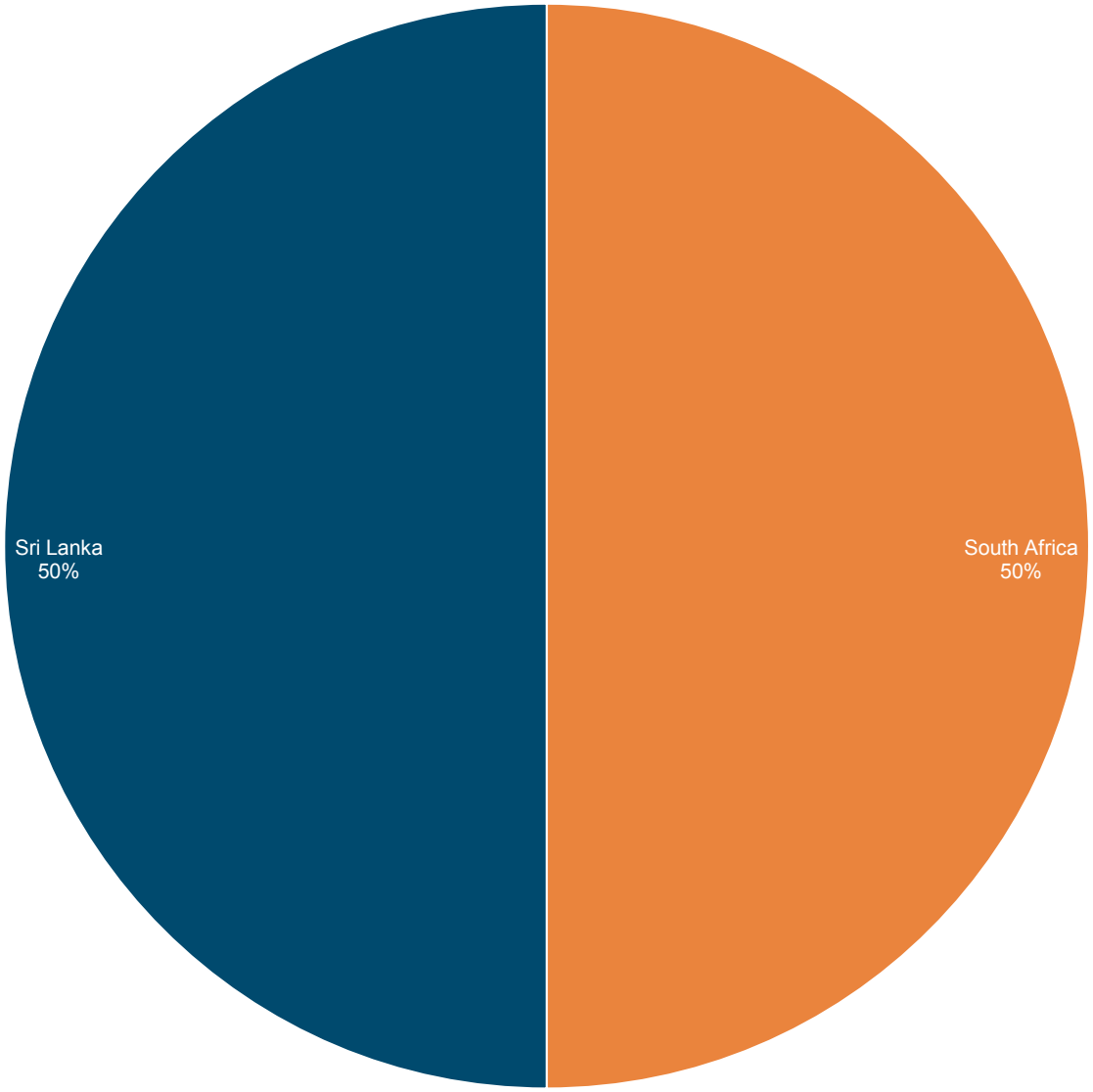



**Medical Board of Australia**

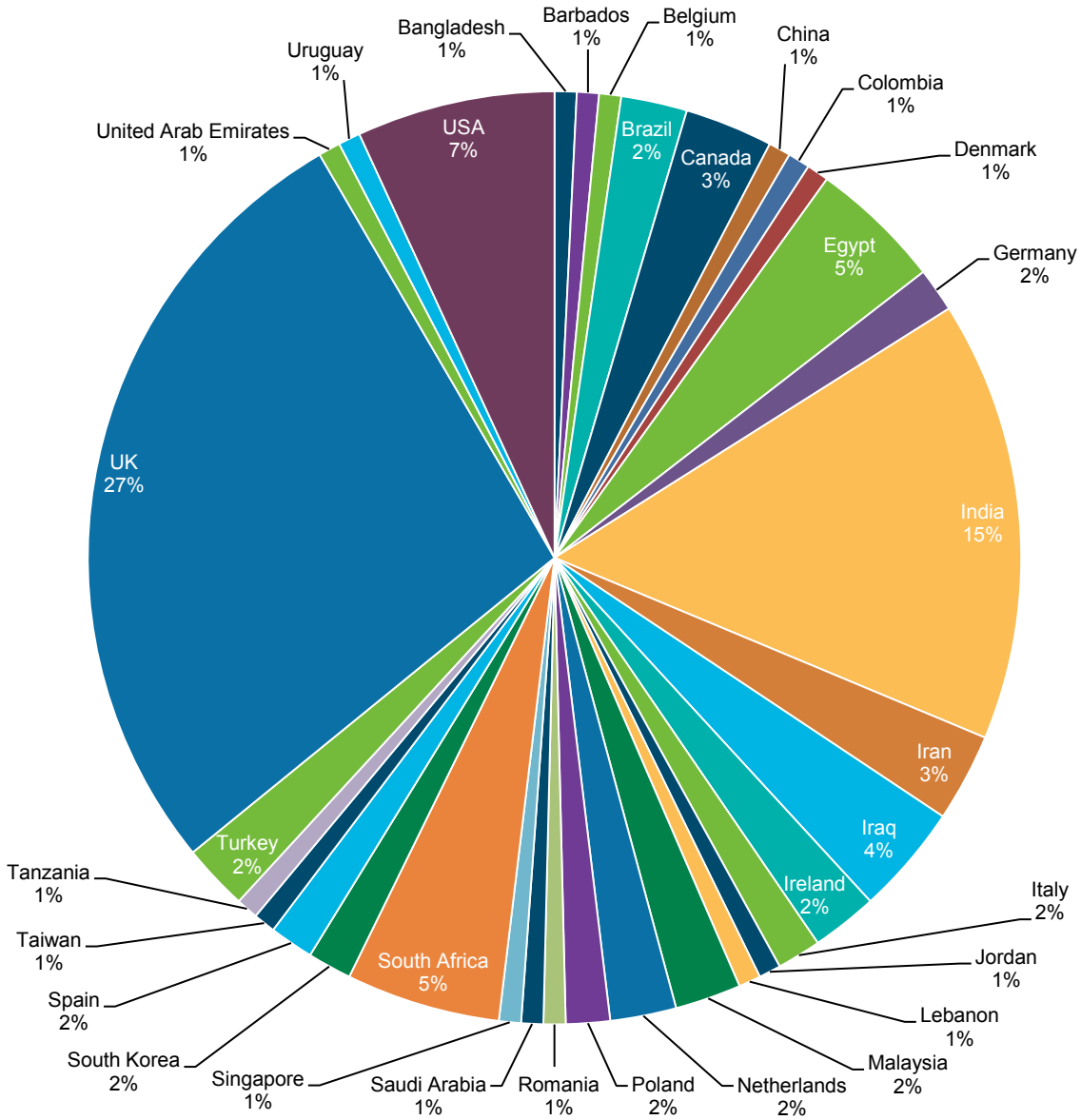
**Royal Australian College of General Practitioners**

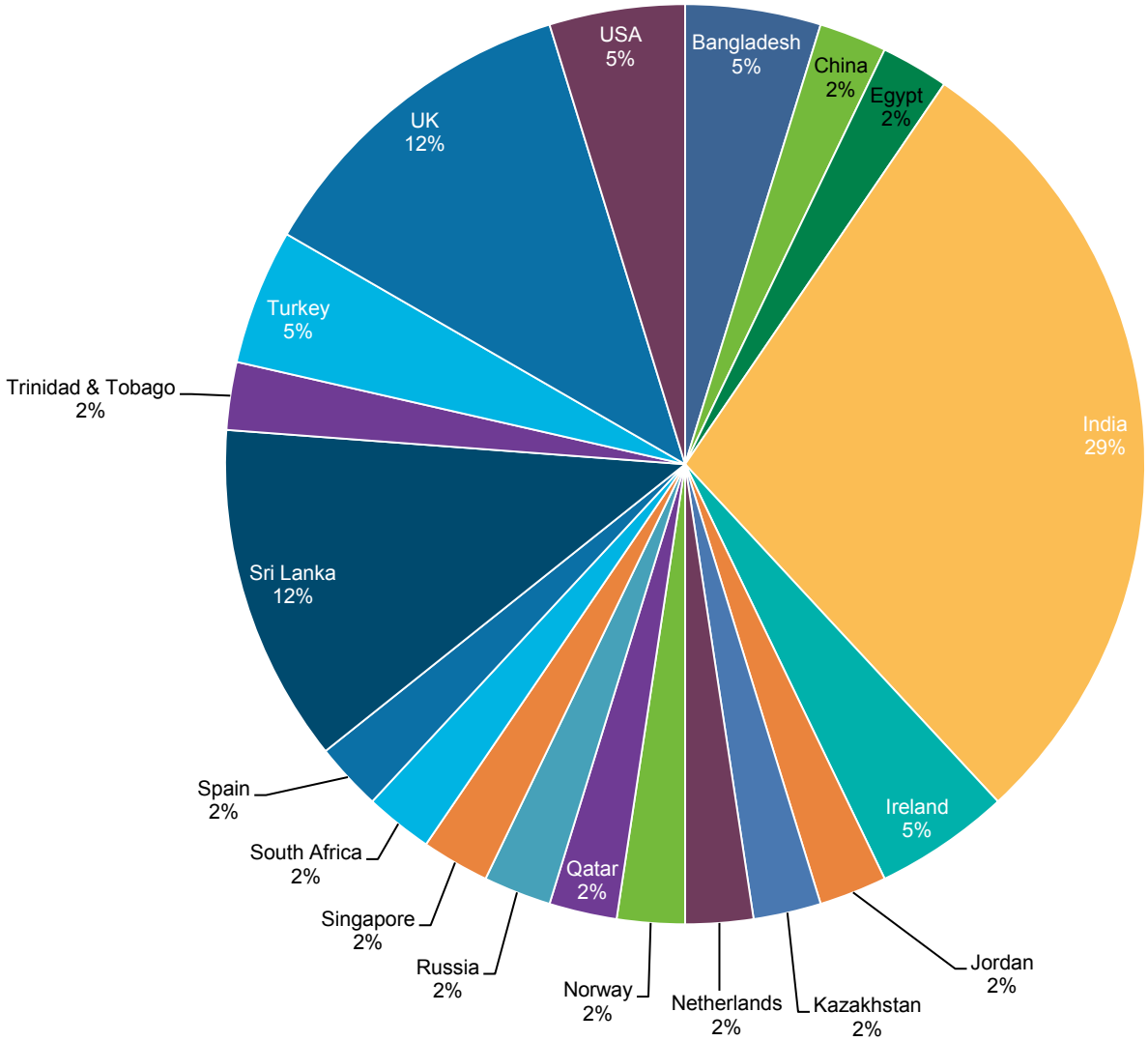


**Royal Australasian College of Medical Administrators**



**Royal Australasian College of Physicians**




USA
5%
Bangladesh
5%
China
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Egypt
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India
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Ireland
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Jordan
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Kazakhstan
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Netherlands
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Russia
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Singapore
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South Africa
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Spain
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Sri Lanka
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Trinidad & Tobago
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Turkey
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UK
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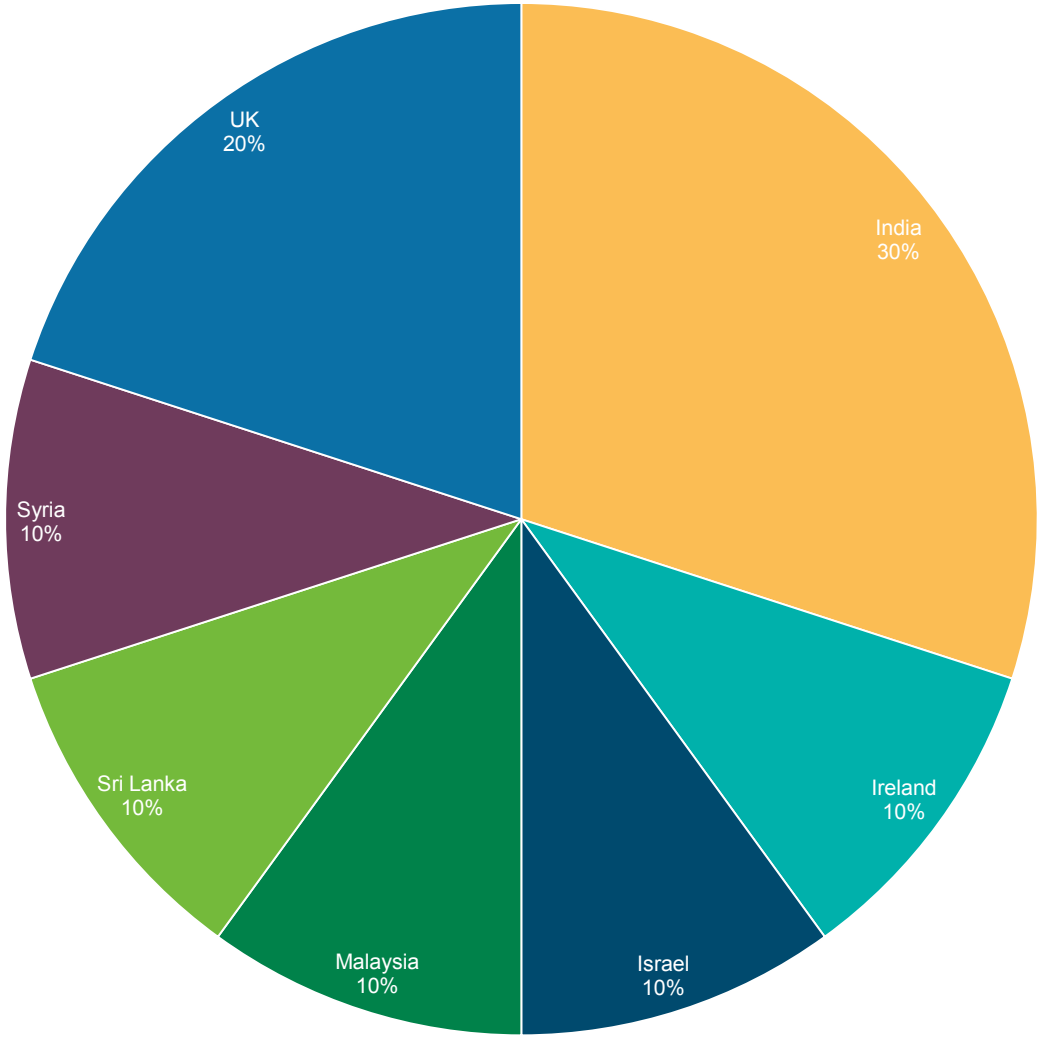
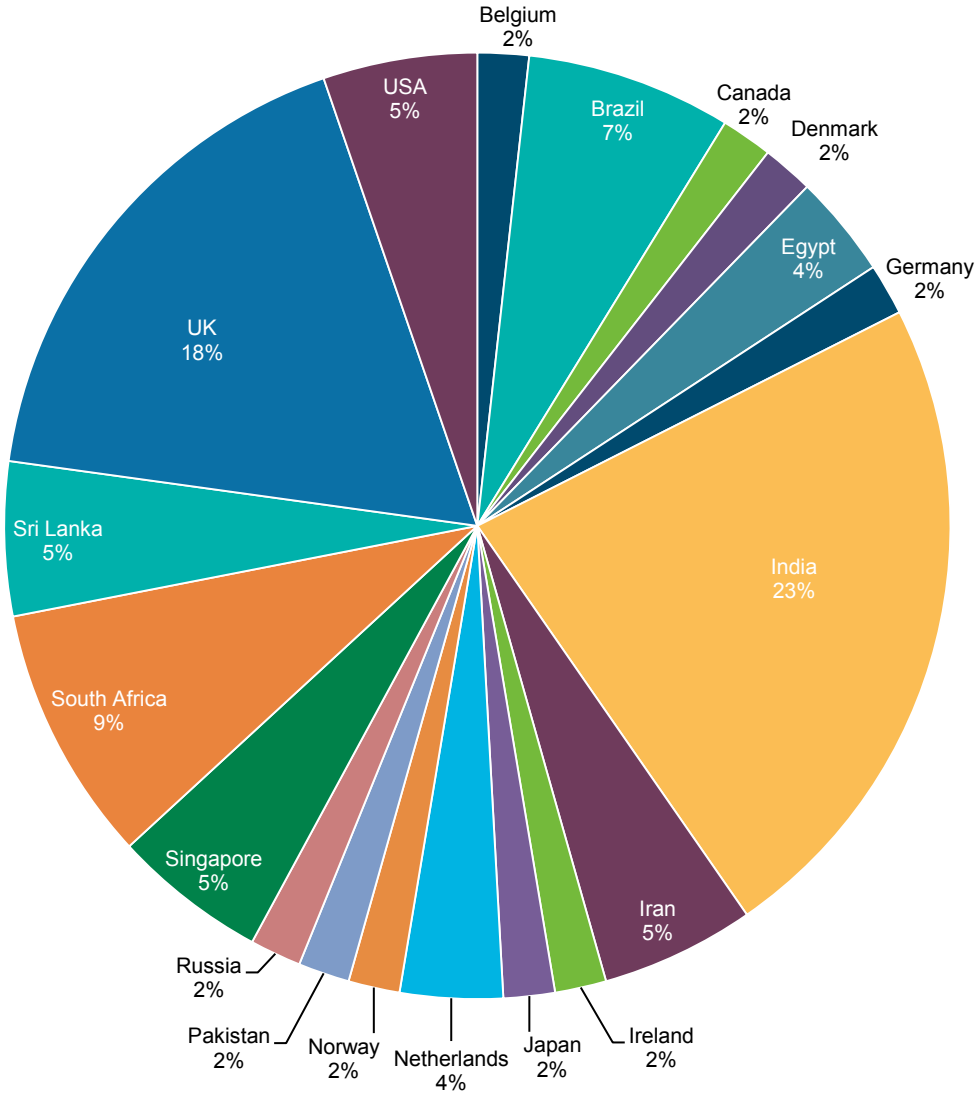
Qatar
2%

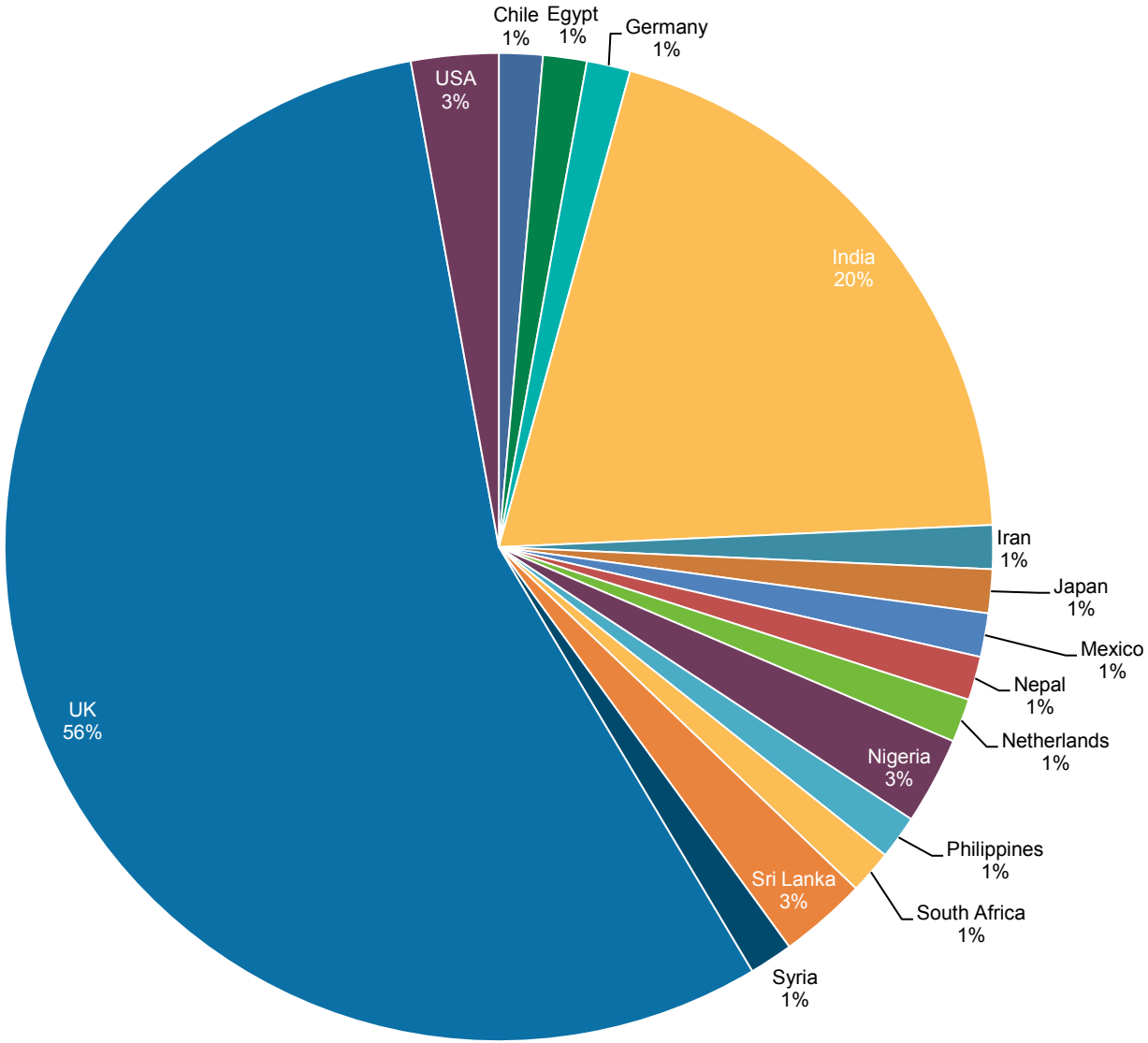
**Royal Australian and New Zealand College of Ophthalmologists**



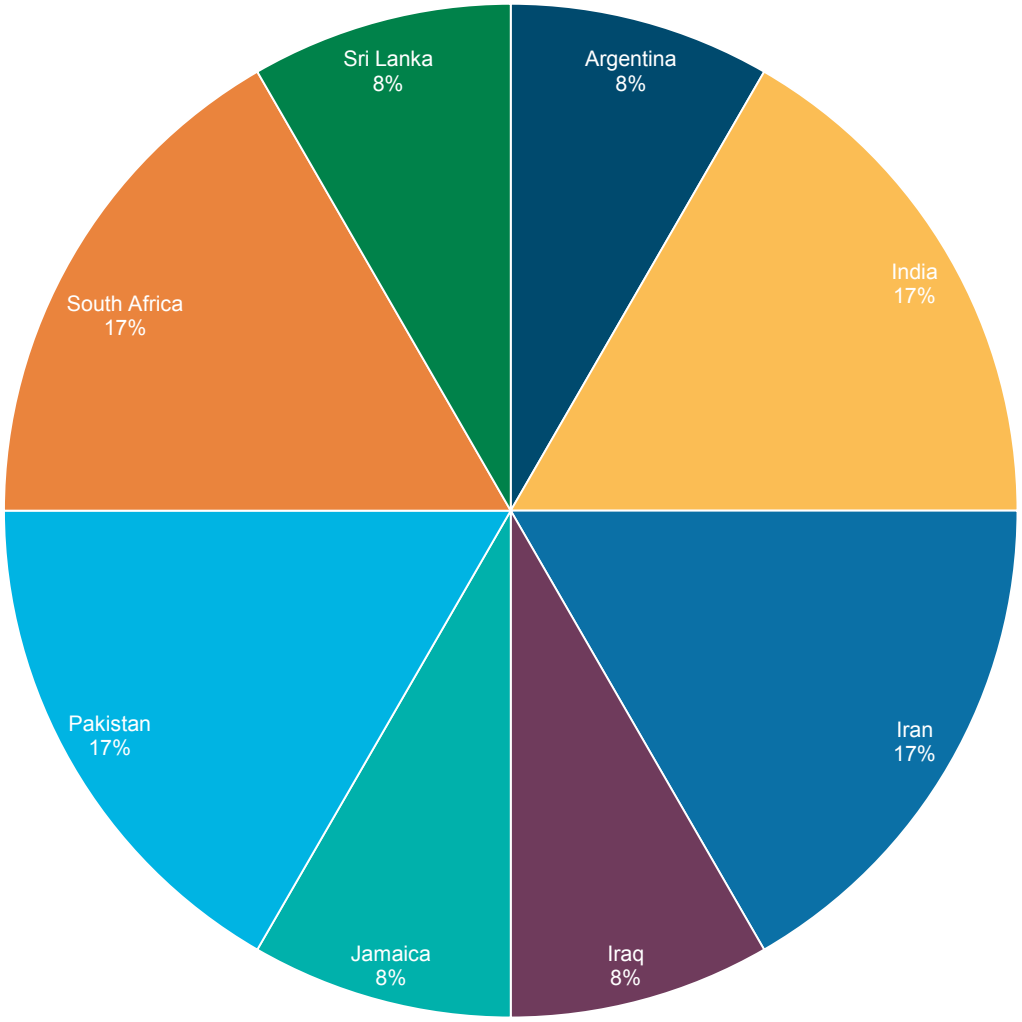
**Royal Australian and New Zealand College of Radiologists**



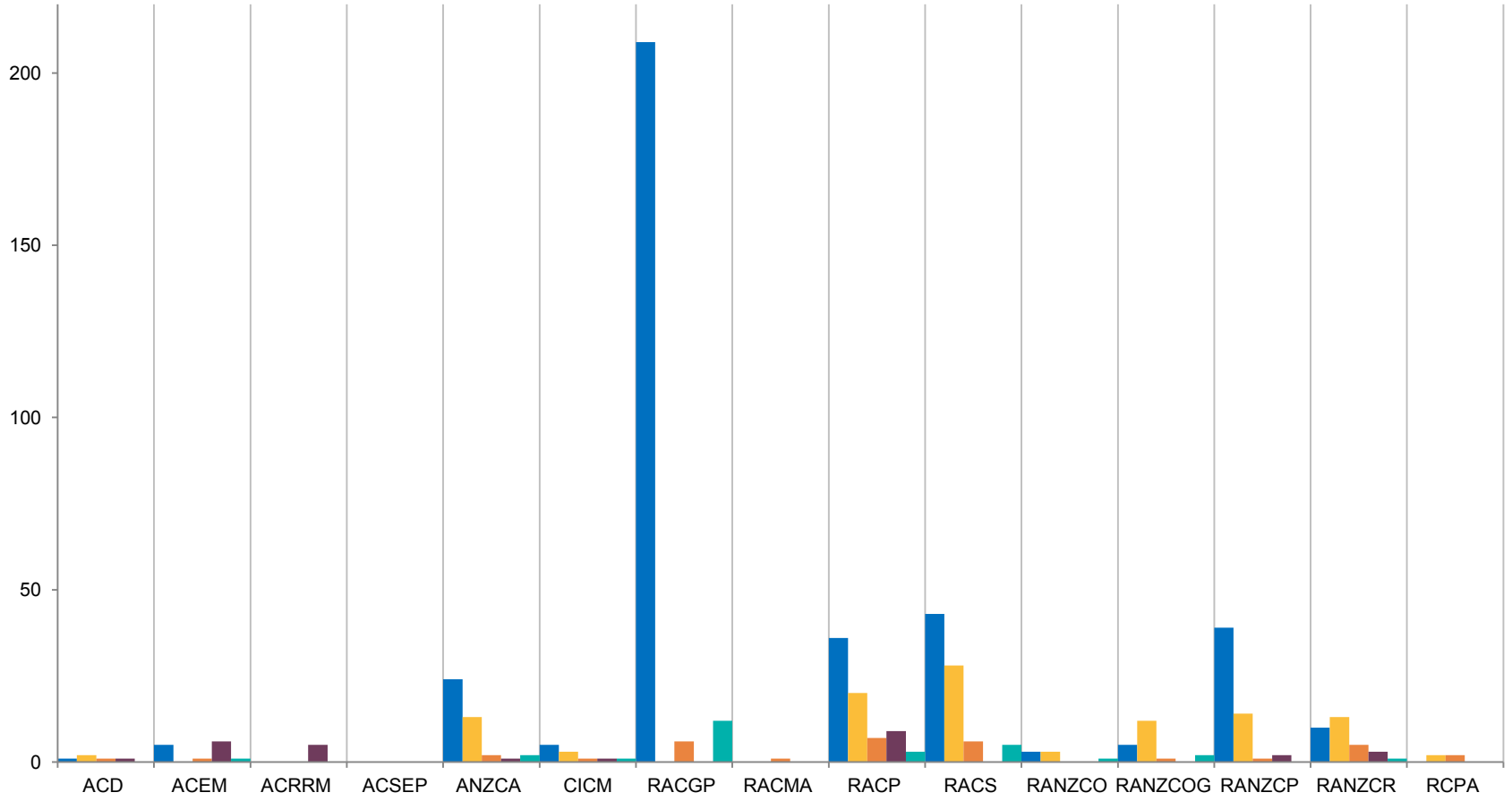
**Royal Australian and New Zealand College of Psychiatrists**



**Royal Australasian College of Pathologists**



## 18. Number of applications received – Top 5 countries




| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| United Kingdom | 1 | 5 | 0 | 0 | 24 | 5 | 209 | 0 | 36 | 43 | 3 | 5 | 39 | 10 | 0 |
| India | 2 | 0 | 0 | 0 | 13 | 3 | 0 | 0 | 20 | 28 | 3 | 12 | 14 | 13 | 2 |
| South Africa | 1 | 1 | 0 | 0 | 2 | 1 | 6 | 1 | 7 | 6 | 0 | 1 | 1 | 5 | 2 |
| United States of America | 1 | 6 | 5 | 0 | 1 | 1 | 0 | 0 | 9 | 0 | 0 | 0 | 2 | 3 | 0 |
| Ireland | 0 | 1 | 0 | 0 | 2 | 1 | 12 | 0 | 3 | 5 | 1 | 2 | 0 | 1 | 0 |

Attachment D

Medical Board of Australia

# Guidelines

2 November 2015

## Good practice guidelines for the specialist international medical graduate assessment process

## 1. Introduction

The Medical Board of Australia (the Board) has developed these guidelines to support specialist medical colleges in their role of assessing specialist international medical graduates (SIMGs) for comparability to an Australian-trained specialist in the same field of specialty practice. The Board relies on the college assessment to make decisions about whether to grant registration to a SIMG.

The guidelines have been developed in accordance with the objectives and guiding principles of the National Registration and Accreditation Scheme (the National Scheme) and aim to ensure a uniform approach to the assessment process for SIMGs.

The Board has developed separate guidance for Australian and New Zealand medical graduates with overseas specialist qualifications who seek specialist registration in Australia. The guidance is available on the Board's website.

## 2. Background

The registration of SIMGs is a feature of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The National Law provides for the registration of SIMGs who have successfully completed any examination or assessment required by an approved registration standard to assess a SIMG's ability to competently and safely practise in the specialty.

The Board has decided that the examination or assessment[1] of SIMGs will be undertaken by the specialist medical colleges that are accredited by the Australian Medical Council (AMC). At the request of the Board, the Australian Health Practitioner Regulation Agency (AHPRA) has appointed each AMC-accredited specialist medical college to undertake the assessment of SIMGs. This appointment provides for colleges and their employees and assessors to be indemnified under the National Law for exercising this function in good faith.

## 3. The objectives and guiding principles of the National Registration and Accreditation Scheme (the National Scheme)

The **objectives** of the National Scheme are defined in the National Law and are:

1. to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
2. to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
3. to facilitate the provision of high quality education and training of health practitioners; and
4. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
5. to facilitate access to services provided by health practitioners in accordance with the public interest; and
6. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The **guiding principles** of the National Scheme are as follows:

1. the scheme is to operate in a **transparent**, **accountable**, **efficient**, **effective** and **fair** way;
2. fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;
3. restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

[1] Section 59, Health Practitioner Regulation National Law, as in force in each state and territory.

## 4. The role of the Medical Board of Australia

The Board is responsible for regulating registered medical practitioners in the public interest. The key functions of the Board are to:

1. register medical practitioners who are suitably trained and qualified to practise in a competent and ethical manner
2. investigate concerns about a medical practitioner's conduct, performance or health and take any necessary action to protect the public
3. approve accreditation standards for education providers and their programs of study
4. approve accredited programs of study that provide a qualification for the purposes of registration
5. develop standards, codes and guidelines for the medical profession.

The assessment of SIMGs is an important function for ensuring that applicants for registration are suitably trained and qualified to practise competently and safely in their specialty and at a level comparable with an Australian trained specialist in the same field of practice. The Board relies on the advice of the specialist medical college when considering whether to grant registration to a SIMG.

## 5. The role of the specialist medical colleges under the National Registration and Accreditation Scheme

Specialist medical colleges are a part of the National Scheme. They:

1. are accredited under the National Law by the AMC
2. provide accredited programs of study approved by the Board as providing a qualification for the purposes of specialist registration
3. are education providers, and as such, have specific status and responsibilities under the National Law
4. have a defined role in the Board's approved registration standard for specialist registration
5. are appointed by AHPRA on behalf of the Board to conduct SIMG assessments.

Being part of the National Scheme means that:

1. the role of the specialist medical colleges is formally recognised in the National Law
2. the National Scheme provides opportunities for collaboration and mutual support
3. the appointment of the specialist medical colleges to assess SIMGs gives the colleges, including their employees, assessors and supervisors, protection from personal liability for exercising this assessment function, providing they act in good faith.

## 6. The role of the Australian Medical Council (the AMC)

The AMC facilitates:

1. primary source verification of an IMG's medical qualifications
2. the exchange of relevant information between the AMC, the specialist medical colleges and AHPRA through the AMC secure portal. The secure portal is a repository for certified copies of an IMG's qualifications, their primary source verification documents and the outcome of their specialist medical college assessment. AHPRA (on behalf of the Board) accesses the secure portal to source information for the purposes of registration.

## 7. The role of the National Specialist IMG Committee

The National Specialist IMG Committee is established as a committee of the Board. The terms of reference for the committee are to:

1. review the operation of the assessment of SIMGs (both area of need and specialist recognition assessment) and make recommendations to the Medical Board of Australia

2. consider, consult with stakeholders and in particular specialist colleges, and make recommendations to the Medical Board of Australia about policy issues that arise in relation to the assessment of SIMGs (both area of need and specialist recognition assessment)

3. communicate policy decisions about the assessment of SIMGs to relevant stakeholders

4. enhance communication and dialogue between all major stakeholders

5. explore options for sharing resources in the assessment of SIMGs (both area of need and specialist recognition assessment)

6. monitor and report to the Board on the assessment of SIMGs, including reporting on activity and issues arising

7. coordinate the publication of guidelines for applicants and colleges for the assessment of SIMGs

Specialist medical colleges can raise any issues regarding the operation of the SIMG assessment process with the Board. The Board may refer the matter to the National Specialist IMG Committee.

## 8. Principles of the assessment process

The assessment of SIMGs must be carried out in a manner that is consistent with the guiding principles defined in the National Law. This includes that the assessment process operates in a way which is:

1. Fair

2. Transparent

3. Efficient

4. Effective, and

5. Accountable.

Further, fees required to be paid are to be reasonable having regard to the efficient and effective operation of the National scheme.

The assessment of SIMGs must be:

1. undertaken in good faith

2. undertaken in accordance with the principles of procedural fairness

3. in accordance with the comparability definitions (Appendix 3), applied consistently by all specialist medical colleges as set out below:

> The assessment of comparability is based on the professional attributes, knowledge and clinical skills expected of an Australian trained specialist in the same field of specialist practice.
>
> When assessing a SIMG for comparability, the specialist medical college must consider any training, assessment, experience, recent practice and continuing professional development (CPD) completed by a SIMG to determine whether all these components together will enable the SIMG to practice at a level comparable to the standard expected of an Australian trained specialist commencing in the same field of practice. For example, if a SIMG's specialist training program is of lesser duration to the college program, the college must consider the training and any experience completed after training to determine comparability.

## 9. Establishing a committee to be responsible for the assessment process

Good practice in the assessment of SIMGs includes specialist medical colleges:

1. establishing a committee or a similar body to be responsible for the assessment process, within the college's overall governance arrangements

2. ensuring that members of the committee have the necessary attributes, knowledge and skills in the assessment of college trainees and understand their college's training requirements and standards

3. ensuring that the committee includes at least one fellow who has completed their specialist training overseas and who has been through the college assessment process and if possible at least one community member

4. implementing a documented governance framework for the operation of the committee. This will include:

    a. the terms of reference for the committee (including defining its role, responsibilities, structure, standard operating procedures and key relationships i.e. interaction with other college groups)

    b. procedures for declaring and managing conflicts of interest. For example, individuals involved in the direct supervision / peer review / workplace assessment / employment of a SIMG must not be involved in the decision on whether to recommend the SIMG be granted recognition as a specialist

    c. the guidelines and procedures for ensuring procedural fairness are afforded to SIMG applicants.

## 10. The procedures for assessment

Good practice in the assessment process for SIMGs includes documenting clearly and publishing the requirements and procedures for all phases of the assessment process (e.g. paper-based assessment, interview, supervision, examination, appeals etc). The procedures for assessment will be consistent with the Board approved procedures as outlined in the Guide to the Specialist Pathway. The college procedures should include:

1. the requirement for an applicant to apply to have their medical qualifications verified by the AMC through the Educational Commission for Foreign Medical Graduates (ECFMG) Electronic Portfolio of International Credentials (EPIC) or International Credentials Services (EICS) and provide an EPIC or EICS number with their application for assessment

2. a process to ensure the applicant is notified in a timely manner that their application for assessment will not proceed without an EPIC or EICS number

3. a process for monitoring an application to ensure it progresses in a timely manner

4. a process for assessment in each of the following pathways:

    a. specialist pathway – specialist recognition

    b. specialist pathway – area of need

5. a statement of the documentary evidence that the applicant is required to submit for assessment under each of the pathways

    a. the format of documentary evidence required by the college that is also required by the Board should be consistent with Board requirements wherever possible (e.g. requirements for certifying documents, format of curriculum vitae)

    b. colleges may require proof of English language proficiency to be supplied by applicants before they will commence the assessment process. This requirement should be clearly stated in advice to applicants provided by the college. The standard required will be no higher than that required by the Board's English language skills registration standard

6. documentation of the fees for assessment

7. a clear statement of the assessment standards and criteria against which applicants will be assessed.

Colleges must follow their published procedures. If a college deviates from the published procedures, they must document the reasons as part of their justification for the deviation.

## 11. Fees

Each college is responsible for setting its own fees. Fees must be consistent with the guiding principles in the National Law. Fees are expected to be reasonable in the context of the effective and efficient operation of the assessment process. The college can charge fees for:

1. the initial review of application documentation
2. the assessment interview
3. formal assessments (e.g. examinations, workplace based assessments)
4. further requirements (e.g. peer review, supervision, upskilling, access to college resources including CPD programs)
5. reconsideration, review and appeal of the outcome.

The college will publish a schedule of fees on its website that includes the cost of each element of the assessment process.

## 12. Specialist pathway – specialist recognition

This pathway is for IMGs with overseas specialist qualifications who wish to qualify for specialist registration in Australia. The assessment determines whether a SIMG is comparable to an Australian trained specialist in the same field of practice. See Appendix 1 for an overview of the SIMG process.

**Assessment of comparability**

Good practice in the assessment process involves:

1. assessing SIMGs in accordance with the approved definitions for assessment of comparability to determine whether a SIMG is not comparable, partially comparable or substantially comparable to an Australian trained specialist in the same field of practice. See Appendix 3 for full definitions
2. keeping full and accurate documentation of each stage of the assessment process
3. publishing the information and evidence that the college requires from the SIMG (see section 10 above)
4. only considering evidence that is relevant and been provided for the purposes of assessment. Where a college receives publically available information about a SIMG that may inform the interim assessment decision, such as disciplinary history or conditions recorded on a public register, the college must follow the rules of procedural fairness. This includes providing the SIMG with the information received and giving them an opportunity to make a submission about the information. This process must occur prior to any interview or assessment being undertaken
5. notifying the Board of any information received by the college for the purposes of the interim assessment decision that raises concerns about a SIMG's suitability for registration.

### *Substantially comparable*

SIMGs assessed as substantially comparable may be required to undertake a period of up to 12 months full time equivalent (FTE) practice under peer review by a reviewer/s approved by the college. This may involve the satisfactory completion of workplace-based assessment (WBA).

If the college determines that a SIMG requires more than 12 months (FTE) of peer review to ensure that their level of performance is similar to that of an Australian trained specialist, then the SIMG may not be assessed as substantially comparable and will be assessed as partially comparable or not comparable.

### *Partially comparable*

SIMGs assessed as partially comparable will be required to undertake upskilling with associated assessment under a supervisor(s) and may be required to undertake formal examinations.

If the college determines that a SIMG requires more than 24 months (FTE) of upskilling with associated assessment to reach the level of performance of an Australian trained specialist, then the IMG will be assessed as not comparable.

### *Not comparable*

SIMGs assessed as not comparable require more than 24 months upskilling with associated assessment to reach the level of performance of an Australian trained specialist. SIMGs who are assessed as not comparable can be advised that they may be eligible to apply for medical registration via the Standard Pathway or the Competent Authority Pathway and to contact AHPRA for further assistance.

**Interim assessment**

Good practice in the assessment of SIMGs involves the specialist medical college conducting an interim assessment of a SIMG to determine comparability[2] to an Australian trained specialist in the same field of practice.

The interim assessment:

1. includes a review of documentary evidence provided by the SIMG
2. identifies any gaps/deficiencies compared with Australian specialist training
3. takes into consideration a SIMG's scope of practice
4. may or may not include an interview with the SIMG.

In some cases the college may decide not to interview the SIMG because the documentary evidence indicates that the SIMG's training and experience is not comparable to an Australian trained specialist in the same field of practice.

### *The interview*

Following the paper-based assessment the college may interview the SIMG.

The aim of the interview is to:

1. confirm details of the SIMG's qualifications, training, experience, recent practice in the specialty and CPD provided in the written documentation and if necessary, to seek additional detail
2. assess a SIMG's suitability to commence a period of peer review, supervised practice, upskilling, assessment or formal examination.

The interview is undertaken by trained assessors who have been appointed by the college to undertake this element of the assessment. It is good practice to also include a community member on the interview panel.

### *Process for the interview*

Good practice in the interview process requires that:

1. the assessors have reviewed the documentation submitted by the SIMG in detail prior to the interview
2. the assessors collaborate and plan the interview. The assessors will develop and use structured questions based on the information contained in the SIMG's documentation

[2] Refer to section 8 of this guideline on "Principles of the assessment process" on applying the comparability definitions.

3. the interview is used to explore in greater detail the SIMG's qualifications, training, experience, recency of practice in the specialty, CPD and non-technical professional attributes including the SIMG's knowledge of, respect for, and sensitivity towards, the cultural needs of the community, including Aboriginal and Torres Strait Islander people

4. the SIMG is assessed in accordance with the college's published assessment criteria

5. questions that are not relevant to the college assessment criteria are avoided

6. the SIMG is given an opportunity to ask questions of the interviewers about the process, to ensure that the process is fully understood by the SIMG

7. clinical testing is not undertaken. Clinical testing is the purpose of the period of peer review, supervised practice, upskilling, assessment and/or examination.

### *Outcome of interim assessment*

At the conclusion of the interim assessment process a decision will be made by the college as to whether the SIMG is not comparable, partially comparable or substantially comparable.

If the applicant is assessed as partially or substantially comparable, the college will define the further requirements that need to be met before recommending to the Board that the SIMG be granted recognition as a specialist. The college will inform the SIMG of the interim assessment outcome and additional requirements and will upload its decision using a reporting template developed for this purpose (Report 1 or combined report. See Appendix 4 and 5) to the secure portal for AHPRA to use as part of the registration process.

When communicating the college's further requirements, the college should also inform the SIMG whether the college requires prospective approval of supervisors or positions and what the approval process entails. The college may also inform the SIMG that the college does not have a role in finding the SIMG a suitable post.

Any specified clinical experience and assessment required of SIMGs as part of the college's further requirements should be no more than that required of Australian trainees completing their training. The college should not require a SIMG to complete supervised clinical practice or specific clinical experience that is not required of Australian trainees. Reasons for requiring specific areas of experience should be clearly documented.

### Completing additional requirements

Good practice in the assessment process for SIMGs includes:

1. a documented process for monitoring SIMGs during the period of peer review, supervised practice, assessment or formal examination

2. documentation of the mechanisms that will be used to determine whether a SIMG is satisfactorily fulfilling college requirements (e.g. through satisfactory supervisor reports etc).

This period will enable the college to either confirm or modify its interim assessment of comparability and make a final decision on whether to recommend the SIMG be granted recognition as a specialist.

### Decision regarding eligibility for specialist recognition

After an SIMG has completed the additional requirements specified by the college in Report 1 or combined report (if applicable) the college will document its recommendation. The college will inform the SIMG of the outcome and will upload its decision using a reporting template developed for this purpose (Report 2 – See Appendix 6) to the secure portal for use by AHPRA for the purposes of registration.

Report 2 will confirm:

1. the college's recommendation on whether the SIMG should be granted recognition as a specialist, or
2. whether the SIMG should be granted recognition as a specialist in a limited scope of practice and any recommendations for conditions on registration (see below), or
3. whether the SIMG is considered not comparable and the reasons, or
4. whether the SIMG has withdrawn from completing the additional requirements specified in Report 1 or the combined report.

A SIMG who has been initially assessed as substantially comparable but who is unable to satisfactorily complete the requirements of the college will as a result be determined to be partially comparable or not comparable.

**Options for SIMGs who do not meet college requirements**

The college should provide advice to SIMGs who do not meet college requirements to contact AHPRA for further guidance on what their options are for practising in Australia as a medical practitioner.

**Recommending a SIMG for specialist recognition in a limited scope of practice**

The Board's approved registration standard for specialist registration provides for granting specialist registration in a limited scope of practice within a specialty or field of specialty practice.

Good practice in the assessment of SIMGs includes colleges having a documented policy and process for assessing SIMGs who are practising to a similar standard as an Australian trained specialist practising in a limited scope of practice within a specialty or field of specialty practice. Where a college recommends a SIMG for specialist registration in a limited scope of practice, the Board will impose conditions on the SIMG's specialist registration reflecting the SIMG's limited scope of practice taking into consideration any advice from the college on restricted scope of practice. The conditions will be published on the public Register of Medical Practitioners.

Under section 58(c) of the National Law SIMGs may qualify for specialist registration after successfully completing any examination or other assessment required by the Board. The Board's registration standard for specialist registration provides for granting specialist registration to SIMGs who are assessed by a specialist medical college as competent and safe to practise in the full scope of a specialty or in a limited scope within a specialty or field of specialty practice.

Where a college assesses a SIMG to be practising to a similar standard as an Australian trained specialist in a limited scope of practice, the college may:

1. recommend that a SIMG be granted recognition as a specialist in a limited scope of practice within a specialty or field of specialty practice without awarding fellowship, or
2. consider awarding fellowship in a limited scope of practice within a specialty or field of specialty practice.

**Maximum timeframe for completing college requirements**

Good practice in the assessment of SIMGs includes defining the maximum timeframe for completing college requirements. The maximum timeframes are:

1. for partially comparable SIMGs - a total of four years to complete up to 24 (FTE) calendar months of supervised practice / upskilling with associated assessment including formal examinations where required
2. for substantially comparable SIMGs - a total of two years to complete up to 12 (FTE) calendar months of peer review / oversight.

The starting point for the maximum timeframes is from the date a SIMG starts practice in a position approved for completion of any college requirements, noting that some colleges may have policies about the length of time permitted to lapse between the interim assessment decision and the start of practice.

Where a college has a policy on the validity period of an interim assessment decision, the college must publish the policy including any requirements for re-assessment of comparability.

The maximum timeframes allow for part-time practice. Any examinations or assessments scheduled after the period of supervised practice / upskilling for partially comparable SIMGs are to be completed within the maximum timeframes. Leave granted for 'exceptional circumstances' is not counted as part of the maximum timeframe.

The college will publish policies for granting extensions for 'interrupted time' or 'exceptional circumstances' consistent with policies for Australian trainees.

**Re-assessment of comparability**

Good practice in the assessment process for SIMGs includes documenting the policy and process for SIMGs to apply for re-assessment of comparability and the circumstances under which the college will consider applications for re-assessment. Applications for re-assessment should not be confused with an appeal of a college decision on comparability where a SIMG disputes an interim assessment or where the college initiates a re-assessment.

A SIMG may request a re-assessment because there has been a material change to their training and experience since they were initially assessed by the college. A SIMG may apply for re-assessment of comparability only where they can provide evidence of a further significant period of training or experience that is verifiable and acceptable to the college.

## 13. Specialist pathway – area of need

This pathway is for SIMGs who wish to work in Australia in a designated area of need. The college assesses the SMG's qualifications and relevant experience against the specified requirements of a position in a confirmed area of need. See Appendix 2 for an overview of the SIMG process.

SIMGs in the specialist pathway – area of need may also apply for specialist recognition assessment. Some colleges may choose to assess SIMGs for both pathways at the same time.

## 14. Recency of practice

The Board has an approved registration standard for recency of practice. The registration standard requires medical practitioners to have recent practice in the areas in which they intend to work during the period of registration for which they are applying. The specific requirements for recency of practice depend on the field of practice, the level of experience of the practitioner and the length of any absence from the field.

Good practice in the assessment process for specialist SIMGs includes publishing a policy on the college's requirements for recency of practice for the purposes of assessing a SIMG's comparability or assessing an SIMG's suitability for an area of need position.

The college policy should take into consideration the Board's registration standard for recency of practice. A college can develop its own specific requirements for recency of practice on the basis of the specialty involved and the intended scope of practice.

## 15. Supervision/Peer Review

Good practice in the assessment process for SIMGs includes having guidelines on the supervision or peer review of SIMGs. The guidelines should define:

1. the roles and responsibilities of supervisors, peer reviewers and SIMGs
2. processes for addressing issues arising during the supervision / peer review period
3. the appropriate level of supervision for a SIMG's level of training and experience
4. the requirements for remote supervision (where the supervisor and the SIMG are not located at the same facility).

## 16. Appeals

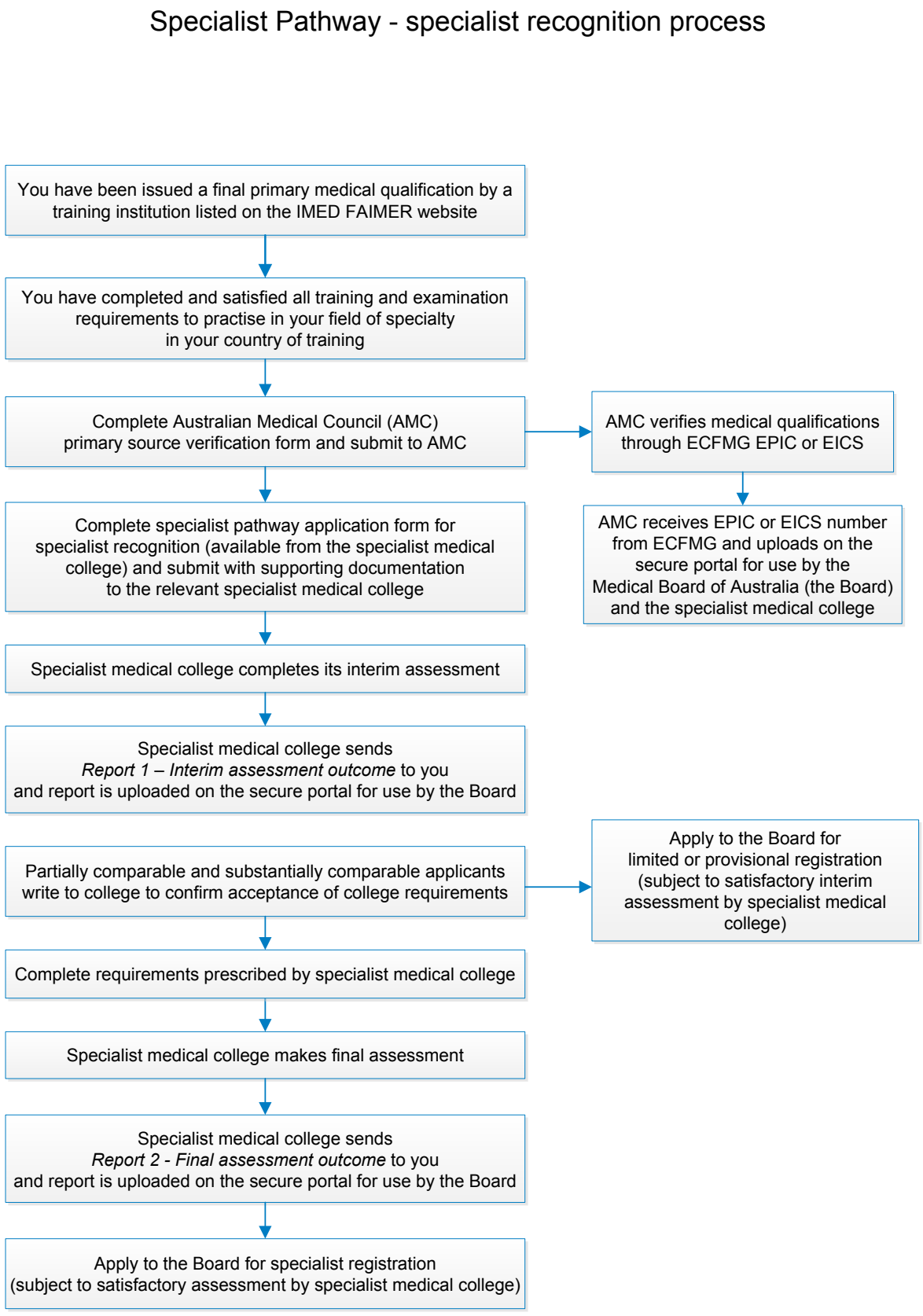
The colleges must have a documented and published appeals process that is consistent with the AMC's accreditation standards for the accreditation of specialist medical education providers and their training programs.

## Review

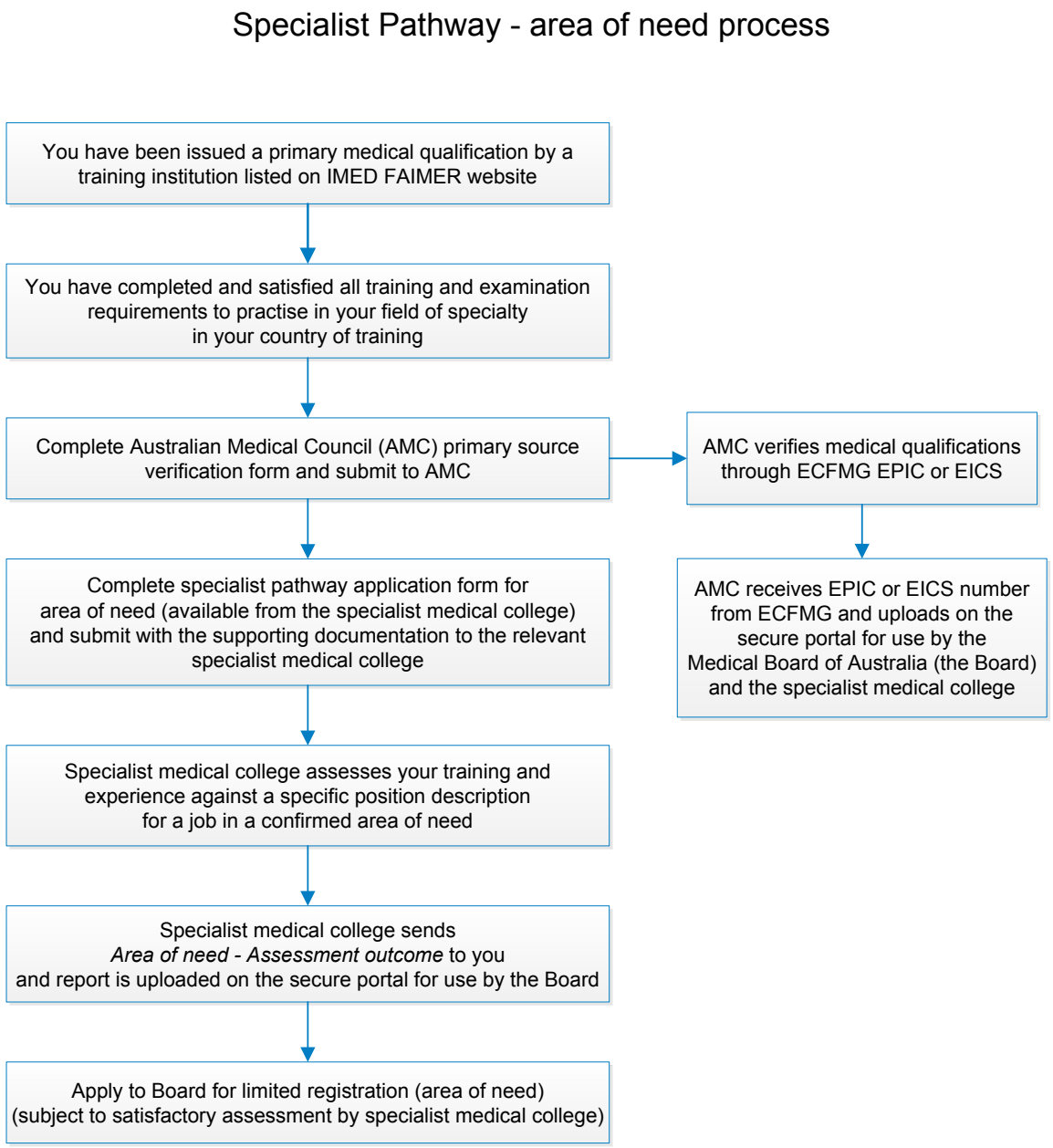
**Date of effect:** 2 November 2015

**Date of review**: This guideline will be reviewed from time to time as required. This will generally be at least every five years.

## Appendix 1 Specialist Pathway - specialist recognition process for SIMGs



## Appendix 2 Specialist Pathway - area of need process for SIMGs



## Appendix 3

**Comparability definitions**

**Substantially Comparable**

Substantially comparable applicants have been assessed as suitable to undertake the intended scope of practice, taking full responsibility for individual patients with only oversight of their practice by a supervisor. In order to be considered substantially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD). The applicant may be required to undertake a period of up to 12 months full time equivalent of practice under peer review by a reviewer approved by the college, which may involve the satisfactory completion of a workplace-based assessment (WBA). This is to ensure that the level of performance is similar to that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access CPD. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis, but the peer review period must not exceed 12 months. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college without formal examination, and may apply for registration as a specialist.

Substantially comparable applicants will not be eligible to apply for specialist registration during the period of peer review.

**Partially Comparable**

Partially comparable applicants have been assessed as suitable to undertake a defined scope of practice in a supervised capacity. In order to be considered partially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD) that will enable them to reach the standard of an Australian trained specialist within a maximum period of 24 months full time equivalent of practice. During this period, the applicant will undertake upskilling with associated assessment under a supervisor(s) approved by the college and may be required to undertake formal examination(s). This is to ensure that the level of performance reaches that of an Australian trained specialist. This period of supervised practice will assist the applicant with the transition to the Australian health system, will provide them with professional support and assist with access to CPD. The length of supervised practice and nature of assessment is up to the individual college to determine on a case-by-case basis, but the supervised practice period must not exceed 24 months full time equivalent of practice. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college and may apply for registration as a specialist.

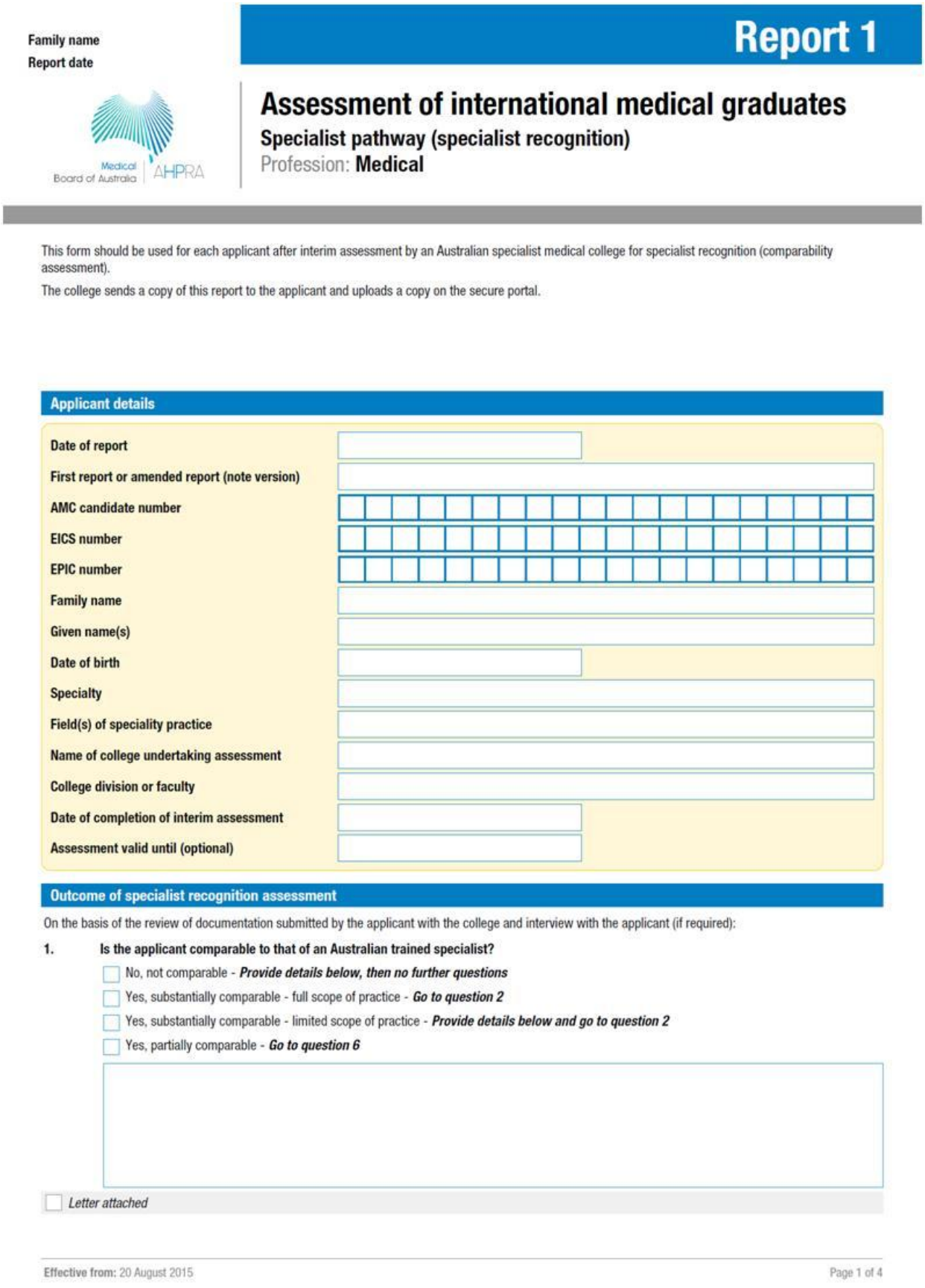
Partially comparable applicants will not be eligible to apply for specialist registration during the period of supervised practice.

**Not comparable**

Applicants who do not meet the requirements of the relevant specialist college in regard to previous training, assessment, recent specialist practice and continuing professional development (CPD) or who are assessed as unable to reach comparability within 24 months full time equivalent of practice will be assessed as not comparable. They may be eligible to seek registration to practise via another pathway that will enable them to gain general registration, and subsequently seek formal college training and assessment.

## Appendix 4

**Report 1**



Family name
Report date

Medical Board of Australia | AHPRA

# Report 1

## Assessment of international medical graduates

### Specialist pathway (specialist recognition)

Profession: **Medical**

This form should be used for each applicant after interim assessment by an Australian specialist medical college for specialist recognition (comparability assessment).

The college sends a copy of this report to the applicant and uploads a copy on the secure portal.

**Applicant details**

| | |
|---|---|
| Date of report | |
| First report or amended report (note version) | |
| AMC candidate number | |
| EICS number | |
| EPIC number | |
| Family name | |
| Given name(s) | |
| Date of birth | |
| Specialty | |
| Field(s) of speciality practice | |
| Name of college undertaking assessment | |
| College division or faculty | |
| Date of completion of interim assessment | |
| Assessment valid until (optional) | |

**Outcome of specialist recognition assessment**

On the basis of the review of documentation submitted by the applicant with the college and interview with the applicant (if required):

1. **Is the applicant comparable to that of an Australian trained specialist?**

- ☐ No, not comparable - ***Provide details below, then no further questions***
- ☐ Yes, substantially comparable - full scope of practice - ***Go to question 2***
- ☐ Yes, substantially comparable - limited scope of practice - ***Provide details below and go to question 2***
- ☐ Yes, partially comparable - ***Go to question 6***

☐ *Letter attached*

**Effective from:** 20 August 2015

Page 1 of 4

## Substantially comparable

2. **Is the applicant required to undertake a period of oversight?**

- ☐ No - ***Go to question 3***
- ☐ Yes - **What period of oversight is required?** Note: If the applicant requires more than 12 months oversight, the applicant is *partially comparable*
  - ☐☐ months (maximum 12 months) - ***Go to question 3***

3. **Are there any other requirements?**

- ☐ Yes - ***Provide details, then no further questions***

- ☐ No - ***Go to question 4***

4. **Does the college recommend that the applicant be granted recognition as a specialist?**

Speciality

- ☐ Yes, full scope of practice - ***No further questions***
- ☐ Yes, limited scope of practice - ***Provide details below and go to question 5***

- ☐ No - ***No further questions***

5. **Does the college recommend any conditions/limitations on specialist registration, if granted?**
For example, the applicant should be restricted to practise in (name the limited scope of practice and/or any other limitations relevant to the scope of practice)
Note: The Medical Board of Australia will take the recommendations into consideration when deciding whether to grant specialist registration

- ☐ Yes - ***Provide details, then no further questions***

- ☐ No - ***No further questions***

## Partially comparable

6. **Is a period of approved, supervised clinical practice required?**

- ☐ No - ***Go to question 8***
- ☐ Yes - **What period of supervised clinical practice is required?**
  Note: If the applicant requires more than 24 months supervised clinical practice, the applicant is *not comparable*
  Note: When determining supervision arrangements, colleges should refer to the Medical Board of Australia's *Guidelines for supervised practice*
  - ☐☐ months (maximum 24 months) - ***Go to question 7***

**7.** **Is specified clinical experience required during this period?**

☐ No - ***Go to question 8***

☐ Yes - ***Specify what is required then go to question 8***

**8.** **Is an examination required?**

☐ No - ***Go to question 9***

☐ Yes - ***Provide details below, then go to question 9***

When will it be held (if known)? What will be its timing in relation to any required supervised clinical practice?

What is the format of the examination? Describe format or provide link to information on website

☐ To be decided

A decision will be made after reports are received from the supervisors of the clinical practice.
A decision must be made and notified to the applicant before the completion of the supervised clinical training and where this is required to extend beyond 18 months, before 18 months is completed.

**9.** **Are there any other requirements?**

☐ Yes - ***Provide details below***

☐ No

**Additional information**

## Report 1 explanatory notes

Where practicable, this report should be completed within three months of receipt by the college of the complete application for assessment.

**Question 1**

The college is asked to assess on the basis of the written application and supporting documentation and interview of the applicant by the college (if required), whether the applicant is comparable to an Australian trained specialist (in a full or limited scope of practice).

The college assessment takes into consideration the applicant's intended scope of practice. The college determines whether the scope of practice is appropriate.

An applicant who would require significant additional training or retraining (more than 24 months) should be assessed as not comparable. The applicant should be advised that he or she could apply for one of the other pathways to registration in Australia. Thereafter, the applicant could apply for entry into a college training program and seek recognition of prior learning/training carried out overseas.

**Questions 2 and 3**

For applicants who are substantially comparable the college specifies a period of oversight

**Questions 4 and 5**

If no oversight is required, a college must confirm that they recommend that the applicant be granted recognition as a specialist, and any recommendations on scope of practice.

**Questions 6 and 7**

If an applicant is partially comparable, the college should recommend a period of supervised clinical practice and/or an examination as part of additional assessments.

The college must specify its duration and detail any specific clinical experience required. The applicant's progress, once they are registered, should be monitored on a regular basis by the college through the submission of progress reports. A decision on the requirement for specific clinical experience should be based on evidence from the documentation or interview that the applicant requires upskilling to reach the standard of an Australian trained specialist. In the documentation provided to the applicant by the college, processes for approval of the supervised training and supervisor must be described. The position and the supervision arrangements must also be approved by the Medical Board of Australia as part of the registration application.

**Question 8**

The college must indicate if an examination will be required or whether this decision will be made towards the end of the period of supervised clinical practice and before 18 months of supervised practice when the total recommended period is 24 months.

The format of the examination must be described.

## Definitions

### Comparability definitions

**Substantially comparable** applicants have been assessed as suitable to undertake the intended scope of practice, taking full responsibility for individual patients with only oversight of their practice by a supervisor. In order to be considered substantially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD). The applicant may be required to undertake a period of up to 12 months full time equivalent of practice under peer review by a reviewer approved by the college, which may involve the satisfactory completion of a workplace-based assessment (WBA). This is to ensure that the level of performance is similar to that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access CPD. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis, but the peer review period must not exceed 12 months. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college without formal examination, and may apply for registration as a specialist.

Substantially comparable applicants will not be eligible to apply for specialist registration during the period of peer review.

**Partially comparable** applicants have been assessed as suitable to undertake a defined scope of practice in a supervised capacity. In order to be considered partially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD) that will enable them to reach the standard of an Australian trained specialist within a maximum period of 24 months full time equivalent of practice. During this period, the applicant will undertake upskilling with associated assessment under a supervisor(s) approved by the college and may be required to undertake formal examination(s). This is to ensure that the level of performance reaches that of an Australian trained specialist. This period of supervised practice will assist the applicant with the transition to the Australian health system, will provide them with professional support and assist with access to CPD. The length of supervised practice and nature of assessment is up to the individual college to determine on a case-by-case basis, but the supervised practice period must not exceed 24 months full time equivalent of practice. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college and may apply for registration as a specialist.

Partially comparable applicants will not be eligible to apply for specialist registration during the period of supervised practice.

**Not comparable** - applicants who do not meet the requirements of the relevant specialist college in regard to previous training, assessment, recent specialist practice and continuing professional development (CPD) or who are assessed as unable to reach comparability within 24 months full time equivalent of practice will be assessed as not comparable. They may be eligible to seek registration to practise via another pathway that will enable them to gain general registration, and subsequently seek formal college training and assessment.

**Overseas trained specialist** refers to a medical practitioner who has completed specialist training overseas and who is seeking specialist registration in Australia.

**Oversight** – practice under peer review by reviewer appointed by the college.

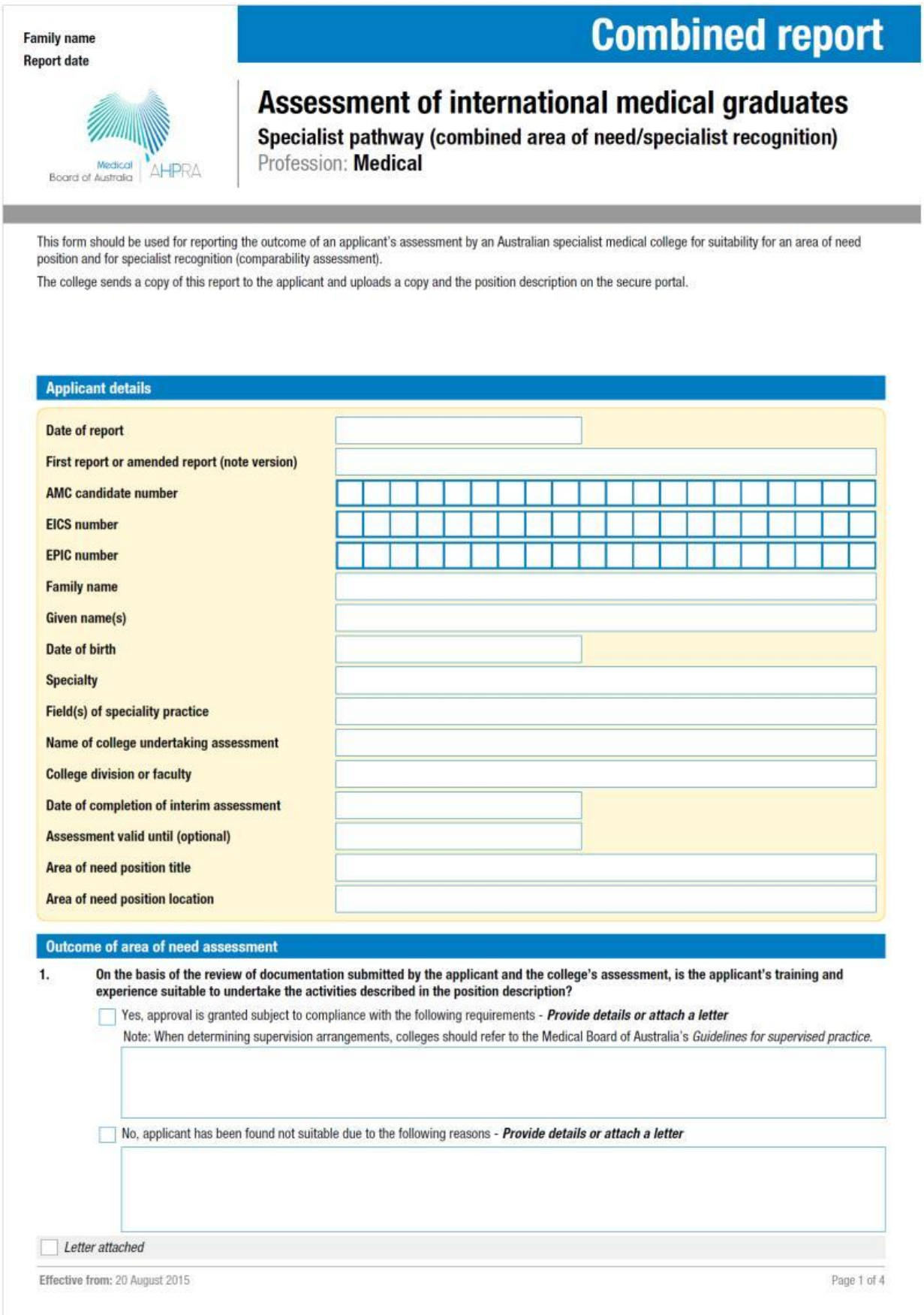
**Supervised clinical practice** is practice in a supervised capacity which, on the basis of the college's interim assessment, is required by an applicant who is considered as 'partially comparable' to an Australian trained specialist. The supervised practice is designed to enable the applicant - within a reasonably short period of time (24 months or less) - to upskill to enable him or her to be further assessed on the basis of his or her equivalence to an Australian trained specialist.

The supervisor provides reports to the college on the applicant's performance in the position. The reports are part of the college's overall assessment processes.

It is important to note that supervised clinical practice is NOT intended to address deficiencies in training and experience in an applicant who is assessed as partially comparable currently entering the Australian workforce - that is, an applicant who would require more than 24 months additional training and experience in order to reach a standard of an Australian trained specialist.

## Appendix 5

### Combined report



Family name
Report date

Medical Board of Australia | AHPRA

# Combined report

## Assessment of international medical graduates

**Specialist pathway (combined area of need/specialist recognition)**
Profession: **Medical**

This form should be used for reporting the outcome of an applicant's assessment by an Australian specialist medical college for suitability for an area of need position and for specialist recognition (comparability assessment).

The college sends a copy of this report to the applicant and uploads a copy and the position description on the secure portal.

**Applicant details**

| | |
|---|---|
| Date of report | |
| First report or amended report (note version) | |
| AMC candidate number | |
| EICS number | |
| EPIC number | |
| Family name | |
| Given name(s) | |
| Date of birth | |
| Specialty | |
| Field(s) of speciality practice | |
| Name of college undertaking assessment | |
| College division or faculty | |
| Date of completion of interim assessment | |
| Assessment valid until (optional) | |
| Area of need position title | |
| Area of need position location | |

**Outcome of area of need assessment**

1. **On the basis of the review of documentation submitted by the applicant and the college's assessment, is the applicant's training and experience suitable to undertake the activities described in the position description?**

☐ Yes, approval is granted subject to compliance with the following requirements - ***Provide details or attach a letter***

Note: When determining supervision arrangements, colleges should refer to the Medical Board of Australia's *Guidelines for supervised practice.*

☐ No, applicant has been found not suitable due to the following reasons - ***Provide details or attach a letter***

☐ *Letter attached*

**Effective from:** 20 August 2015 Page 1 of 4

## Outcome of specialist recognition assessment

On the basis of the review of documentation submitted by the applicant with the college and interview with the applicant (if required):

**2. Is the applicant comparable to that of an Australian trained specialist?**

- ☐ No, not comparable - ***Provide details below, then no further questions***
- ☐ Yes, substantially comparable - full scope of practice - ***Go to question 3***
- ☐ Yes, substantially comparable - limited scope of practice - ***Provide details below and go to question 3***
- ☐ Yes, partially comparable - ***Go to question 7***

## Substantially comparable

**3. Is the applicant required to undertake a period of oversight?**

- ☐ No - ***Go to question 4***
- ☐ Yes - **What period of oversight is required?** Note: If the applicant requires more than 12 months oversight, the applicant is *partially comparable*
  ☐☐ months (maximum 12 months) - ***Go to question 4***

**4. Are there any other requirements?**

- ☐ Yes - ***Provide details, then no further questions***
- ☐ No - ***Go to question 5***

**5. Does the college recommend that the applicant be granted recognition as a specialist?**

Speciality

- ☐ Yes, full scope of practice - ***No further questions***
- ☐ Yes, limited scope of practice - ***Provide details below and go to question 6***

**6. Does the college recommend any conditions/limitations on specialist registration, if granted?**
For example, the applicant should be restricted to practise in (name the limited scope of practice and/or any other limitations relevant to the scope of practice)
Note: The Medical Board of Australia will take the recommendations into consideration when deciding whether to grant specialist registration

- ☐ Yes - ***Provide details, then no further questions***
- ☐ No - ***No further questions***

## Partially comparable

**7.** **Is a period of approved, supervised clinical practice required?**

☐ No - ***Go to question 9***

☐ Yes - **What period of supervised clinical practice is required?**

Note: If the applicant requires more than 24 months supervised clinical practice, the applicant is *not comparable*

Note: When determining supervision arrangements, colleges should refer to the Medical Board of Australia's *Guidelines for supervised practice*

☐☐ months (maximum 24 months) - ***Go to question 8***

**8.** **Is specified clinical experience required during this period?**

☐ No - ***Go to question 9***

☐ Yes - ***Specify what is required then go to question 9***

**9.** **Is an examination required?**

☐ No - ***Go to question 10***

☐ Yes - ***Provide details below, then go to question 10***

When will it be held (if known)? What will be its timing in relation to any required supervised clinical practice?

What is the format of the examination? Describe format or provide link to information on website

☐ To be decided

A decision will be made after reports are received from the supervisors of the clinical practice.
A decision must be made and notified to the applicant before the completion of the supervised clinical training and where this is required to extend beyond 18 months, before 18 months is completed.

**10.** **Are there any other requirements?**

☐ Yes - ***Provide details below***

☐ No

## Additional information

## Definitions

### Comparability definitions

**Substantially comparable** applicants have been assessed as suitable to undertake the intended scope of practice, taking full responsibility for individual patients with only oversight of their practice by a supervisor. In order to be considered substantially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD). The applicant may be required to undertake a period of up to 12 months full time equivalent of practice under peer review by a reviewer approved by the college, which may involve the satisfactory completion of a workplace-based assessment (WBA). This is to ensure that the level of performance is similar to that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access CPD. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis, but the peer review period must not exceed 12 months. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college without formal examination, and may apply for registration as a specialist.

Substantially comparable applicants will not be eligible to apply for specialist registration during the period of peer review.

**Partially comparable** applicants have been assessed as suitable to undertake a defined scope of practice in a supervised capacity. In order to be considered partially comparable an applicant must have satisfied the college requirements in relation to previous training, assessment, recent specialist practice and continuing professional development (CPD) that will enable them to reach the standard of an Australian trained specialist within a maximum period of 24 months full time equivalent of practice. During this period, the applicant will undertake upskilling with associated assessment under a supervisor(s) approved by the college and may be required to undertake formal examination(s). This is to ensure that the level of performance reaches that of an Australian trained specialist. This period of supervised practice will assist the applicant with the transition to the Australian health system, will provide them with professional support and assist with access to CPD. The length of supervised practice and nature of assessment is up to the individual college to determine on a case-by-case basis, but the supervised practice period must not exceed 24 months full time equivalent of practice. Following satisfactory completion of this process, the applicant will be eligible for Fellowship of the relevant specialist college and may apply for registration as a specialist.

Partially comparable applicants will not be eligible to apply for specialist registration during the period of supervised practice.

**Not comparable** - applicants who do not meet the requirements of the relevant specialist college in regard to previous training, assessment, recent specialist practice and continuing professional development (CPD) or who are assessed as unable to reach comparability within 24 months full time equivalent of practice will be assessed as not comparable. They may be eligible to seek registration to practise via another pathway that will enable them to gain general registration, and subsequently seek formal college training and assessment.

**Overseas trained specialist** refers to a medical practitioner who has completed specialist training overseas and who is seeking specialist registration in Australia.

**Oversight** – practice under peer review by reviewer appointed by the college.

**Supervised clinical practice** is practice in a supervised capacity which, on the basis of the college's interim assessment, is required by an applicant who is considered as 'partially comparable' to an Australian trained specialist. The supervised practice is designed to enable the applicant - within a reasonably short period of time (24 months or less) - to upskill to enable him or her to be further assessed on the basis of his or her equivalence to an Australian trained specialist.

The supervisor provides reports to the college on the applicant's performance in the position. The reports are part of the college's overall assessment processes.

It is important to note that supervised clinical practice is NOT intended to address deficiencies in training and experience in an applicant who is assessed as partially comparable currently entering the Australian workforce - that is, an applicant who would require more than 24 months additional training and experience in order to reach a standard of an Australian trained specialist.

## Appendix 6

**Report 2**

Family name
Report date

Medical Board of Australia | AHPRA

# Report 2

## Assessment of international medical graduates

**Specialist pathway (specialist recognition)**
Profession: **Medical**

This form is to be used for each applicant after final assessment by an Australian specialist medical college for specialist recognition (comparability assessment). The college sends a copy of this report to the applicant and uploads a copy on the secure portal.

### Applicant details

| | |
|---|---|
| Date of report | |
| First report or amended report (note version) | |
| AMC candidate number | |
| EICS number | |
| EPIC number | |
| Family name | |
| Given name(s) | |
| Date of birth | |
| Specialty | |
| Field(s) of speciality practice | |
| Name of college undertaking assessment | |
| College division or faculty | |
| Date of completion of final assessment | |

### Final assessment outcome

**Applicant's interim assessment outcome was *substantially comparable* (report 1)**

1. **Was the required period of oversight satisfactorily completed?**

☐ Yes - ***Go to question 2***
☐ No - ***Go to question 2***

Additional comments

☐ *Letter attached*

2. **Were the other requirements satisfactorily completed?**

- ☐ Yes - ***Go to question 8***
- ☐ No - ***Go to question 8***
- ☐ Not applicable - ***Go to question 8***

Additional comments

**Applicant's interim assessment outcome was *partially comparable* (report 1)**

3. **Was a period of supervised clinical practice required?**

- ☐ Yes - ***Go to question 4***
- ☐ No - ***Go to question 5***

4. **Were the supervised clinical practice and supervisor reports satisfactory?**

- ☐ Yes - ***Go to question 5***
- ☐ No - ***Go to question 5***

Additional comments

5. **Was an examination required?**

- ☐ Yes - ***Go to question 6***
- ☐ No - ***Go to question 7***

6. **Were the examination requirements satisfactorily completed?**

- ☐ Yes - ***Go to question 7***
- ☐ No - ***Go to question 7***

Additional comments

7. **Were the other requirements satisfactorily completed?**

- ☐ Yes - ***Go to question 8***
- ☐ No - ***Go to question 8***
- ☐ Not applicable - ***Go to question 8***

Additional comments

Report 2 - **Family name** **Report date**

## All applicants

**8.** **Does the college recommend that the applicant be granted recognition as a specialist?**

Speciality

☐ Yes, full scope of practice - ***No further questions***

☐ Yes, limited scope of practice - ***Provide details and go to question 9***

☐ No

**9.** **Does the college recommend any conditions/limitations on specialist registration, if granted?**

For example, the applicant should be restricted to practise in (name the limited scope of practice and/or any other limitations relevant to the scope of practice)

Note: The Medical Board of Australia will take the recommendations into consideration when deciding whether to grant specialist registration.

☐ Yes - ***Provide details***

☐ No

## Report 2 explanatory notes

All the questions in Report 2 simply require a yes or no factual answer. Colleges need to ensure they have documentation that will justify the decisions that are the basis to the answers to these questions.

Medical Board of Australia

## Guideline

# Short-term training in a medical specialty for international medical graduates who are not qualified for general or specialist registration

[Date]

### 1. Background

Short-term training in a medical specialty for international medical graduates (IMGs) who are not qualified for general or specialist registration (short-term training in medical specialty pathway) is a pathway that allows internationally qualified specialists or international specialists-in-training to undertake short-term training in Australia without having to complete the Australian Medical Council (AMC) examination or to have a full comparability assessment by the relevant specialist medical college.

The short-term training in a medical specialty pathway is for individuals with specialist qualifications or for specialists-in-training who are close to completing specialist training in another country[1] and who want to undertake short-term training in a particular medical specialty area in Australia. In this context, 'short-term' is usually considered to be up to 24 months.

The short-term training in a medical specialty pathway also promotes opportunities for exchange fellowships.

IMGs eligible for the short-term training in a medical specialty pathway can apply for limited registration for postgraduate training or supervised practice. Medical practitioners with this type of registration must comply with the supervision and training requirements on registration approved by the Medical Board of Australia (the Board).

The short-term training in a medical specialty pathway does not lead to general or specialist registration. Medical practitioners who intend to practise in Australia for more than two years need to meet the requirements for the competent authority pathway, standard pathway (AMC certificate) or specialist pathway (either specialist recognition or area of need).

### 2. Purpose of this guideline

This guideline has been developed to inform IMGs and specialist medical colleges about the requirements for registration for IMGs who are eligible for the short-term training in a medical specialty pathway. It also describes the role of the specialist medical colleges accredited by the AMC which advise the Board about the suitability of the training position for the specific applicant for registration.

This guideline should be read in conjunction with the Board's registration standard for limited registration for postgraduate training or supervised practice which sets out the requirements for this type of registration and the specific requirements for the short-term training in a medical specialty pathway.

[1] There is one exemption to the requirement to be no more than two years away from completing specialist training – see the section on exemptions.

## 3. Eligibility for the short-term training in a medical specialty pathway

The short-term training in a medical speciality pathway is available to IMGs who are applying for limited registration for postgraduate training or supervised practice AND

1. are recognised as qualified specialists in another country of training (outside Australia) OR
2. are specialists-in-training in another country (outside Australia) and who:
    a. are likely to be no more than two years away from completing their specialist training, and
    b. have passed a basic specialist examination or have satisfactorily completed substantial training (generally three or more years, i.e. PGY 5).

## 4. The role of specialist medical colleges - assessing the suitability of the training position for the specific applicant

The specialist medical colleges have an important role in advising the Board whether:

1. an individual appears to be a genuine specialist-in-training or internationally qualified specialist, on the basis of a paper-based assessment of documents
2. the position that the individual has applied for is a genuine training position that is appropriate for that individual's training requirements, taking into consideration their reported level of training and experience, and
3. there is adequate supervision and support for the individual's level of training and experience. This assessment will take into consideration the purpose and principles of supervision as set out in the Board's guidelines for the supervision of IMGs.

The specialist medical college assessment does not:

1. assess the competence of the individual applying for registration
2. decide whether or not to register a medical practitioner. This is the responsibility of the Board, or
3. assess the IMG's training and experience for comparability against the training and experience of an Australian trained specialist in the same field of practice.

For a specialist medical college to undertake this assessment, you must apply to the AMC accredited specialist medical college on the application form approved by the Board. This form requires the following information:

1. a training plan providing details of the purpose, anticipated duration, location, content and structure of training and the anticipated date of any examinations or assessments
2. a position description for the proposed training position
3. details of how supervision will be provided and the names and contact details of proposed supervisor/s
4. a curriculum vitae
5. a statement from the overseas specialist college or body awarding the specialist qualification with whom you:
    a. are a specialist-in-training:
        i. confirming your trainee status with the college/body
        ii. outlining the content, structure and length of the training program
        iii. confirming that you are not likely to be more than two years from completing your specialist training
        iv. confirming that you have passed a basic specialist examination or satisfactorily completed substantial training (generally three or more years, i.e. PGY 5), and
        v. identifying the objectives of the training to be undertaken in Australia, or

b. are a specialist, confirming your specialist qualification in the country of training

5. written confirmation from you that, at this time, you have no intention of making further applications for registration at the end of the specified training period.

Due to the nature of each specialty, the relevant specialist medical college may specify what information is required in a position description, training plan or in other documentation described above. You should refer to the relevant specialist medical college website for detailed information.

The specialist medical colleges advise the Board on the outcome of their assessment by completing the applicable section in the application form submitted by you to the college. The completed form is provided directly to the Board by the specialist medical college and a copy is also provided to you (or your authorised nominee).

See Attachment A for an overview of the process for applying for registration.

## 5. Renewal of limited registration postgraduate training or supervised practice

Under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), limited registration may be renewed up to three times. After this, you must make a new application for limited registration and meet any registration standards which are current at the time.

Although practitioners in this pathway should not need to make more than one application for renewal of registration (as short-term training is usually for up to 24 months), you should be aware that renewal of limited registration for postgraduate training or supervised practice is subject to meeting a number of requirements, including providing evidence that you are satisfactorily progressing towards general or specialist registration.

Medical practitioners are usually exempt from this requirement if they will not apply for more than three renewals of registration.

As training in this pathway is for a defined period, after which you have undertaken that you will no longer be seeking medical registration in Australia, practitioners in this pathway are not required to demonstrate satisfactory progress towards general or specialist registration.

However, if circumstances arise that require you to apply for registration beyond 24 months, you:

1. must provide a letter from the relevant AMC accredited specialist medical college confirming support for the longer period of training and providing an assessment of your suitability for the training position in accordance with this guideline, and

2. may be required to demonstrate progress towards general or specialist registration, which will require you to apply for the competent authority pathway, the standard pathway or the specialist pathway (specialist recognition).

The Board will consider each application on a case-by-case basis.

## 6. Application for a change in circumstances

Limited registration for postgraduate training or supervised practice is granted for a specified purpose. The Board imposes requirements on registration as defined in its approved registration standard. The Board's registration standard for limited registration for postgraduate training or supervised practice requires medical practitioners to apply to the Board when they propose to change the circumstances under which they were granted limited registration for postgraduate training or supervised practice.

A change in circumstances includes a proposal to:

1. change the designated training position. This may include changing locations, adding additional work sites, changing your scope of practice (including moving to a role with increased clinical responsibilities e.g. PGY3 to registrar level) or applying for a new position with a new employer. (**Note:** practitioners who are no longer employed in their designated training position are unable to comply with the requirements on registration and therefore cannot practise medicine.)

2. change the approved training plan, or
3. extend training beyond the specified period of training that you had confirmed with the Board at your initial application for registration.

An application for a change in circumstances must be made on an application form approved by the Board and include a letter from the specialist medical college confirming support for your change in circumstances and providing an assessment of your suitability for the training position based on the proposed changes.

## 7. Exemption from the eligibility criteria for the short-term training in a medical specialty pathway

### Background

Most of the AMC accredited specialist medical colleges provide training for medical practitioners in Australia and New Zealand. The colleges may accept for specialist training IMGs who are not qualified for general registration in Australia but who have registration in a general scope in New Zealand. From time to time, the New Zealand trainees are required to do a rotation in Australia.

This exemption allows this cohort of practitioners to be granted limited registration, if they are more than two years away from completing their specialist training.

### Requirements

If you are a specialist-in-training and you are more than two years away from completing specialist training, you may be exempt from the eligibility criteria for this pathway, if you:

1. are not qualified for general registration in Australia, and
2. hold registration in a general scope with the Medical Council of New Zealand, and
3. are an accredited trainee with an AMC accredited specialist medical college in New Zealand.

You are required to provide a letter from the relevant AMC accredited specialist medical college confirming your accredited trainee status and providing an assessment of your suitability for the training position in accordance with this guideline.

## 8. Definitions

**Genuine specialist-in-training** means an applicant who:

1. has commenced a specialist training program in another country (outside Australia) that is delivered by a recognised/accredited body for specialist training. The overseas training program includes formal assessment processes and mechanisms for measuring learning outcomes, AND
2. is not likely to be more than two years away from completing their specialist training, and has passed a basic specialist examination or has satisfactorily completed substantial training (generally three or more years, i.e PGY 5), OR
3. holds registration in a general scope with the Medical Council of New Zealand but is not qualified for general registration in Australia and is an accredited trainee with an AMC accredited specialist medical college in New Zealand.

**Internationally qualified specialist** means an applicant is recognised as a qualified specialist by a recognised/accredited overseas authority responsible for awarding specialist qualifications and/or the qualified specialist is recognised by the registering authority as a specialist in another country (outside of Australia). The applicant is also seeking to up-skill their specialist qualifications in a particular specialist area and is not seeking specialist recognition in Australia.

**Genuine training position** means that the Australian training position that the applicant has applied for is a training position accredited by an AMC accredited specialist medical college or is a formal structured training position which consists of formal assessment processes and mechanisms for measuring learning outcomes. The training position is not primarily a service position.

## Implementation date and review

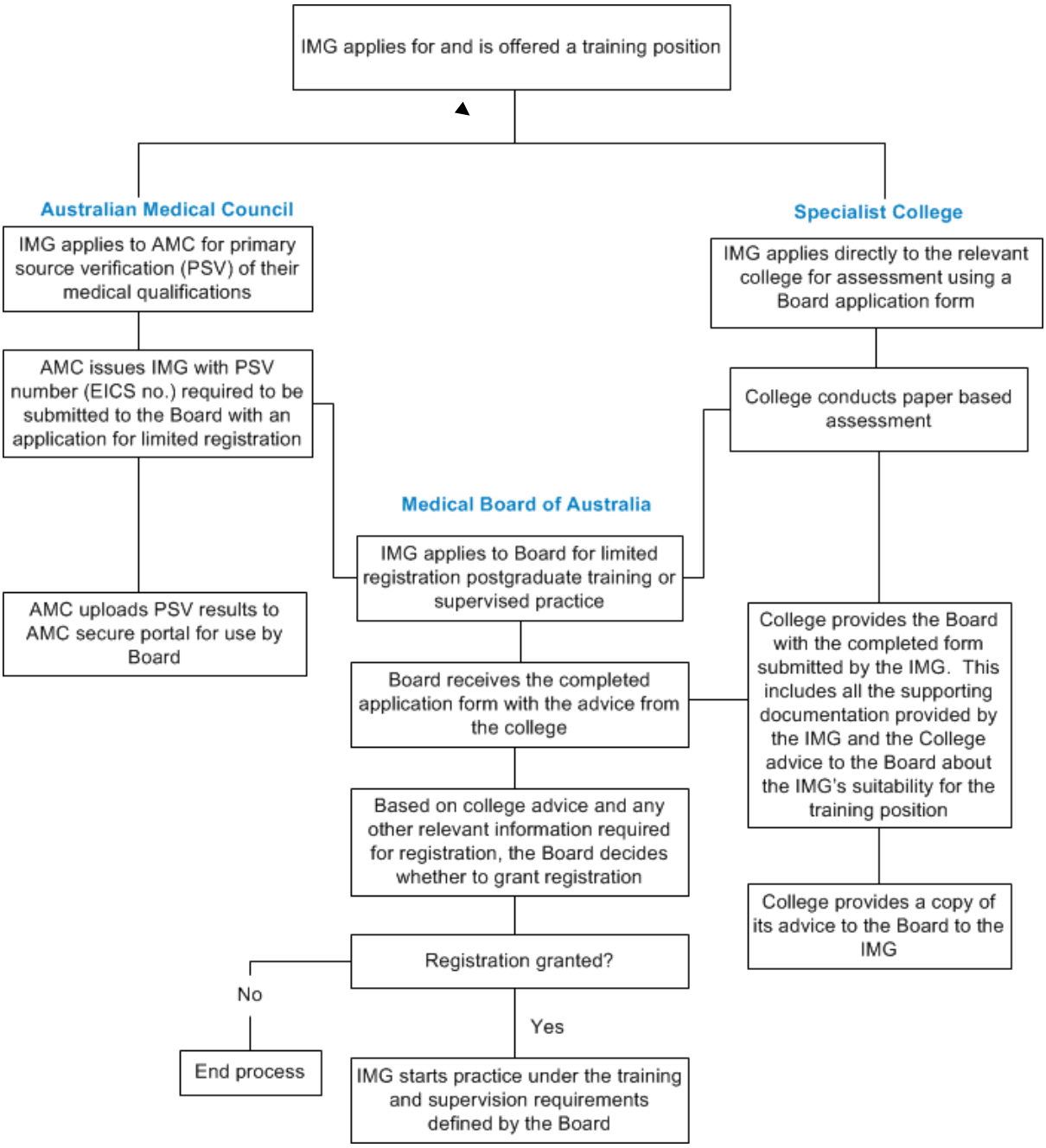
These guidelines will take effect on <date>.

The Board will review these guidelines from time to time.

**Attachment A**

# Short-term training in a medical specialty pathway

## Pathway flow chart



Attachment F

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

# English language skills registration standards

## Consultation report

May 2015

# Contents

# Foreword

National Boards work in partnership with the Australian Health Practitioner Regulation Agency (AHPRA) to implement the national scheme for regulating health practitioners in Australia (National Scheme).

National Boards set the national standards that practitioners must meet to be registered in Australia. These standards include five core registrations standards, required by the National Law[1]. One of these core registration standards is an English language skills standard which all applicants must meet for their profession.

The National Boards regulating the first ten health professions[2] under the National Scheme developed English language standards that took effect on 1 July 2010. Four more professions[3] joined the National Scheme on 1 July 2012 and the English language skills standards for these professions commenced at that time.

In keeping with good regulatory practice, all the standards were scheduled for regular review. As part of the review of the English language skills registration standards, all National Boards (except for the Aboriginal and Torres Strait Islander Health Practice Board of Australia, which did not take part in the review[4]) consulted widely on the proposed draft standard.

Submissions were invited over an eight week period from October to December 2013 and a total of 170 responses were received, from both Australian and overseas stakeholders.

The feedback received in the consultation helped inform the participating National Boards' review of the standards. The draft standards were sent to the Australian Health Workforce Ministerial Council for its consideration and approved on 17 March 2015.

From 1 July 2015, two new standards will come into effect, replacing the previous standards:

1. the ***Common English language skills registration standard***, which applies to all applicants for initial registration in Chinese medicine, chiropractic, dental, medical, medical radiation, occupational therapy, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. For clarity, three versions are published:
    a. the standard for 10 boards (no additional wording)
    b. the standard for dental, with the addition for some very brief dental-specific words for applicants for limited registration
    c. the standard for medical, with the addition of information about two medicine-specific English language tests
2. the ***Nursing and Midwifery English language skills registration standard***, which applies to all applicants for registration as enrolled nurses, registered nurses and midwives.

The new standards will be published on National Board websites in May 2015 to allow health practitioners time to become familiar with the new requirements.

The new standards are intended to provide an effective balance between public protection and increased flexibility for applicants by ensuring that the high level of English language skills required of registered health professionals in Australia is maintained.

[1] Health Practitioner Regulation National Law, as in force in each state and territory.

[2] Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology

[3] Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Medical Radiation Practice and Occupational Therapy

[4] The Aboriginal and Torres Strait Islander Health Practice Board of Australia will conduct its own profession-specific review starting in 2015/16.

The National Boards will continue work on the complex issue of the English language skills necessary for practice in Australia, including further research and periodic review of the English language skills registration standards.

The National Boards and AHPRA would like to thank all those who responded to this consultation. Responses to the consultation are published on the AHPRA website.

## About this document

This report identifies key themes from the submissions, provides a summary of responses to each of the questions posed in the consultation paper, gives a rationale for any changes made to the draft standard and sets out the proposed way forward, including areas where further work is planned.

The document is divided into four sections.

Section 1 gives an introduction and overview of the consultation process

Section 2 gives a summary of the responses to each of the questions found in the consultation document.

Section 3 outlines the changes that were made to the consultation draft English language skills registration standard and gives a rationale for these changes and other decisions relating to the final standard.

Section 4 sets out the National Boards' proposed future work in this area.

This report also contains four appendices.

Appendix 1 contains a supplementary report on the revised Nursing and midwifery English language standard.

Appendix 2 contains a summary of the research used to inform the review.

Appendix 3 lists the new common standard with changes from the consultation draft marked up. Additions to the consultation draft are shown in shaded text, while deletions are show in ~~strikethrough~~.

Appendix 4 is a clean version of the common *English language skills registration standard*.

Appendix 5 is the nursing and midwifery *English language skills registration standard.*

## 1. Introduction

Most current English language standards for the regulated professions in the National Scheme are very similar. The main exceptions are the standards for the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA) and Nursing and Midwifery Board of Australia (NMBA).

The ATSIHPBA standard differs from the English language skills standards of other National Boards to better reflect the specific language requirements of that profession. For this reason, ATSIHPBA did not participate in the joint review in late 2013 and will conduct its own profession-specific review starting in 2015/16.

The NMBA also has some differences in its standard, reflecting specific issues for nursing and midwifery. Although the NMBA conducted an early review of its 2010 standard in 2011, it chose to participate in the 2014 review so that the Board could consider any new evidence that might arise.

The joint approach to the review of the standards by 13 National Boards has been taken to maximise consistency across the registered health professions, given the similarity of the issues involved. However, issues specific to the nursing and midwifery profession continue to merit a slightly modified approach to language skills assessment.

A report on the revised Nursing and midwifery English language skills standard, including the rationale for differences from the draft standard common to the other 12 boards (with the minor variances for dental and medicine), is presented in Appendix 1.

The Chinese Medicine Board of Australia currently has transitional arrangements in place that allow for specified alternative evidence of English language skills to be accepted in certain circumstances described in the Board's English language skills registration standard. These transitional arrangements will end on 30 June 2015.

### 1.1 The main issues

The review of the English language skills registration standards was informed by the National Boards' experiences with the standards in the first three years of operation of the National Scheme. Three major issues were identified: assessment of tests results, the list of 'recognised countries', and flexibility.

#### Assessment of test results

Currently, the standards require that results for each module must be obtained in one sitting for the two prescribed English language tests (IELTS 7 and OET B). Some applicants considered this unfair, particularly those who were required to sit another full test when their test results were close to, but only slightly below the required standard. Other applicants were unable to consistently achieve the required standard in all modules in a single sitting, despite receiving an 'overall' grade at or above the required standard across several sittings.

#### List of 'recognised countries'

The current standards provide exemptions from having to sit an English language test in certain circumstances for practitioners whose education has been taught and assessed in English in Australia, Canada, New Zealand, Republic of Ireland, South Africa, United Kingdom or the United States of America. Some applicants for registration have argued that National Boards should recognise education in English from other countries, such as Hong Kong, Singapore and Malaysia. Others stakeholders have argued that South Africa should be removed from the list, as it is not a country recognised by the Department of Immigration and Border Protection (DIBP) for English language assessment purposes, despite a history of recognition in health practitioner regulation.

### Flexibility

A number of applicants for registration have argued that the current standards are too rigid and that more flexibility is needed to provide individual applicants with additional options to demonstrate that they have the necessary English language skills.

Additional research was commissioned specifically to inform the review. This research informed both the development of the consultation draft of the revised English language skills registration standard and the consideration of the issues raised by stakeholders in response to the consultation. A summary of this research is included in Appendix 2.

## 1.2 Consultation process

The National Law requires National Boards to undertake wide-ranging consultation on the content of any proposed registration standard.

In undertaking the review of the English language skills registration standards, National Boards followed the agreed process set out in the *Consultation process* document which is published on the AHPRA website.[5] The consultation paper included an assessment of the proposed standard against the *Procedures for the development of registration standards* which include the COAG principles for best practice regulation.

From 25 October 2013 to 23 December 2013 the National Boards consulted on a proposed revised standard. The consultation paper was published on the websites of the National Boards and was emailed to government and key stakeholders for each profession, including professional associations and consumer organisations. National Boards also published a media release about the consultation and publicised the consultation in communiqués and newsletters.

## 1.3 Feedback and questions for consideration

The consultation asked for views on a proposed revised English language skills registration standard, including whether the proposed standard was preferred to the status quo (existing English language skills registration standards). In addition, responses to nine specific questions were sought.

1. From your perspective, how is the current registration standard working?
2. Should the countries recognised in the standard be consistent with those countries recognised by the Department of Immigration and Border Protection for exemptions from English language testing? If so, should the recognition of South Africa in the National Boards' English language skills registration standard be phased out over time?
3. Is there any evidence to assist National Boards to assess whether there are any additional countries that should be recognised in their English language skills registration standard?
4. Do you have comments about how the National Boards should approach test results that are very close to, but slightly below, the current standard?
5. Should National Boards accept results from more than one sitting or is there a better way to address this issue, such as the approaches described above?
6. Is the content of the draft revised registration standard helpful, clear, relevant and more workable than the current standard?
7. Is there any content that needs to be changed or deleted in the revised draft registration standard?
8. Is there anything missing that needs to be added to the revised draft registration standard?
9. Do you have any other comments on the revised registration draft standard?

[5] The *Consultation process* can be accessed at: www.ahpra.gov.au/Publications/Procedures.aspx

### 1.4 Breakdown of responses

170 written responses were received from external stakeholders. Most submissions were from individuals (116), with another 37 from organisations (including regulators, specialist colleges, professional associations and accreditation councils). A further ten submissions were received from government bodies and departments; four submissions were from universities and three submissions were from English language test providers. Almost 100 submissions in total came from the nursing and midwifery and medical professions. The following table provides a more detailed breakdown.

Table 1: Submissions received by profession

| | |
|---|---|
| Chinese Medicine | 4 |
| Chiropractic | 2 |
| Dental | 6 |
| Medicine | 45 |
| Nursing and Midwifery | 47 |
| Occupational Therapy | 3 |
| Optometry | 1 |
| Osteopathy | 1 |
| Pharmacy | 3 |
| Physiotherapy | 2 |
| Podiatry | 3 |
| Psychology | 2 |
| Cross profession | 51 |
| *Total* | *170* |

## 2. Overview of responses

Overall, there was general support to move to a revised standard. Submissions were largely supportive of the proposed standard.

Some submissions supported greater flexibility in the standard, while others proposed a slightly more restrictive approach. The proposed standard seemed to represent a reasonable middle ground between these viewpoints.

Submissions which were not supportive of the proposals generally highlighted what they felt was the lack of a strong and conclusive evidence base in this area, preferring the status quo in the absence of hard data.

### 2.1 Summary of responses to key questions

Q1: From your perspective, how is the current registration standard working?

This question received 31 responses.

A majority of respondents identified issues with the current standard. These included:

- lack of flexibility, leading to a perceived lack of fairness
- high costs associated with multiple test sittings
- questions about the relevance or appropriateness of the list of recognised countries
- issues with the current two year validity period of test results, particularly with respect to international medical graduates (IMGs) and others for whom the registration process may take longer than two years.

Approximately a third of respondents to this question were in favour of maintaining the current standard, with a small number of these respondents suggesting minor modifications.

Q2: Should the countries recognised in the standard be consistent with those countries recognised by the Department of Immigration and Border Protection (DIBP) for exemptions from English language testing? If so, should the recognition of South Africa in the National Boards' English language skills registration standard be phased out over time?

This question received 41 responses.

Overall, the majority of submissions supported maintaining broad consistency with the DIBP-listed countries for the purpose of English language testing exemptions. However, some respondents submitted that it was not necessary to align AHPRA's list of recognised countries with that of the DIBP as the purpose of the lists for the two organisations is not the same.

A number of these respondents felt that the standard of English language required for the purposes of migrating to, or obtaining citizenship within, Australia should be separated from the standard of English language required for the purposes of providing health services in Australia, given that migration or citizenship requires only a competent or basic level of English language (IELTS score of 5 or 6, or equivalent) for most visa categories[6], compared with the higher level of competency (IELTS score of at least 7 or equivalent) required by the current English language skills registration standards.

Views differed as to whether consistency with the DIBP meant that South Africa should be phased out as a recognised country, with ten respondents in favour of removal of South Africa from the list and six in favour of South Africa remaining. A further five respondents felt that additional evidence was

[6] DIPB recognises five English language proficiency levels: Functional (IELTS 4.5 or equivalent); Vocational (IELTS 5.0 or equivalent); Competent (IELTS 6.0 or equivalent); Proficient (for points tested Skilled visas - IELTS 7.0 or equivalent); and Superior (for points tested Skilled visas – IELTS 8.0 or equivalent).

needed before an informed decision could be made. Several submissions noted that a transition period would be required if South Africa were to be removed from the list.

A number of respondents expressed the view that the list of recognised countries should be expanded to include countries where English is one of the official languages, including Hong Kong, Singapore, Malaysia, Nepal, India, the Philippines, Papua New Guinea, Fiji, Nauru, Singapore and Zimbabwe. These individuals were generally health practitioners who had been educated in English and felt that their English language skills were comparable to those with equivalent levels of education in English in one of the recognised countries. However, overall there was little support for including additional countries on the list of recognised countries, in the absence of clear, objective evidence to support such additions (see Q3).

Some submissions also proposed additional or alternate approaches to including more countries on the recognised country list in order to demonstrate English language competence. Little evidence was provided in support of these proposals.

### Q3: Is there any evidence to assist National Boards to assess whether there are any additional countries that should be recognised in their English language skills registration standard?

This question received 51 responses.

Overall, respondents to this question felt that there was not enough evidence to support expanding the list of recognised countries in the standard.

There were mixed views regarding adding Asian countries such as Singapore, Malaysia and Hong Kong. Of the Asian countries referenced, Singapore had the strongest support, with six respondents providing a variety of reasons for inclusion. Other respondents supported the inclusion of Malaysia, Hong Kong and/or the Philippines.

A number of respondents supported adding various other countries but little evidence was provided to support their inclusion. Other suggestions included adding countries where English is the official language of communication; where English is used in education and delivery of healthcare; and those that follow the UK education curriculum.

One complaints body noted that some complaints received by its office asserted that the current Nursing and midwifery English language skills registration standard was discriminatory and reflected an outdated view of what constitutes the English speaking world. In particular these complainants felt that applicants from Asian countries who could prove that they had been taught and assessed in English were not being assessed in the same way as applicants from the ‘recognised countries’.

Many submissions acknowledged that more research was needed in this area. In particular, one respondent recommended that thorough research be undertaken to provide a sound basis on which to make decisions about which countries should be on the list and to encourage transparency around the decisions to exempt or not exempt applicants from sitting an English language test.

### Q 4: Do you have comments about how the National Boards should approach test results that are very close to, but slightly below, the current standard?

This question received 47 responses.

Responses to this question were mixed, with approximately a third of respondents supporting accepting test scores that were very close to, but just below the required score. Another third of respondents did not support this approach, while a further third suggested that an overall score be the deciding factor, with a minimum score specified for each unit.

Of those that supported accepting scores that were just below the required score, most felt that this should be assessed on a case by case basis. The justification for this approach was that it introduces flexibility in the assessment process and it is fairer to applicants. One respondent felt that clear criteria

would be needed to guide the assessment of these cases. Another respondent suggested that some kind of standard secondary assessment method may be needed to supplement the test results where they are slightly below the current standard.

However, there was opposition to this approach from a number of respondents. One regulator expressed the view that it was much easier to administer a system that gives a clearly defined minimum standard, rather than one that gives consideration to each borderline case.

A number of professional organisations were strongly of the view that the score required by the current English language skills registration standards should not be lowered and that any relaxation of this requirement would result in an erosion of the English language skills required of health professionals, which could impact on public safety.

Sixteen submissions suggested introducing an overall score rather than individual scores for each component to address the issue of scores for some components being close to but slightly below the required score. There were various views about the overall score and the minimum score for each component, with proposals for a minimum overall score ranging from 6 to 7.5.

A number of submissions noted the importance of the 'listening' and 'speaking' components of the tests to assess a practitioner's ability to communicate with patients. Correspondingly, some respondents suggested that lower minimum scores could be accepted for the reading and writing components, with one body noting that achieving a high score in these components of the academic module of IELTS was quite challenging, even for native speakers.

Another body questioned whether the IELTS test was 'fit for purpose', while several submissions noted that more research was needed in this area.

### Q5: Should National Boards accept results from more than one sitting or is there a better way to address this issue, such as the approaches described above?

This question received 97 responses.

Of the 97 responses, 78 supported accepting results from more than one sitting. Although the majority of responses clearly supported accepting multiple test results, many of those in support were individuals who had personally experienced difficulties passing the tests in one sitting. Organisational responses were evenly split as to whether multiple test results should be allowed or not.

Individual respondents provided examples of variable scores across multiple sittings. A number argued that they had the necessary English language skills and if they had been permitted to submit results from at least two sittings, they would have demonstrated the required competency. Instead, due to the variable results, many had to sit the test multiple times to achieve the required result, often at a high cost. A number questioned the validity of the tests and results.

Opinions differed as to how many sittings could be counted, and over what time period. Some submissions were supportive of the proposal in the draft ELS Standard (accept results from up to three test sittings in a twelve month period) while some argued for more restrictive conditions (for example, in a six month period instead of twelve).

The submission from one test provider was supportive of accepting test results from more than one sitting under certain circumstances, as this would 'provide flexibility for applicants while maintaining an appropriate focus on public safety.'

This provider initially suggested that applicants who fail one component only should be allowed to re-sit that sub-test only within three months of the initial testing. If the applicant subsequently fails that sub-test, he or she should be required to sit the entire test again.

Conversely, the submission from another test provider initially did not support accepting test results for more than one sitting, expressing the view that policy should not be driven by the fact that candidates for some English language tests regularly achieve inconsistent results on retests.

Six submissions supported following the advice of the particular test provider regarding the number of sittings.

One regulator noted that there is conflicting information about the validity of English language tests when results are achieved over multiple sittings. In light of this, the respondent felt that the status quo should be maintained until further research findings have been published to support a change.

Of those that were opposed to relaxing the requirement for only accepting results from a single sitting, several expressed that view that this could send the wrong message to applicants and result in an erosion of standards, which could then compromise public safety.

Q6: Is the content of the draft revised registration standard helpful, clear, relevant and more workable than the current standard?

This question received 23 responses.

Overall, there was general support for the draft revised registration standard. The majority of respondents submitted that the proposed new standard is an improvement and is clearer, helpful, relevant and more workable than the current standard.

There were several specific comments on the standard as it applies to nursing and midwifery, with one organisation submitting that the proposed new standard was not clear and not an improvement on the current *Nursing and midwifery English language registration standard*. Another organisation suggested that a significant research project was needed to review the most appropriate way to measure English language competence.

### 2.2 Summary of responses to the remaining questions

The responses to Q7, Q8 and Q9 in many cases spanned one or more of the questions. A number of submissions also did not relate specifically to any particular question. The collective responses have been divided into key themes and summarised below.

Q7: Is there any content that needs to be changed or deleted in the revised draft registration standard?

This question received 19 responses.

Q8: Is there anything missing that needs to be added to the revised draft registration standard?

This question received 26 responses.

Q9: Do you have any other comments on the revised registration draft standard?

This question received 89 responses.

Of these, 34 responded to question 9 and the remainder made general comments as well that could are relevant to this question.

#### Key themes from responses to questions 7, 8 and 9

Ten key themes were identified from these responses.

1. Need to maintain high standards

A number of submissions pointed to the need to maintain high standards for English language competency and that any changes to the current standard must not compromise patient safety.

Many stakeholders recognised that the current English language skills registration standard presents a challenge for many overseas based applicants seeking registration in Australia and were generally supportive of reasonable flexibility in applying the standard. A number of respondents expressed the view flexibility should not come at the expense of the high language standards currently required of registered health practitioners. Any deterioration in language standards, it was argued, could compromise the public protection role of the National Scheme required by the National Law.

2. Need for further research or evidence

A number of respondents submitted that further research or evidence is needed to support any changes to the standard. Many noted the research gaps that currently exist and the difficulty in forming policy in the absence of conclusive data.

3. Comments on the English language tests

Some of the submissions expressed concern about the validity of the current English language tests (IELTS and OET) and some suggested alternative tests. Anecdotally, respondents reported instances of large variances in test scores in particular components of the test, repeated in a short period of time. Some respondents questioned whether the tests were 'fit for purpose', suggesting that further research was needed in this area.[7]

4. Validity period for test results

The consultation draft proposed extending the validity period for test results from two to three years. It also proposed accepting test results older than three years if active employment has been maintained as a registered health practitioner in one of the recognised countries using English as the primary language of practice, or if the applicant has been continuously enrolled in an approved program of study. A number of submissions raised the issue of the test validity or shelf life of English language test results. Again, many noted the absence of conclusive research in this area.

5. Other options to demonstrate English language competency

The proposed revised registration standard includes more options for applicants to demonstrate their English language skills. A number of submissions suggested adding further options for demonstrating English language skills, such as successful completion of courses in Australia and/or extended periods of work in an English speaking environment.

6. Exemptions

Two organisations submitted that an exemption from having to undertake an English language test for exceptional circumstances is needed and that this should be included in the standard.

7. English language competence and communication skills

Six submissions indicated that English language skills are not evidence of communication ability. Several of these questioned whether the standard is intended to be an English language test or a communication test.

8. Trans Tasman Mutual Recognition

A small number of submissions pointed to the need for consistency with New Zealand requirements due to the Trans-Tasman Mutual Recognition Act.

[7] Although little Australian data exists, the UK General Medical Council conducted research in 2013 which found that the IELTS test provided an appropriate measure of English language ability for overseas practitioners. The research can be accessed at www.gmc-uk.org/about/research/25015.asp

9. Early testing of students

A small number of submissions indicated that students should meet the standard prior to starting their health profession course.

10. Issue with the current *Nursing and midwifery English language registration standard*

Twelve submissions from both individuals and organisations expressed concern about the current Nursing and midwifery English language standard.

## 3. Summary of changes and other decisions

Following the public consultation, a number of agreed changes were made to the consultation draft of the English language skills registration standard. A marked-up version of the new standard showing the changes that were made to the consultation draft is at Appendix 3. In finalising the changes, National Boards took into consideration feedback from the consultation, their experience with the existing standards, research commissioned for the review and information from relevant English language testing and translating organisations, the objectives and guiding principles of the National Law and the regulatory principles of the National Scheme.

### 3.1 Changes to the consultation draft standard

Revisions to the draft standard, together with rationale for each change, are outlined below.

#### 1. Test results from multiple sittings

*Change*

The proposal that National Boards accept English language test results from multiple sittings has been retained, but with two modifications. The period for accepting multiple test results has been reduced from 12 to six months, and the maximum number of test results that will be considered has been reduced from three to two.

*Rationale*

The issue of whether to accept test results from multiple sittings was one of the most contentious issues considered in the review. This question received the greatest number of responses, with most expressing support for the proposal. Of those in support, the majority were individuals who had experienced difficulty passing the tests in one sitting and their views reflect this. However, significant support also came from organisations, government and universities.

Conversely, a number of organisations and one test provider were not in favour of accepting results from multiple sittings. These respondents expressed the view that accepting test results from multiple sittings undermines score reliability, particularly when a test has been configured to provide maximum reliability in a single sitting. In particular, IELTS advised that the score which has the most validity is the overall score from a sitting, rather than the scores for the individual test components.

However, all test providers accepted that a test score may include an element of error or reflect factors relating to circumstances on the test day. Anecdotal evidence was provided about significant variability in individuals' test results across multiple sittings for English language tests, which were difficult to explain based on language ability alone.

The commissioned research[8] did not provide a conclusive answer to the question of whether test results from multiple sittings should be accepted. However, accepting test results from a single sitting is the norm for regulators in comparator countries. Of those surveyed, only the Nursing Council of New Zealand accepted results from multiple sittings and the Canadian Alliance of Physiotherapy Regulators previously did so.

The National Boards' view is that it is reasonable to accept test results from up to two sittings within tightly controlled parameters for applicants whose scores in some components are very close to the required standard. This gives these applicants another opportunity to meet the standard while potentially reducing the overall impact on applicants. However, this relatively small amount of additional flexibility must be balanced against the risk that accepting test results from multiple sittings may not give as accurate an indication of an applicant's overall English language competency as a test result from a single sitting.

[8] A summary of the commissioned research used to inform the review is at Appendix 2.

The option to accept test results from a maximum of two sittings taken in a relatively short period (between three to six months) as long as no individual component result falls below a specified level, provides a reasonable degree of flexibility for applicants and will address the concerns raised by a number of affected applicants. It also provides an appropriate level of protection as it is likely to ensure that the test results indicate the applicant's true language ability rather than expected minor variation in test results.

Requiring an overall score of IELTS 7 (or equivalent), in addition to the minimum component score of 6.5 (or equivalent), provides an additional safeguard that the skill level set by the standard is maintained.

This option has been discussed with test providers who have indicated that it could be a workable and reasonable compromise, provided the parameters outlined above are met. AHPRA's administrative experience with English language skills testing timelines is that the maximum resitting period needs to be longer than three months to allow enough time for waiting periods and test results to be received. This issue was discussed with test providers to determine the final recommended timeframe of six months.

### 2. NAATI pathway

*Change*

The pathway included in the consultation paper based on National Accreditation Authority for Translators and Interpreters Ltd (NAATI) accreditation as a translator/interpreter has not been included in the revised standards.

*Rationale*

The consultation draft standard proposed that an interpreter accredited by NAATI would meet the English language standard and could therefore be exempted from English language testing. Subsequently, NAATI has advised that there is no research which anchors a NAATI accreditation test, which reflects the ability to accurately transfer meaning between 2 languages, with English language proficiency. Language proficiency skills are part of the skills required to transfer meaning between two languages but there are also additional transfer-specific skills.

This pathway has therefore not been included.

### 3. Validity period for test results

*Change*

The validity or currency period for English language test results will continue to be two years.

*Rationale*

The consultation draft proposed that the validity or currency period for English language test results be extended from two years to three years.

This proposal was based in part on the Department of Immigration and Border Protection (DIBP) decision to extend its test result currency period to three years. This was a pragmatic decision by DIBP relating on the time to process applications rather than the validity of test results. Additionally, DIBP appears to focus on a candidate's potential English language ability, rather than their language ability at a particular point in time. By contrast, National Boards need to be assured of an applicant's English language ability at the time they commence practice.

Some research and language experts have indicated that extending the currency period to three years would be appropriate and supported by the evidence about language attrition, in particular the finding that that high level skills take a reasonable time to deteriorate.

On the other hand, a two year validity period is the norm for regulators in comparator similar countries. Test providers also recommend a two year validity period, highlighting the risk of attrition if there is no English language use in this period.

National Boards consider that the validity period should remain at two years, but with the ability to extend the validity or currency period where the applicant has maintained their English language skills through continued use of English language, either through study or work in English in one of the recognised countries.

### 4. Additional pathway for applicants whose primary language is English

*Change*

A new pathway to demonstrate English language skills has been added to the standard for applicants whose primary language is English and who completed all of their primary and secondary education in English in one of the recognised countries, and completed their qualification for registration under the National Law solely in English.

*Rationale*

Individuals who meet these criteria would be expected to exceed the English language skills represented by the other pathways to address the standard but could have technical difficulties meeting these pathways if they completed their professional qualification in English outside one of the recognised countries. This pathway reflects that National Boards do not intend to require applicants in this category to sit an English language skills test.

### 5. Additional English language tests

*Change*

Two additional English language tests have been added:

- PTE Academic with a minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills (listening, reading, writing and speaking)
- TOEFL iBT with a minimum total score of 94 and minimum scores or 24 for listening, 24 for reading, 27 for writing and 23 for speaking.

*Rationale*

These tests have been added in line with DIBP approval of these tests for all visa categories after a comprehensive review of the tests during a two year trial period for student visas.

The scores for these tests for have been benchmarked against the IELTS score.

The DIBP report on the review of the tests in the Student visa programme *Review of the implementation of alternative English language proficiency tests in the Student visa programme* is available at www.immi.gov.au/about/_doc/report-english-test.pdf

National Boards will consider recognising additional English language tests in the future when there is relevant evidence.

### 6. Initial registration

*Change*

'Initial registration' has been defined.

*Rationale*

The definition has been amended to ensure that practitioners who have already been registered in Australia will only be required to meet the standard again when they apply to move from non-practising to practising registration if they have not been using English as their primary language for a period of five years or more.

### 7. Additional terms have been defined in the standard to improve clarity

Boards may publish additional information about the meaning of other terms used in the standard from time to time.

## 3.2 Other decisions

### 1. Test scores

A number of submissions proposed accepting a minimum overall score for IELTS and specifying a minimum in each component. The proposed overall minimum scores and minimum scores for each component were variable, ranging from 7.5 overall (one submission) to 6 overall (one submission) with the most common being 7 overall with no individual component score below 6.5.

The commissioned research indicated that the National Boards' current (and proposed) minimum IELTS score of 7 in each of the four components and a minimum of Grade B for the OET is appropriate in the context of health profession regulation. According to the eight-country global audit that was undertaken as part of the commissioned research, a minimum IELTS score of 7 in each of the four components is specified for a number of health professions in comparator countries. The audit also indicated that a minimum score of B in the OET is accepted by some health profession regulators in comparator countries.

However, research recently commissioned by the General Medical Council (GMC) in the UK found that the current overall IELTS score of 7, with no separate skill score lower than 7 is not adequate as a preliminary language screening device for International Medical Graduates (IMGs). The research report recommended that the IELTS scores be revised and that the GMC should consider adopting the following profile which reflects the importance of oral skills, with listening being of paramount importance, but allows for some flexibility in assessing written skills:  Overall 8 (Listening 8.5; Speaking 8; Reading 7.5; Writing 7.5).

The GMC has decided to adopt an overall score of 7.5, commencing June 2014 with a score of at least 7.0 in each of the four components of the test.

Test providers including TOEFL and OET have recommended undertaking work to determine whether the required scores are appropriate for individual professions. Some international regulators have done similar work.

The National Boards will consider further work on whether there should be any difference in the level of scores required for individual professions before the next review of the English language skills standard.

### 2. Exemptions

Some respondents submitted that an exemption from having to undertake an English language test for exceptional circumstances is needed to allow 'common sense' to prevail in cases when an individual can clearly meet the standard for English language  skills but is unable to demonstrate this through the education pathway/s specified in the draft standard.

There is a risk that a general 'exceptional circumstances' exemption would be difficult to administer because of the difficulty in establishing clear parameters that would not erode the intent of the standard and the possibility that this kind of exemption would attract large numbers of applications

that do not satisfy the criteria. Submissions from other regulators such as the Medical Council of New Zealand and the Australian Medical Council indicate that general 'exceptional circumstances' exemptions are difficult to administer, leading to these bodies adopting alternative approaches.

It is evident that there will occasionally be applicants who appear to have the necessary English language skills to easily meet the standard, yet cannot demonstrate this without sitting an English language test. The additional pathway in the revised standard would allow some of these candidates to meet the standard without sitting a test. However, there may still be occasional instances where requiring certain candidates to sit an English language test could be perceived as unfair, unreasonable or contrary to common sense.

This is one of the most complex issues that the reviews considered. Given the challenges of establishing general exemptions and the potential to undermine the aims of the standards, National Boards have decided to maintain the current approach of no general exemption or discretion in the standard. Instead, Boards have aimed to ensure that there is a pathway to meet the standard for all applicants, which for some applicants will involve sitting an English language test.

National Boards will continue to monitor the application of the standard to identify any specific circumstances where applying the standard would not achieve their intentions and/or or align with their regulatory principles, and will consider appropriate action in these situations including collecting information to inform future reviews.

## 4. Future work

As part of the review of English language standards, National Boards have identified a number of areas for further work. It is planned that such work will be undertaken prior to the next review of the standard.

The areas identified for further work may include the following:

1. Undertake further research on whether South Africa should continue to be a recognised country or whether recognition should be phased out.
2. Identify key areas for further research on issues relating to English language skills requirements in the regulation of health practitioners, to both promote independent research and commission research in critical areas (if required) as part of the next review of the standard. Research topics might include:
    a. studies about the use of English language tests in the health practitioner regulation context
    b. whether there are valid and reliable ways to use an extended period of work in the relevant health profession in an English speaking environment as a measure of English language skills
    c. whether it is valid and reliable to use NAATI accreditation as a measure of English language skills, and
    d. whether other countries should be added to the list of recognised countries, and if so, what criteria should apply
3. Investigate how the National Scheme can make the best use of its data to inform the next review of the English language skills registration standard.
4. Monitor implications for the standards of any changes made to DIBP policy regarding English language skills requirements as a result of the review of the Skilled Migration and 400 Series Visa Programmes, or adopted by international health practitioner regulators, such as those in the United Kingdom.

## 5. Conclusion

Communication is a key component of effective health care. For registered practitioners providing health services in Australia, English language skills are a fundamental part of the communication skills necessary for safe and competent practice. The National Law reflects this by requiring all National Boards to develop English language skills registration standards.

This report describes National Boards' most recent work on those standards. Boards received a wide range of views which they have carefully considered in framing the new standard, which will be common across 12 health professions, with some very minor variations for dental and medicine. The Nursing and Midwifery Board of Australia has developed an ELS Standard which has been modified slightly to reflect issues specific to those professions, while the Aboriginal and Torres Strait Islander Health Practice Board of Australia will continue to use a profession-specific standard which it will review starting in 2015/16.

In developing new standards, National Boards must balance their statutory duty to protect the public with the other objectives of the National Law and their underlying regulatory principles, such as proportionality and fairness for those subject to their regulation. The National Boards believe that this balance has been achieved in the new standard.

While the research evidence base about English language skills for health practitioners is still developing, National Boards are keen to contribute to building the evidence through targeted research and will seek opportunities to do this. They will also continue to monitor the effectiveness of the new standards and the emergence of any new evidence in this area. Further reviews of the standard will be conducted in future, incorporating new research and any information gathered about how the standards are working in practice.

AHPRA and the National Boards thank all those who contributed to the review and provided valuable feedback on these important issues.

## Glossary

**Draft standard** means the 12-profession (all the professions mentioned above, excluding Aboriginal and Torres Strait Islander Health Practice and Nursing and Midwifery) common draft English language skills registration standard (with minor variances for dental and medicine).

The **National Boards** are the Aboriginal and Torres Strait Islander Health Practice Board of Australia, the Chinese Medicine Board of Australia, the Chiropractic Board of Australia, the Dental Board of Australia, the Medical Board of Australia, the Medical Radiation Practice Board of Australia, the Nursing and Midwifery Board of Australia, the Occupational Therapy Board of Australia, the Optometry Board of Australia, the Osteopathy Board of Australia, the Pharmacy Board of Australia, the Physiotherapy board of Australia, the Podiatry Board of Australia and the Psychology Board of Australia.

**National Law** means the Health Practitioner Regulation National Law, as in force in all states and territories.

**National Scheme** means the National Registration and Accreditation Scheme for health professions. More information about the National Scheme is available at www.ahpra.gov.au

**Revised standard(s)** means the new English language skills registration standard(s) developed by National Boards as part of this review and approved by the Ministerial Council on 17 March 2015.

## Appendix 1: supplementary report on the revised Nursing and midwifery English language registration standard.

### Background

At the commencement of the National Scheme on 1 July 2010, the first English language standard developed by the Nursing and Midwifery Board of Australia (NMBA) came into effect. This standard required all internationally qualified applicants or applicants who did not undertake and complete their secondary education to the requisite level required for entry into a nursing and midwifery program taught and assessed in English, to demonstrate English language competence through successful completion of the IELTS academic module or OET test, achieving in one sitting a minimum score of 7 (IELTS) or B (OET) in each component. The NMBA conducted a review of this standard in 2011. As a result of the review, the standard was modified to include an additional pathway for demonstrating English language competence, through the completion of five years of continuous education in English in one of the recognised countries (Australia, Canada, New Zealand, Republic of Ireland, South Africa, UK and USA).

Although the NMBA's English language skills registration standard was not due for review, the NMBA chose to participate in the 2014 review so that the Board could consider any new evidence that might arise from this national review. The new NMBA standard has been developed to maximise consistency with the new common English language skills registration standard. However, issues specific to nursing and midwifery continue to merit a slightly modified standard that reflects issues specific to these professions.

### Why has the NMBA English language skills registration standard been modified?

The NMBA has drawn on information from the review of the common English language skills registration standard to refine the nursing and midwifery English language skills registration standard and provide additional flexibility without compromising the protective purpose of the standard, consistent with best available evidence and the outcomes of the all-Boards review. The NMBA has also drawn on its experience working with its 2011 English language skills registration standard.

The nursing and midwifery registers include nurses, enrolled nurses and midwives. As each of these programs of study differ in length, the requirements of the NMBA English language skills registration standard must necessarily reflect this. Additional factors, such as the high proportion of nurses and midwives who return to study as mature age students, have also been taken into consideration.

### How does the NMBA standard differ from the common standard?

The new common English language skills registration standard establishes four different pathways, via which applicants can demonstrate English language proficiency:

1. primary language pathway
2. combined secondary and tertiary education pathway
3. extended education pathway
4. English language test pathway.

The NMBA English language skills registration standard has adapted three of these pathways – the *primary language pathway*, the *combined secondary and tertiary education pathway* and the *extended education pathway* to take into account issues specific to the nursing and midwifery professions. The NMBA English language skills registration standard has adopted the same English language test pathway as the common English language skills registration standard. Additionally, the NMBA standard includes the capacity for the NMBA to publish a policy to describe additional pathway(s) in prescribed circumstance. These modifications are described below, followed by a rationale for the changes.

1. The *primary language pathway* and the *combined secondary and tertiary education pathway*

The primary language pathway in the NMBA standard requires that at least six years of an applicant's primary and secondary education were taught and assessed in English in one of the recognised countries, in addition to a relevant qualification which was taught and assessed solely in English in a recognised country.

The primary language pathway in the common English language skills registration standard is formulated differently. It reflects that these National Boards do not intend to require applicants whose primary language is English and who completed all their primary and secondary education in English in one of the recognised countries, in addition to completing their qualification for registration under the National Law solely in English, to undertake an English language test.

The *combined secondary and tertiary education pathway* in the common English language skills registration standard has not been included in the NMBA standard, as the NMBA *primary language pathway* effectively combines these two pathways for nurses and midwives.

This pathway in the NMBA English language skills registration standard recognises the significant numbers of applicants who return to study nursing and midwifery as mature age students, who may have difficulty providing evidence of secondary education, but speak no language other than English and completed all their study in English in Australia or another recognised country.

2. The *extended education pathway*

The *extended education pathway* reflects the equivalent pathway in the current NMBA English language skills registration standard, which requires five years of continuous education taught and assessed in English in a recognised country, rather than the six years required in the new common English language skills registration standard. This modification recognises the different length of programs of study and the role of vocational education in the nursing and midwifery professions, compared with other registered professions. Adopting the common standard without modification would increase the years of study in English that a nurse or midwife would need to demonstrate to meet the standard compared with the current NMBA standard, which could have potentially negative impacts on workforce supply. This pathway also reflects the different lengths and types of study typically undertaken by nurses and midwives, and enrolled nurses.

3. Additional pathways in prescribed cases/circumstances.

The current NMBA English language skills registration standard makes provision for the NMBA to establish exemptions for cohorts of applicants, although the Board has not acted on this. The new NMBA English language skills registration standard includes the capacity for the NMBA to establish new ways of demonstrating English language competence in a policy published by the Board. This approach is similar to the provision for an exemption in the current NMBA standard, but clarifies that the pathway would not operate unless the Board publishes a policy which sets out clear criteria which must be satisfied. This avoids the risks of introducing broad discretion, but enables the NMBA to establish new pathways where justified and consistent with the objectives and guiding principles of the National Law.

Appendix 2: Summary of commissioned research used to inform the review

# Summary of research findings

## Background

The National Boards conducted a scheduled review of their registration standards after three years of experience with the National Scheme. To support evidence-based policy setting, the National Boards commissioned research on English language skills for health professionals.

The research, undertaken in 2012/13 by Professor Lesleyanne Hawthorne (Australian Health Workforce Institute, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne), included an examination of the evidence base in relation to current Australian English language skills registration standard requirements in health fields and the requirements of comparative international regulators. The research was framed in a broad context, including migration issues and included analysis of a range of issues outside the scope of the registration standard.

## Summary of research outcomes

| | |
|---|---|
| **Limits to the research base** | The literature to inform English language skills registration standards to date is slight. Few health-specific studies exist. Many are based on small sample sizes. There are major research gaps. |
| **Global ELSRS practice in medical and allied health fields** | Global regulatory bodies adopt highly variable requirements in terms of English testing. This is currently a dynamic area of policy. Regulators may specify few or multiple tests; different test types (ranging from generic, to field-specific, to embedded, to interview-based); require diverse scores by test and field; allow different types of exemption; permit variable lengths of result validity (ranging from six to 24 months, which may vary from Immigration e.g. three years in Australia); and impose different operational requirements (for example to pass sub-tests at a single or sequential sittings). |
| **Range of acceptable tests** | International English Language Testing System (IELTS) and Test of English as a Foreign Language (TOEFL) are the main tests accepted worldwide, with TOEFL dominant in select parts of Asia and North America.<br>IELTS is accepted for skilled migration and OET is also accepted for health professionals for skilled migration. The relatively new Pearson Test of English Academic and the TOEFL iBT have been approved since November 2011 for student visa purposes in Australia.<br>The National Boards' current reference to IELTS and OET is consistent with the approach of other global health regulators. |
| **Standard setting** | Existing research does not provide a clear direction about the English language test results that National Boards should require. In terms of benchmarking, global health regulatory bodies accept a range of test results, with IELTS scores ranging from 6 on some skills to 7.5 overall, with 7 the norm. There is limited research to validate these levels in the context of health practitioner regulation. While National Board requirements are consistent with many other regulators, tests also have differential impacts by field with some professions having higher failure rates. |
| **Requirement to pass all four subtests at a** | The research does not provide a conclusive answer to this question.<br>Test providers advise that the validity and reliability of results from multiple |

| | |
|---|---|
| **single sitting** | test sittings depend on how the individual tests are constructed.<br>Accordingly, the Occupational English Test (OET) has advised that it is valid to accept test results from more than one sitting, after an applicant has initially sat all components of the test, provided the results are relatively close to the required level. This is because linguistic research has shown that a range of affective and physical factors can influence candidate performance on the test day and OET considers that in these circumstances it is justifiable to allow a single sub-test re-sit to achieve the required score.<br>However, the International English Language Testing System (IELTS) advises that it was not designed to be a modular test. The four component modules are not offered as separate tests to be taken at different times. Rather, performance in the four skill areas is combined to provide a maximally reliable composite assessment of a candidate's overall language proficiency at a given point in time. |
| **Length of test result validity** | The length of test result validity may merit review (particularly for candidates resident and engaged in clinical practice in Australia). A range of studies have demonstrated that 'high proficiency learners plateau for several years until attrition begins', within minimal change anticipated in a 3-4 year period for users scoring IELTS 7 and OET B (or higher), even with little or no use. The Department of Immigration and Border Protection has recently moved to a three-year validity period for English Language test results. |

## Appendix 3 – revised draft standard with changes from consultation draft

***Please note:***

***This draft has been developed for all National Boards apart from the Aboriginal and Torres Strait Islander Health Practitioner Board of Australia and the Nursing and Midwifery Board of Australia. There are some profession-specific aspects which are highlighted in boxes.***

## Registration standard: English language skills

### Effective date:

The <xx> Board of Australia (Board) requires all applicants for **initial registration**[9] to demonstrate English language skills to be suitable for registration.

This registration standard sets out how an applicant for registration can demonstrate to the Board that their competency in speaking and communicating in English is sufficient to practise the <xx> profession.

### Does this standard apply to me?

This standard applies to all applicants for **initial registration** ~~as defined~~.

~~See the definitions section of this registration standard for the definition of initial registration~~.

It does not apply if you are applying for non-practising registration or if you are a **student**.

### What must I do?

If you are applying for **initial registration** you must demonstrate your English language competency in one of the following ways:

1. English is your **primary language** and you have undertaken and satisfactorily completed:

    a. all of your primary and **secondary education** which was taught and assessed solely in English in a **recognised country**, and

    b. tertiary qualifications in the relevant professional discipline, which you are relying on to support your eligibility for registration under the **National Law**, which were taught and assessed solely in English.

**OR**

2. You have a combination of **secondary education** and tertiary qualifications, where you have undertaken and satisfactorily completed:

    a. at least two years of your **secondary education** which was taught and assessed solely in English in ~~one of the recognised countries~~ a **recognised country** ~~(listed in the *Definitions* section of this standard)~~, **and**

    b. tertiary qualifications in the relevant professional discipline, which you are relying on to support your eligibility for registration under the **National Law**, ~~that~~ which were taught and assessed solely in English in ~~one of the recognised countries~~ a **recognised country**.

**OR**

3. ~~Extended studies undertaken solely in English, when~~ You have undertaken and satisfactorily completed at least **six years' (full time equivalent) continuous education** taught and assessed solely in English, in any of the **recognised countries**, which includes ~~a~~ tertiary qualifications in the

[9] Bolded terms are defined in the *Definitions* section of this registration standard.

relevant professional discipline ~~or a Board approved program of study for the <xx> profession~~ which you are relying on to support your eligibility for registration under the **National Law**.

~~**OR**~~

~~3. Accreditation by the National Accreditation Authority for Translators and Interpreters (NAATI) for translating and/or interpreting English~~

**OR**

4. ~~Completion of~~ You achieve the required minimum scores in one of the following ~~tests of~~ English language tests ~~proficiency at the specified standard~~ and meet the requirements for **test results** specified in this standard:

   a. the **IELTS** (academic module) with a minimum overall score of 7 and a minimum score of 7 in each of the four components (listening, reading, writing and speaking). ~~Results from [one] or [up to three] tests sittings in a 12 month period may be used, only if all scores are 6.0 or above.~~

      **NOTE:**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - you achieve a minimum overall score of 7 in each sitting, and
      - you achieve a minimum score of 7 in each component across the two sittings, and
      - no score in any component of the test is below 6.5

   b. the **OET** with ~~an overall pass and grades A or B~~ a minimum score of B in each of the four components (listening, reading, writing and speaking). ~~Results from more than one sitting may be used within a 12 month period.~~

      **NOTE**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - you are tested in all four components in each sitting, and
      - you achieve a minimum score of B in each component across the two sittings, and
      - no score in any component of the test is below C.

OET IS NOT APPLICABLE FOR CHIROPRACTIC, OSTEOPATHY AND PSYCHOLOGY, AS OET HAS NOT YET DEVELOPED A SPECIFIC TEST FOR THESE PROFESSIONS

   c. the **PTE Academic** with a minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills (listening, reading, writing and speaking).

      **NOTE:**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - a minimum overall score of 65 is achieved in each sitting, and

- you achieve a minimum score of 65 in each of the communicative skills across the two sittings, and
- no score in any of the communicative skills is below 58

d. the **TOEFL iBT** with a minimum total score of 94 and the following minimum score in each section of the test:

- 24 for listening,
- 24 for reading,
- 27 for writing, and
- 23 for speaking.

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**
ii. a maximum of **two test sittings in a six month period** only if:

- a minimum total score of 94 is achieved in each sitting, and you achieve a minimum score of 24 for listening, 24 for reading, 27 for writing and 23 for speaking across the two sittings, and

- no score in any of the sections is below:

  - 20 for listening
  - 19 for reading
  - 24 for writing, and
  - 20 for speaking

e. other English language tests approved by the Board from time to time and published on the Board's website with the required minimum scores.

ADDITIONAL OPTIONS FOR MEDICINE

successful completion of the **NZREX**, or

successful completion of the **PLAB** test.

~~ADDITIONAL OPTIONS FOR CHINESE MEDICINE~~

~~Completion of the American Test for English as a Foreign Language (TOEFL test) including the spoken component and a minimum of 237 (test of written English 4.5)~~

### *Test results*

The following ~~additiona~~l requirements apply to the English language ~~proficiency~~ **test results**:

1. **Test results** will be accepted if they were obtained:

   1.1 within the two years ~~[or three years]~~ ~~prior to applying to registration~~ before the date you lodge your application for registration

**OR**

1.2 more than ~~three~~ two years ~~prior to applying for registration~~ before the date you lodge your application for registration if, in the period since the **test results** were obtained, ~~and~~ you:

a. Have ~~actively maintained employment~~ been in **continuous employment** as a registered health practitioner in the <xx> profession (which commenced within 12 months of the date of the test) ~~using English as the primary language of practice~~ in one of the **recognised countries** ~~since the test result was obtained~~ where English was the primary language of practice, and

b. lodge your application for registration within 12 months of finishing your last period of employment

**OR**

1.3 more than ~~three~~ two years ~~prior to applying for registration~~ before the date you lodge your application for registration if, in the period since the test result was obtained, ~~and~~ you:

a. have been continuously enrolled in a **Board approved program of study** (which commenced within 12 months of the date of the test) ~~since the test result was obtained~~ and undertook subjects in each semester, with no break from study apart from the education provider's scheduled holidays, and ~~applied for registration~~

b. lodge your application for registration within 12 months of completing the **Board approved program of study**.

2. For the purposes of calculating time, if an applicant relies on **test results** from two sittings, time begins to run from the date of the earlier sitting.

## Exemptions

1. The Board may grant an exemption to this standard when you apply for limited registration in the following circumstances:
   a. to perform a demonstration in clinical techniques

   b. to undertake research that involves limited or no patient contact, or

   c. to undertake a period of postgraduate study or supervised training *Dental Board of Australia only* that involves no patient contact while working in an appropriately supported environment that will ensure patient safety is not compromised.

2. Conditions will generally apply to these exemptions, which will require supervision by a registered health practitioner and may also require the use of an interpreter.

3. The Board reserves the right at any time to revoke an exemption and/or require an applicant to undertake a specified English language test.

## More information

1. Practitioners who meet this standard on the basis of results from an English language test will be asked to declare that they have continued to use English as their **primary language** when they apply to move from non-practising to **practising registration**.

2. Further information regarding the evidence that applicants must provide to the Board to prove that they meet this standard is set out in the relevant application form.

3. Your **test results** will be verified independently with the test provider.

4. You are responsible for the cost of English language tests.

## Authority

This registration standard was ~~developed by <<NAME>> Board of Australia under section 38 of the Health Practitioner Regulation National Law (the National Law) as in force in each state and territory~~

~~after wide ranging public consultation. It has been~~ approved by the Australian Health Workforce Ministerial Council on <date>.

Registration standards are developed under section 38 of the National Law and are subject to wide ranging consultation.

## Definitions

**Board approved program of study** means an accredited program of study approved by the <name> Board of Australia under section 49(1) of the National Law and published in the Board's list of approved programs of study on the Board's website.

**Continuous employment** means working the equivalent of at least 26 weeks per year.

**IELTS** means the International English Language Testing System.

**Initial registration** ~~– for the purpose of this registration standard and applicant for initial registration~~ means:

- a practitioner applying for registration in Australia in the <xx> profession for the first time; **or**
- a practitioner applying for registration (including moving from non-practising to another registration type) who has not ~~practised the profession in one of the recognised countries~~ used English as their *primary language** for a period of greater than five years ~~or more~~; **or**
- a practitioner who currently holds limited registration on the basis that they were granted an exemption from this standard in the limited circumstances described under *Exemption*s and who is applying for another type of registration.

Initial registration otherwise does not include a practitioner who has had continual registration in the <xx> profession and is applying for a different category or division of registration in that profession, for example, a practitioner who holds provisional registration and is applying for general registration; or a practitioner who holds general registration and is applying for specialist registration.

**National Law** means the *Health Practitioner Regulation National Law Act* (as in force in each state and territory).

**OET** means Occupational English Test ~~(OET) administered by the OET Centre.~~

**Practising registration** means provisional, general, specialist or limited registration.

**Primary language** means the language primarily used for reading, writing, listening, and speaking and the language known best and most comfortable with.

**PTE Academic** means the Pearson Test of English Academic

**Recognised country** means one of the following countries:

- Australia
- Canada
- New Zealand
- Republic of Ireland
- South Africa
- United Kingdom
- United States of America.

**Secondary education** means Australian school years 7 through to 12, even where year 7 is classified as part of primary school in a particular state or territory.

**Six years (full time equivalent) continuous education** means education over a period of six consecutive calendar years without a break from study apart from the education institutions' (e.g. school or university) scheduled holidays.

**Student** means a student currently registered under the National Law.

**Test results** means the official results provided by the English language test provider. If you are providing test results from two test sittings as defined, the results from both sittings must meet the requirements of this standard.

**TOEFL iBT** means the Test of English as a Foreign Language internet-based test.

**Two test sittings in a six month period** means that the dates of the sittings must not be more than six months apart. For example, if your first test sitting was on 1 March, the second sitting must be no later than 30 August. If you are providing test results from two sittings, you may provide results of any two tests taken within a six month period as defined.

MEDICINE ONLY

**NZREX** means New Zealand Registration Examination administered by the New Zealand Medical Council.

MEDICINE ONLY

**PLAB** test means the test administered by the Professional and Linguistic Assessments Board of the General Medical Council of the United Kingdom.

~~CHINESE MEDICINE ONLY~~

~~**TOEFL** means the Test for English as a Foreign Language.~~

## Review

This standard will be reviewed at least every three years.

Last reviewed: XXXX

## Appendix 4 – revised draft *Common English language skills registration standard*

***Please note:***

***This draft has been developed for all National Boards apart from the Aboriginal and Torres Strait Islander Health Practitioner Board of Australia and the Nursing and Midwifery Board of Australia. There are some profession-specific aspects which are highlighted in boxes.***

## Registration standard: English language skills

**Effective date:**

FOR CHINESE MEDICINE – THE STANDARD WILL COMMENCE ON 1 JULY 2015

The <xx> Board of Australia (Board) requires all applicants for **initial registration**[10] to demonstrate English language skills to be suitable for registration.

This registration standard sets out how an applicant for registration can demonstrate to the Board that their competency in speaking and communicating in English is sufficient to practise the <xx> profession.

### Does this standard apply to me?

This standard applies to all applicants for **initial registration**.

It does not apply if you are applying for non-practising registration or if you are a **student**.

### What must I do?

If you are applying for **initial registration** you must demonstrate your English language competency in one of the following ways:

1. English is your **primary language** and you have undertaken and satisfactorily completed:

    a. all of your primary and **secondary education** which was taught and assessed solely in English in a **recognised country**, and

    b. tertiary qualifications in the relevant professional discipline, which you are relying on to support your eligibility for registration under the **National Law**, which were taught and assessed solely in English.

**OR**

2. You have a combination of **secondary education** and tertiary qualifications, where you have undertaken and satisfactorily completed:

    b. at least two years of your **secondary education** which was taught and assessed solely in English in **a recognised country**, **and**

    b. tertiary qualifications in the relevant professional discipline, which you are relying on to support your eligibility for registration under the **National Law**, which were taught and assessed solely in English in a **recognised countr**y.

**OR**

3. You have undertaken and satisfactorily completed at least **six years' (full time equivalent) continuous education** taught and assessed solely in English, in any of the **recognised**

[10] Bolded terms are defined in the *Definitions* section of this registration standard.

**countries**, which includes tertiary qualifications in the relevant professional discipline which you are relying on to support your eligibility for registration under the **National Law**.

**OR**

4. You achieve the required minimum scores in one of the following English language tests and meet the requirements for **test results** specified in this standard:

   a. the **IELTS** (academic module) with a minimum overall score of 7 and a minimum score of 7 in each of the four components (listening, reading, writing and speaking).

      **NOTE:**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - you achieve a minimum overall score of 7 in each sitting, and
      - you achieve a minimum score of 7 in each component across the two sittings, and
      - no score in any component of the test is below 6.5

   b. the **OET** with a minimum score of B in each of the four components (listening, reading, writing and speaking).

      **NOTE**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - you are tested in all four components in each sitting, and
      - you achieve a minimum score of B in each component across the two sittings, and
      - no score in any component of the test is below C.

      OET IS NOT APPLICABLE FOR CHIROPRACTIC, OSTEOPATHY AND PSYCHOLOGY, AS OET HAS NOT YET DEVELOPED A SPECIFIC TEST FOR THESE PROFESSIONS

   c. the **PTE Academic** with a minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills (listening, reading, writing and speaking).

      **NOTE:**

      We will only accept test results:

      i. from one test sitting, **or**

      ii. a maximum of **two test sittings in a six month period** only if:

      - a minimum overall score of 65 is achieved in each sitting, and
      - you achieve a minimum score of 65 in each of the communicative skills across the two sittings, and
      - no score in any of the communicative skills is below 58

   d. the **TOEFL iBT** with a minimum total score of 94 and the following minimum score in each section of the test:

      - 24 for listening,
      - 24 for reading,

- 27 for writing, and
- 23 for speaking.

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**
ii. a maximum of **two test sittings in a six month period** only if:

- a minimum total score of 94 is achieved in each sitting, and you achieve a minimum score of 24 for listening, 24 for reading, 27 for writing and 23 for speaking across the two sittings, and

- no score in any of the sections is below:

  - 20 for listening
  - 19 for reading
  - 24 for writing, and
  - 20 for speaking

e. other English language tests approved by the Board from time to time and published on the Board's website with the required minimum scores.

| ADDITIONAL OPTIONS FOR MEDICINE<br><br>successful completion of the **NZREX**, or<br><br>successful completion of the **PLAB** test. |
|---|

### *Test results*

The following requirements apply to the English language **test results**:

1. **Test results** will be accepted if they were obtained:

1.1 within the two years before the date you lodge your application for registration

**OR**

1.2 more than two years before the date you lodge your application for registration if, in the period since the **test results** were obtained, you:

c. have been in **continuous employment** as a registered health practitioner in the <xx> profession (which commenced within 12 months of the date of the test) in one of the **recognised countries** where English was the primary language of practice, and

d. lodge your application for registration within 12 months of finishing your last period of employment

**OR**

1.3 more than two years before the date you lodge your application for registration if, in the period since the test result was obtained, you:

a. have been continuously enrolled in a **Board approved program of study** (which commenced within 12 months of the date of the test) and undertook subjects in each semester, with no break from study apart from the education provider's scheduled holidays, and

b. lodge your application for registration within 12 months of completing the **Board approved program of study**.

3. For the purposes of calculating time, if an applicant relies on **test results** from two sittings, time begins to run from the date of the earlier sitting.

## Exemptions

2. The Board may grant an exemption to this standard when you apply for limited registration in the following circumstances:
    d. to perform a demonstration in clinical techniques

    e. to undertake research that involves limited or no patient contact, or

    f. to undertake a period of postgraduate study or supervised training *Dental Board of Australia only* that involves no patient contact while working in an appropriately supported environment that will ensure patient safety is not compromised.

2. Conditions will generally apply to these exemptions, which will require supervision by a registered health practitioner and may also require the use of an interpreter.

3. The Board reserves the right at any time to revoke an exemption and/or require an applicant to undertake a specified English language test.

## More information

1. Practitioners who meet this standard on the basis of results from an English language test will be asked to declare that they have continued to use English as their **primary language** when they apply to move from non-practising to **practising registration**.

2. Further information regarding the evidence that applicants must provide to the Board to prove that they meet this standard is set out in the relevant application form.

3. Your **test results** will be verified independently with the test provider.

4. You are responsible for the cost of English language tests.

## Authority

This registration standard was approved by the Australian Health Workforce Ministerial Council on 17 March 2015.

Registration standards are developed under section 38 of the National Law and are subject to wide ranging consultation.

## Definitions

**Board approved program of study** means an accredited program of study approved by the <name> Board of Australia under section 49(1) of the National Law and published in the Board's list of approved programs of study on the Board's website.

**Continuous employment** means working the equivalent of at least 26 weeks per year.

**IELTS** means the International English Language Testing System.

**Initial registration** means:

- a practitioner applying for registration in Australia in the <xx> profession for the first time; **or**
- a practitioner applying for registration (including moving from non-practising to another registration type) who has not used English as their *primary language** for a period of greater than five years; **or**
- a practitioner who currently holds limited registration on the basis that they were granted an exemption from this standard in the limited circumstances described under *Exemption*s and who is applying for another type of registration.

Initial registration otherwise does not include a practitioner who has had continual registration in the <xx> profession and is applying for a different category or division of registration in that profession, for example, a practitioner who holds provisional registration and is applying for general registration; or a practitioner who holds general registration and is applying for specialist registration.

**National Law** means the *Health Practitioner Regulation National Law Act* (as in force in each state and territory).

**OET** means Occupational English Test.

**Practising registration** means provisional, general, specialist or limited registration.

**Primary language** means the language primarily used for reading, writing, listening, and speaking and the language known best and most comfortable with.

**PTE Academic** means the Pearson Test of English Academic

**Recognised country** means one of the following countries:

- Australia
- Canada
- New Zealand
- Republic of Ireland
- South Africa
- United Kingdom
- United States of America.

**Secondary education** means Australian school years 7 through to 12, even where year 7 is classified as part of primary school in a particular state or territory.

**Six years (full time equivalent) continuous education** means education over a period of six consecutive calendar years without a break from study apart from the education institutions' (e.g. school or university) scheduled holidays.

**Student** means a student currently registered under the National Law.

**Test results** means the official results provided by the English language test provider. If you are providing test results from two test sittings as defined, the results from both sittings must meet the requirements of this standard.

**TOEFL iBT** means the Test of English as a Foreign Language internet-based test.

**Two test sittings in a six month period** means that the dates of the sittings must not be more than six months apart. For example, if your first test sitting was on 1 March, the second sitting must be no later than 30 August. If you are providing test results from two sittings, you may provide results of any two tests taken within a six month period as defined.

MEDICINE ONLY

**NZREX** means New Zealand Registration Examination administered by the New Zealand Medical Council.

MEDICINE ONLY

**PLAB** test means the test administered by the Professional and Linguistic Assessments Board of the General Medical Council of the United Kingdom.

## Review

This standard will be reviewed at least every three years.

Last reviewed: 17 March 2015

## Appendix 5 – revised draft *Nursing and midwifery English language skills registration standard*

***Please note:***

***This draft has been developed for the Nursing and Midwifery Board of Australia.***

### Registration standard: English language skills

**Effective date:** (This standard will commence within six months of being approved by the Ministerial Council and the date of commencement will be inserted when published)

The Nursing and Midwifery Board of Australia (Board) requires all applicants for **initial registration**[11] to demonstrate English language skills to be suitable for registration.

This registration standard sets out how an applicant for registration can demonstrate to the Board that their competency in speaking and communicating in English is sufficient to practise nursing and/or midwifery.

### Does this standard apply to me?

This standard applies to all applicants for **initial registration**.

It does not apply if you are applying for non-practising registration or if you are a **student**.

### What must I do?

If you are applying for **initial registration** you must demonstrate your English language competency in one of the following ways:

1. English is your **primary language** and:

    a. you have attended and satisfactorily completed at least **six years of primary and secondary education** taught and assessed in English in one of the **recognised countries**, including at least two years between years 7 and 12, **and**

    b. your qualification in the relevant professional discipline, which you are relying on to support your eligibility for registration under the **National Law** was taught and assessed solely in English in one of the **recognised countries** and:

        i. in the case of a registered nurse or registered midwife, you must provide evidence of at least a two (2) years full-time equivalent pre-registration program of study approved by the recognised nursing and/or midwifery regulatory body in any of the **recognised countries.**

        ii. in the case of an enrolled nurse, you must provide evidence of at least a one year full-time equivalent pre-registration program of study approved by the recognised nursing and/or midwifery regulatory body in any of the **recognised countries** listed in this registration standard.

**OR**

2. **Registered nurses and registered midwives**

    If you are applying for registration as a registered nurse and/or a registered midwife, you must provide evidence of the completion of five (5) *years**(full-time equivalent) of education taught and assessed in English, in any of the **recognised countries.**

[11] Bolded terms are defined in the *Definitions* section of this registration standard

**NOTE:**

a) The Board will only accept the completion of five (5) *years** (full-time equivalent) of:

i) tertiary and secondary education taught and assessed in English; or

ii) tertiary and vocational education taught and assessed in English; or

iii) combined tertiary, secondary and vocational education taught and assessed in English; or

iv) tertiary education taught and assessed in English

from one of more of the **recognised countries** listed in this registration standard.

b) The five (5) years referred to in paragraph 2(a) above must include evidence of a minimum of two (2) years full-time equivalent pre-registration program of study approved by the recognised nursing and/or midwifery regulatory body in any of the **recognised countries** listed in this registration standard.

**OR**

**Enrolled nurses**

3. If you are applying for registration as an enrolled nurse, you must provide evidence of the completion of five (5) *years**(full-time equivalent) of education taught and assessed in English, in any of the **recognised countries**.

**NOTE:**

a) The Board will only accept the completion of five (5) *years** (full-time equivalent) of:

i) vocational and secondary education taught and assessed in English; or

ii) tertiary and vocational education taught and assessed in English; or

iii) combined tertiary, secondary and vocational education taught and assessed in English; or

iv) tertiary education taught and assessed in English

from one of more of the **recognised countries** listed in this registration standard.

b) The five (5) years referred to in paragraph 3(a) above must include evidence of a minimum of one (1) year* full-time equivalent pre-registration program of study approved by the recognised nursing and/or midwifery regulatory body in any of the **recognised countries**.

**OR**

4. You achieve the required minimum scores in one of the following English language tests and meet the requirements for **test results** specified in this standard:

a. the **IELTS** (academic module) with a minimum overall score of 7 and a minimum score of 7 in each of the four components (listening, reading, writing and speaking).

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**

ii. a maximum of **two test sittings in a six month period** only if:

- you achieve a minimum overall score of 7 in each sitting, and

- you achieve a minimum score of 7 in each component across the two sittings, and
- no score in any component of the test is below 6.5

b. the **OET** with a minimum score of B in each of the four components (listening, reading, writing and speaking).

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**

ii. a maximum of **two test sittings in a six month period** only if:

- you are tested in all four components in each sitting, and
- you achieve a minimum score of B in each component across the two sittings, and
- no score in any component of the test is below C.

c. the **PTE Academic** with a minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills (listening, reading, writing and speaking).

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**

ii. a maximum of **two test sittings in a six month period** only if:

- a minimum overall score of 65 is achieved in each sitting, and
- you achieve a minimum score of 65 in each of the communicative skills across the two sittings, and
- no score in any of the communicative skills is below 58

d. the **TOEFL iBT** with a minimum total score of 94 and the following minimum score in each section of the test:

- 24 for listening,
- 24 for reading,
- 27 for writing, and
- 23 for speaking.

**NOTE:**

We will only accept test results:

i. from one test sitting, **or**
ii. a maximum of **two test sittings in a six month period** only if:

- a minimum total score of 94 is achieved in each sitting, and you achieve a minimum score of 24 for listening, 24 for reading, 27 for writing and 23 for speaking across the two sittings, and
- no score in any of the sections is below:
  - 20 for listening
  - 19 for reading
  - 24 for writing, and
  - 20 for speaking

e. other English language tests approved by the Board from time to time and published on the Board's website with the required minimum scores.

5. In other defined circumstances/cases where there is compelling evidence demonstrating English language proficiency at least equivalent to the other pathways in this standard set out in a policy published by the Board.

### *Test results*

The following requirements apply to the English language test results:

1. **Test results** will be accepted if they were obtained:

1.1 within the two years before the date you lodge your application for registration

**OR**

1.2 more than two years before the date you lodge your application for registration if, in the period since the *test results** were obtained, you:

e. have been in **continuous employment** as a registered health practitioner in the nursing and/or midwifery profession (which commenced within 12 months of the date of the test) in one of the **recognised countries** where English was the primary language of practice, and

f. lodge your application for registration within 12 months of finishing your last period of employment

**OR**

1.3 more than two years before the date you lodge your application for registration if, in the period since the test result was obtained, you:

a. have been continuously enrolled in a **Board approved program of study**, which commenced within 12 months of the date of the test result and undertook subjects in each semester, with no break from study apart from the education provider's scheduled holidays, and

b. lodge your application for registration within 12 months of completing the **Board approved program of study**.

4. For the purposes of calculating time, if an applicant relies on **test results** from two sittings, time begins to run from the date of the earlier sitting.

### Exemptions

3. The Board may grant an exemption to this standard when you apply for limited registration in the following circumstances:

g. to perform a demonstration in clinical techniques

h. to undertake research that involves limited or no patient contact, or

i. to undertake a period of postgraduate study or supervised training while working in an appropriately supported environment that will ensure patient safety is not compromised.

4. Conditions will generally apply to these exemptions, which will require supervision by a registered health practitioner and may also require the use of an interpreter.

5. The Board reserves the right at any time to revoke an exemption and/or require an applicant to undertake a specified English language test.

## More information

1. Practitioners who meet this standard on the basis of results from an English language test will be asked to declare that they have continued to use English as their **primary language** when they apply to move from non-practising to **practising registration**.

2. Further information regarding the evidence that applicants must provide to the Board to prove that they meet this standard is set out in the relevant application form.

3. Your **test results** will be verified independently with the test provider.

4. You are responsible for the cost of English language tests.

## Authority

This registration standard was approved by the Australian Health Workforce Ministerial Council on 30 April 2015.

Registration standards are developed under section 38 of the National Law and are subject to wide ranging consultation.

## Definitions

**Board approved program of study** means an accredited program of study approved by the Nursing and Midwifery Board of Australia under section 49(1) of the National Law and published in the Board's list of approved programs of study on the Board's website

**Continuous employment** means working the equivalent of at least 26 weeks per year.

**IELTS** means the International English Language Testing System

**Initial registration** means:

- a practitioner applying for registration in Australia in nursing and/or midwifery for the first time; **or**
- a practitioner applying for registration (including moving from non-practising to another registration type) who has not used English as their *primary language** for a period of greater than five years; **or**
- a practitioner who currently holds limited registration on the basis that they were granted an exemption from this standard in the limited circumstances described under *Exemption*s and who is applying for another type of registration.

Initial registration otherwise does not include a practitioner who has had continual registration in nursing and/or midwifery and is applying for a different category or division of registration in that profession, for example, a practitioner who holds provisional registration and is applying for general registration; or a practitioner who holds general registration and is applying for specialist registration.

**National Law** means the *Health Practitioner Regulation National Law Act* (as in force in each state and territory).

**OET** means Occupational English Test

**Practising registration** means provisional, general, specialist or limited registration

**Primary language** means the language primarily used for reading, writing, listening, and speaking and the language known best and most comfortable with.

**PTE Academic** means the Pearson Test of English Academic

**Recognised country** means one of the following countries:

- Australia
- Canada

- New Zealand
- Republic of Ireland
- South Africa
- United Kingdom
- United States of America.

**Secondary education** means Australian school years 7 through to 12, even where year 7 is classified as part of primary school in a particular state or territory.

**Six years primary and secondary education** means six years of Australian school years 1 through to 12 or the equivalent in a recognised country.

**Student** means a student currently registered under the National Law

**Test results** means the official results provided by the English language test provider. If you are providing test results from two test sittings as defined, the results from both sittings must meet the requirements of this standard.

**TOEFL iBT** means the Test of English as a Foreign Language internet-based test

**Two test sittings in a six month period** means that the dates of the sittings must not be more than six months apart. For example, if your first test sitting was on 1 March, the second sitting must be no later than 30 August. If you are providing test results from two sittings, you may provide results of any two tests taken within a six month period as defined.

## Review

This standard will be reviewed at least every three years.

Last reviewed: 17 March 2015

# Attachment B

## Statement from the Tasmanian Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency on matters concerning Dr Gary Fettke

The Tasmanian Board of the Medical Board of Australia (TBMBA), the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) are aware of statements made by Dr Gary Fettke at the public hearing for the Community Affairs References Committee inquiry into the medical complaints process in Australia on 1 November 2016. The Committee heard a number of serious allegations regarding the handling of notifications and the conduct of both the TBMBA and AHPRA during the course of managing notifications made concerning Dr Fettke. We believe that notifications concerning Dr Fettke were managed in accordance with both the TBMBA's and AHPRA's procedures, including the collection, analysis and handling of evidence relating to these notifications.

We can find no evidence of corruption or falsification of evidence. However, we are concerned about the allegations raised by Dr Fettke and will be writing to him seeking further information about these allegations so we can thoroughly investigate.

We have clear processes to manage conflicts of interest and these were applied by the TBMBA in considering the matters concerning Dr Fettke.

The Health Practitioner Regulation National Law (the National Law) sets out strict privacy and confidentiality protections for registered health practitioners. As the TBMBA and AHPRA are bound by and respect the privacy protections of the National Law for registered health practitioners, we are limited in our public comments regarding Dr Fettke. The TBMBA and AHPRA also recognise the need for public confidence in the system of notifications and complaints under the National Law. With this in mind, we make the following comments to reassure the public and registered health practitioners that the system of notifications and complaints protects the public and is fair to registered health practitioners.

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice. All registered medical practitioners are held to account against the professional standards set by the MBA. Obligations on medical practitioners are clearly outlined in the MBA's *Good Medical Practice: A Code of Conduct for Doctors in Australia*, which is available at www.medicalboard.gov.au.

When someone notifies AHPRA or the TBMBA of a concern regarding a registered health practitioner, we evaluate the types and magnitude of risks that the actions of a practitioner might pose to the public. This has a significant influence on how we manage the notification, and what regulatory actions may ultimately be taken. We provide the practitioner with an opportunity to respond to the notification to ensure fairness in the process, except where doing so might pose a serious risk to the public.

A formal investigation is not required for every notification or complaint. If a formal investigation is required, we use investigators that have been formally trained in undertaking investigations. Again, we provide the registered health practitioner who is the subject of the complaint with an opportunity to respond to any adverse material that is received during the investigation. When a notification or complaint has been formally investigated, the Board (such as the TBMBA) receives a comprehensive report of the investigation and the opportunity to examine all of the evidence collected by the investigator.

The membership of the TBMBA consists of medical practitioners and community members appointed by the Health Minister. This mix helps to ensure fairness when making decisions about the notifications that we receive about registered health practitioners. Where Board members involved in either making decisions about the notification or providing advice about the matters regarding a notification may be in a professional relationship with, or may know the medical practitioner who is the subject of a notification, we have clear processes to manage conflicts of interest to ensure decision making processes are free from bias.

A decision in response to a notification to caution a practitioner is not a decision that can be appealed to a Health Practitioner Tribunal. However, a registered health practitioner who receives a caution may apply to the Supreme Court for judicial review if they believe there are grounds. It is not accurate to state that there are no avenues available to appeal a decision of a Board such as the TBMBA.

Alternatively, registered health practitioners may also complain to the National Health Practitioner Ombudsman and Privacy Commissioner, who may investigate the process that has been undertaken by a Board and AHPRA in managing a notification. These processes are available to any registered health practitioner, including Dr Fettke.

In summary, both the TBMBA and AHPRA recognise the importance of acting fairly and impartially in any matter concerning a registered health practitioner such as Dr Fettke. Our primary concern in our decision-making and processes is to protect the public. There are options available to a registered health practitioner to raise concerns about our administrative processes. We take the integrity of the process, our AHPRA staff and the members of the TBMBA extremely seriously.