4

Issues with accreditation and assessment

4.1 The Australian Medical Council (AMC) is responsible for the assessment of international medical graduates (IMGs) qualifications, skills and experience, leading to various categories of registration provided through the Medical Board of Australia (MBA).

4.2 Accreditation and assessment processes for IMGs can follow a number of pathways. In broad terms, the AMC administers a range of accreditation requirements and assessment processes for non-specialist registration. Where Specialist Registration is sought, the relevant specialist medical college applies its own model of assessment, though accreditation remains the responsibility of the AMC.

4.3 This Chapter outlines evidence received from IMGs and from a range of entities assisting IMGs relating to particular elements of the AMC's assessment and accreditation processes. The Committee will also consider elements of the specialist medical colleges' models of assessment in this Chapter. Issues covered include concerns relating to lengthy timeframes and waiting periods associated with some elements of the assessment and accreditation processes. Issues relating to the assessments themselves, including concerns regarding the means and processes for assessing clinical competency of IMGs are also considered. The Chapter concludes by considering issues associated with perceptions of assessment and accreditation entities.

AMC accreditation and assessment

4.4 In accordance with provisions under the *Health Practitioner Regulation National Law Act 2009* (Qld) (the "National Law"), the AMC is authorised as the external accreditation entity to carry out the qualification

accreditation function on behalf of the MBA.[1] The AMC is also responsible for conducting the assessment of non-specialist IMGs leading to General Registration, as well as liaising with the specialist medical colleges to facilitate the assessment of IMGs who wish to become specialists.[2] Further detail in relation to the AMC's functions and assessment processes may be found at Chapter 3.

Primary source verification

4.5 The first step in the accreditation process for IMGs is verification of their international qualifications. The AMC is responsible for overseeing primary source verification, although the primary medical qualifications are actually verified by the Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services (EICS) of the United States.

4.6 Primary source verification is authorised under the National Law, which states:

> The National Board [MBA in the case of medical practitioners] may ask an entity that issued qualifications that the applicant believes qualifies the applicant for registration for confirmation that the qualification was issued to the applicant.[3]

4.7 Mr Ian Frank, Chief Executive Officer of the AMC, informed the Committee of the value of primary source verification observing:

> It needs to be understood too that [primary source verification] is not just purely a barrier. We have had cases, for example, of people coming out of China where there have been problems with their documents. Because we have access to the verification services, we were able to pursue it back into China and get verification from other sources in China that this person was a legitimate medical practitioner. So it is not just something that sort of stops people going forward; it can actually be used to verify or

1 Australian Medical Council (AMC), *Submission No 42*, p 2. The *Health Practitioner Regulation National Law Act 2009*, originally enacted in Queensland, implemented an agreement reached by COAG to construct a national accreditation scheme for medical practitioners. Similar legislation has been enacted in all states and territories of Australia, under varying names.

2 AMC, *Submission No 42*, p 2. For further information on the AMC assessment process, see Chapter 3 of this report.

3 Section 80(1)(ii), *Health Practitioner Regulation National Law Act 2009* (Qld).

> confirm something that might not be readily available to, say, the regulatory authorities in Australia. So it is a very positive process.[4]

4.8 A range of submissions to the Committee, often from IMGs themselves, outlined concerns relating to primary source verification. Largely, these relate to the amount of time taken by the AMC to verify documents, the lack of updates provided to IMGs on the progress of their application, and the lack of assistance from the AMC in obtaining primary source verification.[5]

4.9 There is no published standard to inform IMGs of the length of time primary source verification may take. However, the AMC's booklet *Quick Guide to Applying to the Australian Medical Council* states:

> EICS [ECFMG International Credentials Service] verification will continue via ECFMG until the candidate's medical school has verified their medical degree. This process may take several months to several years (this is largely determined by the medical school responding to the EICS request – the AMC is unable to contact medical schools to speed this process up).[6]

4.10 Dr Elwin Upton submitted to the Committee that 17 months had elapsed since the date of his applying to the AMC, without primary source verification being received. As at the date of making a submission to this inquiry (6 December 2010), Dr Upton's qualifications had still to be verified. Dr Upton cites an email received from the AMC on 10 February 2010, advising that a request for verification had been made to the institution and the processing time for receiving EICS notification would be approximately 'six to eight weeks'. However, Dr Upton contacted the overseas tertiary institution directly and was told there was no record of any request being received from the AMC.[7]

4.11 Dr Ponraja Thuryrajah highlighted a similar issue. Dr Thuryrajah practised medicine in Western Australia from 2004-2007 on Provisional Registration. In 2008, changes in registration procedures required the AMC to get primary source verification of Dr Thuryrajah's qualifications from the University of Kashmir. Dr Thuryrajah has encountered a number

---

4 Mr Ian Frank, Australian Medical C, *Official Committee Hansard*, Canberra, 19 August 2011, p 2.

5 Dr Elwin Upton, *Submission No 2*, p 2; Dr Ponraja Thuryrajah, *Submission No 102*, p 2; Dr Susan Douglas, *Submission No 111*, p 8.

6 AMC, *Quick Guide to Applying to the Australian Medical Council*, p 22, <http://www.amc.org.au/images/publications/applying-to-the-amc.pdf> viewed 26 January 2012.

7 Dr Elwin Upton, *Submission No 2*, p 2.

of difficulties in obtaining verification since that time.[8] After some initial delays in the process, Dr Thuryrajah told the Committee:

> I decided to focus my energies on expediting communication between the University of Kashmir and the AMC by contacting the University directly. I did contact the University via telephone, and was informed that the University had been subjected to an arson attack circa 1983, and all records of students graduating prior to that year had been destroyed.[9]

4.12 The University of Kashmir requested that Dr Thuryrajah post the original qualification to them so that it could be verified by the institution. However, Dr Thuryrajah was reluctant to post original documentation due to difficulties with the postal service. The offer to send a certified true copy was declined by the institution. Dr Thuryrajah argues that a lack of flexibility associated with the primary source verification requirement has led to three years passing without resolution of this issue. He has been unable to practice since that time.[10]

4.13 The AMC advised that of the 6 014 applications received for primary source verification in 2010, 5 642 sets of qualifications were sent to the ECFMG but only 2 862 verifications were received.[11] The AMC reported that:

> The most common cause of delays in processing verification is the failure of the issuing University or institution to respond to the request for verification. In some instances it appears that additional payments or inducements are sought by officers of the institutions involved to complete the verification process.[12]

4.14 The AMC has developed a list of overseas institutions that have not responded to requests for primary source verification or that have been particularly slow to respond in the past. On the AMC's website, IMGs are encouraged to review the list to identify whether the institution where they received their qualifications is likely to delay or fail to respond to any requests to verify their qualifications.[13] The AMC states:

---

8 Dr Ponraja Thuryrajah, *Submission No 102*, p 2.

9 Dr Ponraja Thuryrajah, *Submission No 102*, p 3.

10 Dr Ponraja Thuryrajah, *Submission No 102*, p 3.

11 AMC, *Submission No 42*, p 9.

12 AMC, *Submission No 42.2*, p 4.

13 AMC, Primary source verification, *Overseas institutions with a high percentage of outstanding EICS requests*, <http://www.amc.org.au/images/info/institutions-with-high-percentage-of-outstanding-EICS-requests.pdf> viewed 3 February 2013.

> If an IMG is able to identify their overseas medical training institution in the list provided by the AMC, we recommend that they contact the institution to confirm that the institution will respond to the EICS verification request through the agreed processes between the AMC, the ECFMG and the relevant overseas institution.[14]

4.15 The AMC has also attempted to rectify some of the issues with respect to primary source verification, including assisting IMGs who have successfully completed all other stages of the registration pathway, excepting the primary source verification process. The AMC submitted that it has identified a group of candidates who have met all requirements for the award of the AMC Certificate but are still waiting for primary source verification. The AMC stated that at the commencement of 2011, 70 individuals were in this position, however this number had reduced to 47 individuals from 15 countries following additional efforts by the ECFMG to expedite the verification the outstanding qualifications.[15]

4.16 Mr Frank expanded further on the AMC's efforts to rectify delays occurring in the verification process for candidates who have completed the assessment process excepting primary source verification, saying:

> We have had some discussions at the Medical Board of Australia to see whether there are ways in which we might be able to deal with those people without holding them up unnecessarily.[16]

Committee comment

4.17 The Committee understands that there is a range of factors that may prevent the timely processing of applications for primary source verification. These factors include whether the applicant's overseas medical school is recognised by the ECFMC, the completeness of the applicant's documentation (including whether correct witnessing requirements have been met) and whether the issuing institutions themselves respond to requests from the ECFMC.

4.18 The Committee notes the AMC's evidence that much of the delay in primary source verification may be sourced to the verification processes of the ECFMG. The Committee acknowledges that the AMC has made substantial efforts to assist candidates to have their qualifications verified through the ECFMG process. In particular, the Committee supports the

14 AMC, *Submission No 42.2*, pp 4-5.

15 AMC, *Submission No 42.2*, pp 4-5.

16 Mr Ian Frank, AMC, *Official Committee Hansard*, Canberra, 19 August 2011, pp 4-5.

AMC continuing efforts to assist IMGs who have passed all other components of the registration pathway but have been unable to achieve primary source verification.

4.19 It is evident to the Committee that a large source of frustration for IMGs is the lack of follow-up or communication from the AMC in relation to the progress of primary source verification, and their inability to take steps to rectify any difficulties. The Committee recommends that the AMC and MBA consider what further assistance might be provided to IMGs seeking to verify their qualifications, including the provision of regular updates on the progress of primary source verification, and an anticipated timeframe for the outcome of the process.

4.20 Further, the Committee proposes that the AMC and MBA in consultation with IMGs take steps to assist IMGs who have encountered obstacles to achieving verification which are beyond their control, such as circumstances regarding an institution's ability or willingness to provide primary source verification.

Recommendation 1

4.21 **The Committee recommends that the Australian Medical Council (AMC), in consultation with the Medical Board of Australia and international medical graduates (IMGs), take steps to assist IMGs experiencing difficulties and delays with primary source verification, including but not limited to:**

- **continuing to assist IMGs who have passed all requirements of a pathway towards registration as a medical practitioner, excepting primary source verification;**
- **liaising with the Educational Commission for Foreign Medical Graduates to ascertain and address any barriers to achieving timely primary source verification; and**
- **providing IMGs with up-to-date information relevant to their application, including the anticipated timeframe for response based on their application, or options on how they might hasten the process, such as contacting the institution directly.**

Competent Authority Pathway

4.22 IMGs seeking non-specialist registration who have completed examinations or accreditation in the UK, Canada, United States, New Zealand or Ireland may seek General Registration through the Competent Authority Pathway. To be eligible for this pathway, IMGs are required to have completed all licensing requirements of the relevant Competent Authority's accrediting body and a minimum specified period of post-examination practise in the relevant Competent Authority country.[17] The AMC submitted to the Committee:

> The CA (Competent Authority) model recognises that there are a number of established international screening examinations for the purposes of medical licensure that represent a 'competent' assessment of applied medical knowledge and basic clinical skills to a standard consistent with that of the AMC examination for non-specialist registration.[18]

4.23 Once recognition under this pathway is granted, IMGs are awarded 'advanced standing' towards the AMC Certificate. IMGs with advanced standing can apply for Provisional or Limited Registration and must undertake a 12 months period of peer reviewed supervision in a designated position prior to being eligible to apply for General Registration. The AMC told the Committee:

> Despite getting some occasional bad press it has probably been one of the most successful things we have been able to implement in Australia and it certainly led to us attracting some fairly high quality people into this country.[19]

4.24 The main advantage of the Competent Authority pathway is that it provides candidates with the ability to expedite their journey towards General Registration.

Competent Authority recognition

4.25 Evidence provided to the inquiry notes that there are other countries (particularly those in Western Europe) in addition to those currently deemed to be Competent Authority countries, which also have very high standards of medical education and training.

---

17 See also: AMC, *Submission No 42*, pp 9-10.

18 AMC, *Submission No 42*, p 9.

19 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 7.

4.26 The Western NSW Local Health Network told the Committee that consideration should be given to extending the number of countries deemed to be Competent Authority countries, saying:

> Several European countries, such as Germany and the Netherlands, appear to produce doctors who are as well-trained as the recognised competent authority nations, however, they enjoy no preference over countries whose training systems are viewed less favourably. It may be that blanket acceptance of medical practitioners from additional countries is not possible due to differences in the approach to some specialities. It could, however, be appropriate to recognise those specialities that do have equivalence to avoid unnecessary assessment and supervision requirements (all of which consume Health System resources and may deter suitable applicants).[20]

4.27 Further, some submissions to the inquiry suggested that the Competent Authority model is discriminatory.[21] For example, Dr Dennis Gonzaga notes:

> The Competent Authority Pathway gave rise to a query of what['s] so special about doctors trained in the USA, UK, Canada and NZ? Isn't [it] that medical knowledge is a universal thing, regardless of language, colour, country status, the biochemical principles, human anatomical landmarks, mode of action of medications, types of bacteria and viruses, etc. are all the same wherever you are on Earth ... Therefore there shouldn't have boundaries in categorising and assessing competency of an IMG regardless of country of origin.[22]

4.28 Dr Johannes Wenzel also submitted:

> For decades the medical system has maintained a two-tier culture where OTDs are treated inferiorly to their Australian trained counterparts ... This dilemma has not been helped by AMC introducing the 'competent authority' pathway, psychologically perceived by majority of OTDs from the other countries that they are INCOMPETENT![23]

4.29 In contrast to these arguments, the Committee also received evidence suggesting that increasing the number of Competent Authority countries

20 Western NSW Local Health Network, *Submission No 49*, p 7.

21 See for example: Dr Jonathan Levy, *Submission No 34*, p 7.

22 Dr Dennis Gonzaga, *Submission No 35*, p 2.

23 Dr Johannes Wenzel, *Submission No 68*, p 7.

is neither feasible nor appropriate. Outlining the reasons for limiting the number of Competent Authority countries, the AMC noted that the diversity of medical training conducted around the world has implications on an IMG's ability to integrate into the Australian health system:

> There is considerable diversity in the format, content and methodology of medical training across these courses. Equally, there are significant variations in:
>
> - The clinical context of medical practice, including the burden of disease, levels of technology and the delivery of health services.
> - Professional ethics, including non-discriminatory treatment and the rights of all patients.
> - The educational context, including principles, systems and delivery of medical education.[24]

4.30 The AMC submitted further:

> In the case of the Competent Authority applicants, the fact that they had already completed formally recognised licensing examinations, that were rigorous and detailed assessments of medical knowledge and clinical skills, meant that their entry to the medical workforce in Australia could be fast-tracked with confidence.[25]

4.31 The AMC advised that it is reviewing international examinations and medical schools and courses that lead to registration for the purpose of accrediting those that meet set criteria as 'Competent Authorities'.[26]

Committee comment

4.32 The Committee notes the AMC's comments that any reduction in rigour or completeness of assessment of IMGs would need to be balanced by a corresponding increase in the monitoring of IMGs in a clinical setting.[27] The Committee understands that entry into the Competent Authority list is based soundly on the similarity between the examination processes of Competent Authority countries to those in Australia, taking into account relevant factors such as the assessment of medical knowledge and basic clinical skills. The Committee is satisfied that the AMC is the appropriate agency to assess whether it is feasible to extend the list of countries that are deemed to be Competent Authorities.

---

24 AMC, *Submission No 42*, p 17.

25 AMC, *Submission No 42*, p 21.

26 AMC, *Submission No 42*, pp 33-34.

27 AMC, *Submission No 42*, p 21.

4.33 The Committee is of the view that the AMC has taken a cautious approach in limiting the ability of IMGs to 'fast-track' the assessment process to those IMGs who have qualifications from a country whose assessment process is comparable to Australia. Such caution ensures that IMGs being assessed under this pathway have the best opportunity possible to integrate into the Australian health system, while also ensuring that the high standards and rigour of assessment and registration as a medical practitioner in Australia is maintained.

4.34 Accordingly, the Committee supports the AMC's view that the list of Competent Authority countries should not be extended to include countries which do not have comparable assessment regime, as this has implications for the overall safety and standards of the health system in Australia.

4.35 Notwithstanding this view, the Committee is also supportive of the AMC undertaking a review of international examinations and assessment processes to determine whether any other countries should be added to the list of Competent Authorities, on the basis of comparability of medical education and assessment standards. The AMC should be proactive in undertaking visits to enquire into examination and assessment processes of selected countries in order to expedite the outcomes of this review.

Standard Pathway (2-part assessment)

4.36 IMGs who do not hold qualifications from a Competent Authority country and who are not seeking registration as a specialist must follow the Standard Pathway of assessment through the AMC. Assessment under the Standard Pathway consists of two components – the AMC Multiple Choice Question (AMC MCQ) examination and the AMC Structured Clinical Examination (SCE). If a candidate successfully completes both components of this process, the IMG will be awarded an AMC Certificate which enables the holder to apply for registration through the MBA.

Part 1 – Multiple Choice Question examination

4.37 The AMC advised that there has been a steady increase in demand for the AMC MCQ examination over the past 5 years, rising from 1,509 candidates in 2005/2006 to 4,466 in 2009/2010.[28] The AMC said of the MCQ examination:

28 AMC, *Submission No 42*, p 11.

> The pattern of passing shows that there is a significant fall-off in the pass rates after two attempts at the MCQ examination with 66.77% of candidates who pass doing so at their first attempt, 19.69% at their second attempt, 7.2% at their third attempt and 6.2% at their fourth or subsequent attempt. The data for 2010, which is consistent with previous years, shows that the majority of candidates who will pass the MCQ examination (84.54%) will do so within two attempts and that the pass rates flatten out after two attempts.[29]

Part 2 – Structured Clinical Examination (SCE)

4.38 The AMC SCE assesses clinical skills through the use of clinical stations. Concerns raised throughout this inquiry regarding the SCE include issues regarding demand for places, how the assessment is administered and concerns regarding the increasing demand for the examination.

Supply and demand

4.39 The AMC submitted to the Committee that the demand for SCE places now exceeds supply, increasing from 887 candidates in 2005/2006 to 1,258 in 2009/2010.[30] The increased number of IMGs successfully completing the MCQ has resulted in an increased demand for the SCE. According to the AMC, the challenge of meeting this increased demand is affected by the availability of appropriately qualified clinical assessors, venues and persons to act in either role playing or patient capacities.[31]

4.40 Commenting on waiting times to sit the SCE, Dr Wenzel noted:

> After passing the AMC MCQ examination, the average wait for a position in the clinical AMC examination is 18 (!) months which exacerbates doctors' 'time out of clinical work'. There are no explanations why some IMGs have to wait much longer than 18 months!!! It gets worse for OTDs who fail in their first attempt, they face a wait of about 22 months, in some cases even up to 3 years! The situation is compounded by the AMC conducing unlimited MCQ examinations locally and overseas at a time where they cannot provide AMC clinical examination positions within a reasonable time![32]

---

29 AMC, *Submission No 42*, p 11.

30 AMC, *Submission No 42*, pp 11-12.

31 AMC, *Submission No 42*, p 12.

32 Dr Johannes Wenzel, *Submission No 68*, p 2.

4.41 Similarly the Government of Western Australia Department of Health noted:

> There is currently an 18-24 month delay for applicants seeking to sit this exam. There have been steady increases in the number of exam places and variety of sites these tests are held, but high rates of failure indicate IMGs are not well supported to pass this exam on the first attempt. Each attempt requires progressing through the 'wait' period and additional financial imposts.[33]

4.42 The Committee has heard concerns regarding access to the SCE from a number of IMGs and organisations.[34] These concerns not only evidence delays in the SCE process, but also the personal consequences resulting from a failure to complete the process. For example, Dr Chaitanya Kotapati states:

> The current delay for AMC clinical examination is not only causing delay in the progress of the training of the overseas doctors but also is contributing to tremendous stress in their personal lives as they are under constant pressure to meet the requirements of AHPRA (Australia Health Practitioners Regulatory Agency) in order to maintain conditional registration.[35]

4.43 In relation to the AMC's capacity to address this demand Mr Frank of the AMC told the Committee:

> We know for example that even now with our current clinical examination we are running 22 series of examinations a year. That is one set of clinical examinations every two-and-a-half weeks through the year. ... Now there are up to three venues, three cities, we are running it in. That is probably the maximum capacity of that system to be able to work.[36]

4.44 In terms of addressing wait times for the SCE Mr Frank added:

> ... one of the things we are looking at is outsourcing part of the clinical examination to universities to see if we can use their facilities and their people outside of the weekends, because at the

33 Government of Western Australia (WA) Department of Health, *Submission No 82*, p 7.

34 See for example: Dr Sunayana Das, *Official Committee Hansard*, 10 March 2011, pp 23-24; Mr Kevin Gillespie, *Submission No 157*, p 2; Government of WA Department of Health, *Submission No 82*, p 4.

35 Dr Chaitanya Kotapati, *Submission No 21*, p 2.

36 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 9.

> moment we can only use the weekend facilities because that is when the hospital facilities are available to us ...[37]

4.45 In addition, in an attempt to balance supply and demand, the AMC advised that it had developed a system which determines a list of priority for SCE places. The priority list aims to distribute the number of available SCE places in an equitable way. Under the priority system first-time applicants are accorded priority over those who have previously attempted the examination.[38] However, the Committee was advised that one-third of all SCE places are reserved for repeat candidates, Mr Frank noting that if only first attempt candidates were selected, repeat candidates would not have the opportunity to re-attempt the examination.[39]

4.46 Mr Frank told the Committee of the current waiting list for the SCE:

> Ideally we like to get everybody into an exam within 12 months of qualifying for a clinical examination. In practical terms it is closer to 18 months, two years now. For repeat-attempt candidates we give priority to people with fewer attempts over people with more attempts. The reason for that ... the data shows that they just flatline out and do not get through.[40]

4.47 The AMC also told the Committee about a 'standby list' that it has to ensure that all available SCE places are filled, explaining:

> ... we also have what is called a standby list and on merit order the next group of candidates down from the ones that have been allocated—so if you have got 250 places allocated—we take another 100 places and we contact the people and say, 'Do you wish to be placed on a standby list in the event that somebody declines one of the places that has been allocated?' If they say yes, we put them on that list and we treat them in merit order. So if a vacancy becomes available—often at the last minute—then we contact those people and say, 'There is a place available. Do you wish to take it?'[41]

4.48 However, Dr Paramban Rateesh made the following observation of his experience of being called from the standby list to take the SCE:

---

37 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 17.

38 AMC, Clinical examination scheduling process, <http://www.amc.org.au/index.php/ass/clinex/clinex-sched> viewed 3 February 2012.

39 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 15.

40 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 15.

41 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 13.

> ... all the times I have failed [the SCE] I have been called from the [standby] list when I was already told no because the last person has dropped out and they wanted that money to come back to them. I am getting a phone call on a Friday saying ... 'Are you ready to take up the exam for the coming Saturday?' The condition is that if I said no then I would go to the bottom of list, then I would have to climb a mountain to get back up.[42]

Committee comment

4.49 The Committee notes statistics provided by the AMC show that a high percentage of candidates pass the AMC MCQ examination within two attempts, while candidates who attempt the examination on more than two occasions find it extremely difficult to pass. As the AMC MCQ is a computer based assessment, the Committee understands that it can be readily accessed by IMGs, and can be taken by applicants who are not based in Australia. The Committee understands that the AMC MCQ is an important screening tool, providing an initial assessment of IMGs clinical knowledge prior to successful applicants progressing to the next stage of the AMC assessment, the SCE.

4.50 In contrast, the Committee perceives that there is a need to increase the availability of places for the SCE. However, it also understands that the resources available to increase the capacity of the SCE are finite. In this circumstance, the Committee is pleased that the AMC is undertaking a number of initiatives to deal more effectively with the demand by establishing prioritisation mechanisms, including prioritisation and standby lists, to maximise the equitable allocation of places and ensure that the available capacity is utilised.

4.51 In addition, the Committee encourages the AMC to continue exploring the full range of options available to increase the availability of SCE places, such as outsourcing to universities. To this end, the Committee recommends that the AMC examine options for increasing the availability of the AMC SCE for the benefit of IMGs.

4.52 Amid concerns that many IMGs are required to wait for up to two years for the opportunity to undertake the AMC SCE, the Committee believes that additional examination places must ensure that IMGs can undertake examination within a reasonable timeframe. The Committee appreciates the AMC's contention that an ideal scenario for IMGs attempting the AMC SCE for the first time should be accommodated within 12 months.

---

42 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 39.

However, the Committee considers that a six month period would be more appropriate. As foreshadowed in Chapter 1, the Committee intends to review progress made in relation to the report's recommendations at a later date. The adequacy and feasibility of this timeframe will be considered in consultation with the AMC and IMGs at that time.

Recommendation 2

4.53 **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.**

4.54 It is evident to the Committee that the scheduling priorities and the standby list used to allocate places for the SCE are not well understood by IMGs, and as such causes confusion and frustration. This is particularly the case for IMGs who are repeat candidates with lower priority, who are likely therefore to experience even longer waiting times. The Committee is of the view that the AMC should alleviate this by publishing detailed information on its website in relation to the allocation of places, and the current anticipated waiting times for undertaking the SCE.

Recommendation 3

4.55 **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.**

4.56 The Committee notes that the AMC is prioritising first-time candidates who attempt the SCE over those who are repeat candidates. The Committee is of the view that a further step towards reducing the demand for the SCE would be to identify the difficulties that repeat candidates

have encountered and consider whether further support might be offered to those candidates. This issue is considered in more detail below.

Provision of feedback

4.57 Another concern raised in evidence relates to feedback received in relation to the SCE. IMGs in particular have expressed their frustration to the Committee about the lack of feedback provided to them once they have been advised that they have failed a component or components of the SCE.

4.58 The AMC's website advises that the overall result for each of the 16 marked 'stations' of the SCE are recorded as a pass or fail mark only. Candidates are graded as a clear pass, marginal performance or clear fail.[43] In his submission to the inquiry, Dr Wenzel criticised the lack of SCE feedback, observing:

> The AMC clinical examination does not entail constructive feedback for candidates who fail a station. No other university or college restricts examination results to a simple pass/fail and provides feedback in [the] form of a global tick box approach which does not relate to individual stations.[44]

4.59 Having failed on three occasions to pass the SCE, Dr Rateesh noted that in the absence of constructive and specific feedback he was not able to determine precisely why he had failed and seek to improve on any deficiencies.[45]

Committee comment

4.60 The Committee is concerned that feedback for candidates attempting the SCE is limited to whether the candidate passed or failed a particular station. This leaves candidates unaware of any shortcomings in their knowledge and unable to take steps to rectify these shortcomings. As the provision of constructive feedback is crucial to assisting IMGs to advance to registration the Committee believes this situation should be rectified.

43 AMC, Clinical examination performance requirements, <http://www.amc.org.au/index.php/ass/clinex/clinex-perform> viewed 3 February 2012.

44 Dr Johannes Wenzel, *Submission No 68*, p 2.

45 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 39.

Recommendation 4

4.61 **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.**

Targeted level of AMC examinations

4.62 The Committee has heard that some IMGs are dissatisfied with the competence level targeted by the AMC through the MCQ and SCE examinations. The AMC's website states:

4.63 The examinations are set at the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to begin intern training.[46]

4.64 Dr Michael Cleary, giving evidence to the Committee on behalf of Queensland Health, compared the AMC examinations to the final examinations provided to medical students in Australia, saying:

> The AMC exam is in two parts: a clinical component and a multi-choice component. In lay terms, the examinations are meant to be equivalent to a sixth-year medical student, so someone who has graduated from university in Australia who has the knowledge, skills and abilities to be able to practise medicine as a junior doctor.[47]

4.65 Dr Cleary also told the Committee:

> The clinical examination requires you to have an understanding of the healthcare system as well as an understanding of medical practice. It is very difficult—I would say it would be extraordinarily difficult—to pass that exam from overseas without having practised in Australia, so generally people come and practise in Australia.[48]

---

46 AMC, AMC examinations (Standard Pathway), http://www.amc.org.au/index.php/ass/apo/sp/exams, viewed 3 February 2012.

47 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 8.

48 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 8.

4.66 Dr Susan Douglas, representing the Australian Doctors Trained Overseas Association (ADTOA), told the Committee:

> The nature of that test is that it actually is a proxy for someone who is just getting out of medical school. The evidence clearly shows that the type of knowledge an experienced clinician has, like an IMG, is very different from an AMC entry test ...[49]

4.67 Similarly, Dr Viney Joshi also representing ADTOA, told the Committee:

> The AMC exam is by no means a test of an individual's ability to safely practise medicine. We are looking at people in their 40s ... It is well known among people who are involved in adult education that when people in their 40s or 50s have been in a particular stream of a profession for 15 or 20 years, they lose the academic ability. I think the assessments should be more pointed towards their safety in their chosen field of expertise. For example, for an ophthalmologist, there should be a peer review process to see whether he is safe as an ophthalmologist—not that he is asked to go and sit the AMC exam, which has directed questions on obstetrics and gynaecology, which this man may have studied 22 or 25 years ago. He will never pass that exam.[50]

Committee comment

4.68 The Committee understands that the AMC examinations are targeted at the level of an Australian medical graduate and is aimed at testing an IMG's basic medical knowledge and knowledge of the Australian medical system. As the examinations do not seek to assess knowledge beyond that which is required of a new medical graduate, the Committee is of the view that the examination achieves its desired outcome and places IMGs seeking employment in Australia on an equal playing-field as Australian-trained graduates.

4.69 The Committee understands that there are a number of IMGs, particularly those who completed their basic medical education some time ago, who feel disadvantaged by this assessment mechanism. The alternative assessment process offered through workplace-based assessment (discussed below) should alleviate these concerns for some IMGs. The Committee considers, however, that the examinations should be retained in their current format, as the assessment appropriately establishes the

49 Dr Susan Douglas, *Official Committee Hansard*, Canberra, 25 February 2011, p 48.

50 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, pp 15-16.

foundation of medical knowledge which is expected of all practitioners seeking employment in Australia.

Standard Pathway (Workplace-based assessment)

4.70 IMGs choosing the Standard Pathway of assessment may choose an alternative to the SCE, this being the workplace-based assessment model (WBA). A candidate for WBA must pass the AMC MCQ and must also comply with a number of other conditions regarding their English language proficiency and employment.

4.71 Although the WBA alternative pathway was included in the 2007 COAG IMG Assessment Initiative proposals[51], it was not endorsed by all Australian jurisdictions and is therefore limited to four sites nationally, being:

- Hunter New England Area Health Service (New South Wales);
- Rural and Outer Metropolitan United Alliance (Victoria);
- Launceston General Hospital (Tasmania);
- Western Australia Health:
  - ⇒ Bunbury Hospital;
  - ⇒ Hollywood Private Hospital and Joondalup Health Campus.[52]

4.72 The Committee has received evidence regarding the effectiveness of this program, as well as evidence advocating for this pathway to be expanded and made available on a national scale for the benefit of all IMGs.

Effectiveness of the workplace-based assessment model

4.73 Mr Frank, representing the AMC, told the Committee that the SCE is a valid form of testing as it provides a three-hour snapshot of an IMG's clinical performance across a range of disciplines.[53] However, Mr Frank noted that assessing somebody in a workplace setting over a longer period of time is the ideal, stating:

> ... being able to assess somebody over a period of time in a workplace setting ... is a far more effective way of testing people, and that is one of the reasons why the AMC was a strong advocate for getting workplace based assessment implemented.[54]

51 AMC, *Submission No 42*, p 6.

52 AMC, *Submission No 42*, p 13.

53 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 8.

54 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 8.

4.74 The AMC submission includes the following observations on WBA:

> This model offers a number of advantages over the AMC clinical examination pathway:
>
> - The assessments are undertaken over time, providing a much more reliable and accurate evaluation of the clinical skills of the IMG.
> - The IMG is assessed in terms of his or her 'performance' rather than 'competence' alone. In other words, they are assessed in relation to how they actually perform in a clinical setting rather than measuring their capabilities in an artificial examination setting.
> - The assessment includes feedback on performance which assists in addressing performance problems and issues, a function that is not available in the AMC clinical examination, unless these can be linked to bridging programs.
> - The IMGs are employed and are better able to offset the cost of their assessments.[55]

4.75 Other evidence to the inquiry was generally supportive of WBA as a credible alternative assessment to the AMC SCE.[56] Ms Marita Cowie, Chief Executive Officer of the Australian College of Rural and Remote Medicine (ACRRM), told the Committee that ACRRM has received seed funding from the Australian Government Department of Health and Ageing (DoHA) to trial a new WBA program which will also provide an alternative to the AMC SCE for IMGs. Ms Cowie told the Committee that ACRRM is hoping that the WBA program will allow candidates working in general practice roles to obtain General Registration more efficiently than the current clinical examination system.[57]

4.76 Concerns expressed in evidence primarily related to the limited availability of WBA places, issues associated with ensuring the quality and independence of WBA review, and the resource implications associated with implementing and participating in WBA.[58]

---

55 AMC, *Submission No 42*, p 28.

56 See for example: Dr Chaitanya Kotapati, *Official Committee Hansard*, Brisbane, 10 March 2011, p 21; Professor Kichu Nair, *Submission No 162*, p 2; Dr David Thurley, General Practice Network Northern Territory, *Official Committee Hansard*, Darwin, 30 January 2012, p 8; Dr Helmut Schoengen, *Submission No 150*, p 2.

57 ACCRM, *Submission No 103*, p 14; Ms Marita Cowie, Australian College of Rural and Remote Medicine, *Official Committee Hansard*, Brisbane, 10 March 2011, p 55. See also: DoHA, *Submission No 84*, p 15.

58 See for example: AMC, *Submission No 42*, p 28; Government of WA Department of Health, *Submission No 82*, p 5, 11; Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 18.

Committee comment

4.77 Based on evidence to the inquiry the Committee understands that WBA model provides a useful and effective method of clinical assessment. As such it offers a credible alternative assessment pathway to the AMC SCE. The Committee is encouraged by the positive feedback in relation to WBA provided during the inquiry by representatives from a number of host sites that are currently offering this model of assessment. The Committee was impressed by the success of the award winning WBA program run by Hunter New England Health[59], noting that in a little over 12 months 49 IMGs had successfully progressed through the assessment and another 19 were expected to complete the program in the near future.[60] Similarly high rates of success were reported for IMGs undertaking WBA through Launceston General Hospital.[61] The Committee considers that these programs provide good examples of WBA program best practice and is encouraged to note that with support from DoHA, ACRRM is in the process of implementing a pilot WBA to operate in general practice settings.

4.78 In view of the AMC's advocacy of WBA, and the positive feedback on the model from those sites currently supporting this type of assessment, it is unclear to the Committee why this model it is not offered more widely around Australia. In Chapter 3 the Committee has already noted information provided by the AMC indicating that although WBA was included in the original 2007 COAG IMG Assessment Initiative proposals, this form of assessment was not endorsed and signed off by all Australian jurisdictions at that time. According to the AMC this resulted in delays in implementing WBA at a national level.[62]

4.79 The Committee concludes that the limited endorsement of WBA by jurisdictions as part of the 2007 COAG IMG Assessment Initiative proposals, combined with other constraints such as the availability of financial, human and administrative resources needed to support WBA may have contributed to the relatively small number of sites available to host this assessment pathway. Although understandable, concerns

59 Hunter New England Health received the following awards for its workplace-based assessment program: 2011 Premier's Public Sector Award for 'Innovation in front-line delivery'; 2011 Ministry of Health Award; 2011 NSW Ministry of Health Director Generals Innovation Award; 2011 Hunter New England Health Quality Award for 'Building the HealthWorkforce'.

60 Mrs Julie Wein, *Official Committee Hansard*, 27 September 2011, Newcastle, p 3.

61 Dr Beth Mulligan, Director of Clinical Training; Chair IMG Subcommittee, Department of Health and Human Services, *Official Committee Hansard*, 14 November 2011, Launceston, p 12.

62 AMC, *Submission No 42*, pp 12–13.

regarding the resource implications of hosting WBA may need to be balanced with consideration of the benefits deriving from the additional clinical services offered by the IMGs who are undertaking WBA.

4.80 Given the evident success of WBA and widespread support for this form of assessment, the Committee believes that action should be taken to increase access to WBA for IMGs seeking registration through the Standard Pathway. To achieve this aim, the Committee recommends that COAG's health workforce agenda include consideration of WBA to increase jurisdictional endorsement of this pathway and increase availability nationally.

Recommendation 5

4.81 **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.**

4.82 Also, to gauge whether improvements could be made to the current WBA model, the Committee recommends that the AMC commission an independent evaluation of WBA. The evaluation should include a cost-benefit analysis of WBA and encompass the views of all stakeholders including IMGs, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public.

Recommendation 6

4.83 **The Committee recommends that the Medical Board of Australia in conjunction with the Australian 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.**

Specialist medical college processes

4.84 IMGs who are deemed to be specialists or who have trained as a specialist in their country of origin may pursue one of the pathways towards registration as a specialist medical practitioner in Australia. The AMC and specialist colleges are required to liaise in order to coordinate the assessment and accreditation processes for IMGs seeking specialist recognition.

Assessing level of comparability

4.85 Assessment of an IMG's claims for Specialist Registration is conducted by one of Australia's sixteen specialist medical colleges, and leads to a determination of the IMG's level of comparability as 'substantially comparable', 'partially comparable' or 'not comparable'. The outcome of this assessment will impact on the length of time an IMG is required to undergo supervised practise under peer review, and whether there are additional requirements to be met (e.g. college examinations).

4.86 Although the specifics of specialist medical college assessments vary, evidence concerning these processes identified common issues of general concern. These issues relate primarily to the transparency and fairness of specialist medical college assessment processes.

4.87 An overview of the specialist medical college assessment processes is provided in Chapter 3 of the report. In brief however, assessing the level of comparability usually involves the relevant college in the first instance reviewing documents as verified by the AMC which detail qualifications, skills and experience gained by overseas trained specialists.

4.88 Applicants are also required to submit an application for assessment to the relevant specialist college. Further assessment usually involves interview with applicants to determine an IMG's level of comparability to the standard expected of an Australian-trained medical specialist. Assessors for this process are generally chosen from the Fellowship of the relevant college.[63]

4.89 The Royal Australian and New Zealand College of Radiologists (RANZCR) explained in its submission that:

> The interview is a structured and thorough process that provides an opportunity for the panel to:

63 See for example: Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission No 45*, p 3.

- explain the assessment process;
- clarify the applicant's training and experience;
- determine the applicant's suitability for practice in Australia.

It is an opportunity for the applicant to:

- detail and explain previous training and working experience.
- ask any questions of the panel about the assessment process.[64]

Distinctions between levels of comparability

4.90 The Committee has heard evidence suggesting that there is some confusion regarding the classification of IMGs level of comparability. Specifically, some members of the IMG community are unsure of the weight accorded to individual aspects of an IMG's prior skills, experience and training.

4.91 In highlighting this issue, the NSW Department of Health suggested that the specialist colleges should develop clear, evidence based criteria by which comparability of training programs can be assessed.[65] In this regard the Department noted:

> The majority of specialist Colleges do not provide a list of qualifications, or guidance on evidence of experience, that they consider to be substantially comparable to Australian qualifications for the benefit of applicants and their potential employers ... This lack of clear information on the criteria to be met makes it difficult for an employer or applicant to easily determine if they will be assessed as partially or substantially comparable at the early stage in an assessment process.[66]

4.92 Alecto Australia Medical Recruitment also noted that it is unclear what overseas qualifications are likely to be considered substantially comparable or otherwise, and submitted:

> It would be helpful to provide a listing of the qualifications that are generally deemed to be 'substantially comparable'.[67]

4.93 The submission from Queensland Health also raised concerns regarding criteria for determining comparability, noting:

---

64 Royal Australian and New Zealand College of Radiologists (RANZCR), *Submission No 43*, p 5.

65 NSW Department of Health, *Submission No 124*, p 3.

66 NSW Department of Health, *Submission No 124*, p 2.

67 Alecto Australia, *Submission No 85*, p 4. See also: South Eastern Local Health Network, *Submission No 16*, p 1.

> The definitions of comparability are recognised by all colleges; however each college stipulates extra requirements beyond the comparability definition without clear explanation of the reasons.[68]

4.94 The Western NSW Local Health Network raised the issue of consistency of college assessments within, and between colleges, saying:

> The approaches to assessment also vary between colleges and some consistency would be useful. Greater transparency would improve the whole assessment system. It would allow health services to better understand college processes and improve recruitment decisions.[69]

4.95 The AMC noted that the Joint Standing Committee on Overseas Trained Specialists (JSCOTS), formed by the AMC and Committee of Presidents of Medical Colleges, had examined the issue of assessment comparability with input and support from the colleges. While progress had been made toward achieving a common definitions and understandings of the different comparability levels, the AMC added:

> ... it appears that there are still some problems with the application of the terminology, including outcome reports of a 'substantially comparable' assessment, but with an additional 24 months oversight (the terminology for 'substantially comparable' makes it very clear that the maximum oversight is 12 months). Some outcome reports have confirmed 'substantially comparable' but with workplace based assessment (of summative nature). Again this is inconsistent with the agreed assessment outcomes. These examples illustrate the need to ensure that processes are monitored and continually updated and confirmed to ensure consistency. This has been a key role for JSCOTS.[70]

Recognition of prior training and experience

4.96 Some evidence to the inquiry suggests that not enough weight is afforded to previous medical training and experience that IMGs have gained in their home country when applications for specialist recognition are assessed.

4.97 The Committee has been told that where an IMG's prior experience is not given adequate recognition, an IMG can spend significantly longer under peer reviewed supervision, and may be required to demonstrate basic

68 Queensland Health, *Submission No 126*, p 9.

69 Western NSW Local Health Network, *Submission No 49*, p 7.

70 AMC, *Submission No 42*, p 26.

skills and experience which they would argue they have previously gained in their home country. Drs David Wood and David Levitt submitted:

> When an OTD has significant experience in a speciality and is actively and successfully progressing towards appropriate registration in that speciality they are required to do a requisite amount of general training at an intern level. This shows a lack of understanding of:
>
> - The experience level of the OTD in this speciality; and
> - The experience that this OTD will have had in the basic specialties by exposure in current training at a higher level.[71]

4.98 Dr Paramban Rateesh told the Committee that the Royal Australian College of General Practitioners (RACGP) requires that IMGs have a minimum of four years experience before sitting the RACGP exams:

> For the Royal Australian College of General Practitioners, I need to be a general practitioner for a minimum of four years, but my 30 years of experience has been counted only as one year and nine months.[72]

Peer review

4.99 IMGs who are deemed to be 'substantially' or 'partially' comparable to an Australian-trained specialist may also be required to undertake a period of supervision under peer review, before they are eligible to apply for Fellowship with the relevant specialist medical college. The Royal Australasian College of Physicians (RACP) provided the following evidence in relation to the peer review process:

> The purpose of the period of peer review is two-fold. Firstly, it allows the overseas trained doctors the opportunity to be orientated to the Australian health care system and his/her workplace. It also allows practising specialists to interact with the overseas trained doctors in a clinical context to determine if he/she is performing at an appropriate level and to identify any areas of practice that might require improvement prior to fulfilling the requirements for specialist recognition.[73]

4.100 IMGs assessed as substantially comparable may be required to undertake a period of peer review of up to 12 months, or up to two years for IMGs

71 Dr David Wood and Dr David Levitt, *Submission No 78*, p 1.

72 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 26.

73 Royal Australian College of Physicians (RACP), *Submission No 65*, p 22.

assessed as partially comparable. However the periods vary for individual IMGs as this is determined on a case-by-case basis. In the document *Assessment of Overseas Trained Specialists Guidance for Colleges*, prepared by the JSCOTS, the peer review process for an IMG assessed as substantially comparable is discussed as follows:

> The applicant is eligible for registration as a recognised specialist and may apply for fellowship without further examination, but may be required to undertake a period of up to 12 months oversight or practice under peer review by a reviewer appointed through the college assessment unit. 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 continuing professional development. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis.[74]

4.101 For IMGs assessed as partially comparable the same document provides the following guidance on the period of peer review:

4.102 In order for a partially comparable applicant to be considered substantially comparable the applicant will be required to undertake a period of up to 24 months of training and assessment' under a supervisor appointed through the college assessment unit, to ensure that the level of performance reaches 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 continuing professional development.[75]

4.103 The Western NSW Local Health Network submitted to the Committee that the 'probationary' period imposed on some IMGs seeking specialisation accreditation should be tailored to each individual to ensure the period is focussed on that individual's knowledge, experience and skills, stating:

> Although there is a careful assessment of the qualifications and experience of overseas trained specialists, there appears to be a blanket approach to the question of probation. In many cases, two years is clearly unnecessary and has led to situations in rural areas

74 AMC, *Submission No 42*, Appendix K: Joint AMC/CPMC Standing Committee on Overseas Trained Specialists - Assessment of Overseas Trained Specialists Guidance for Colleges, p 65.

75 AMC, *Submission No 42*, Appendix K: Joint AMC/CPMC Standing Committee on Overseas Trained Specialists - Assessment of Overseas Trained Specialists Guidance for Colleges, p 68.

> where 'probationary' specialists have been leaders in teaching and advising their colleagues.[76]

4.104 The NSW Department of Health also noted that it is unclear what implications a period of peer review would have on an IMG's registration status:

> Currently there is confusion for both employers and registrants on whether an overseas trained specialist, who is assessed as being substantially comparable but requiring 12 months peer review/ supervision, is eligible for specialist registration or only limited registration.[77]

Committee comment

4.105 The Committee understands that college assessment interviews and peer review are vital elements of the assessment of an IMG's qualifications, skills and experience gained overseas for those seeking specialist recognition. However, the evidence provided during the course of the inquiry suggests that there are a number of elements which could be clarified and improved.

4.106 The Committee has observed that among IMGs there is confusion about the classification of comparability levels and how they are determined in the context of past skills and experience. To avoid this confusion the Committee encourages the specialist medical colleges to keep IMGs well informed on the definitions for each level of comparability. Specifically, guidelines outlining how particular qualifications might ordinarily be considered by a college determining comparability would be a helpful indicator for IMGs to digest prior to making their application for assessment. For ease of access the Committee recommends that the AMC and specialist medical colleges ensure that the clarified definitions and guidelines are made available on their websites.

4.107 The Committee notes the role of the Joint Standing Committee on Overseas Trained Specialists (JSCOTS), as outlined by the Australian Medical Council[78], in clarifying the definitions of each level of comparability. The Committee supports the continued role of JSCOTS,

76 Western NSW Local Health Network, *Submission No 49*, p 7.

77 NSW Department of Health, *Submission No 124*, p 4.

78 For further information on Joint Standing Committee on Overseas Trained Specialists (JSCOTS), see AMC, *Submission No 42*, pp 24-25.

seeing this as is an important step in ensuring consistency and transparency between colleges.[79]

4.108 Another prevalent issue relates to the period of time an IMG is required to spend in supervised practice under peer review following an assessment as 'substantially' or 'partially' comparable. The Committee acknowledges that peer review by individual colleges is an integral component of the pathway towards specialisation. While noting that the period is determined on a case-by-case, it is apparent to the Committee that IMGs are frustrated by the lack of objective guidelines explaining how an individual's qualifications, skills and past experience are used to determine the duration of peer review. The current system of informing IMGs that the period of peer review is 'up to' one or two years is unhelpful and could be further detailed for clarity. The Committee is of the view that the colleges should seek to rectify this situation.

Recommendation 7

4.109 **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:**

- **publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration;**
- **develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability;**
- **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**
- **develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs' professional qualifications and rates of success.**

79 AMC, *Submission No 42*, p 26.

Specialist medical college examinations

4.110 In addition to interview and peer review, some specialist colleges may require an IMG to undertake the relevant college examinations for their chosen specialisation.[80] Evidence to the Committee has highlighted a range of issues regarding the requirement for IMGs to sit college examinations which require further investigation.

Competence level of college examinations

4.111 Evidence to the Committee suggests that college examinations generally assess IMGs at the level of competence expected of an Australian-trained medical graduate entering the relevant specialist medical college training program. Specifically, IMGs who have acquired significant specialist experience in their home countries have been frustrated by the target level of the college examinations.

4.112 Some IMGs have informed the Committee that they have been required to re-learn skills and basic specialist knowledge which they have not utilised in practise since their early training as a specialist overseas. These IMGs have argued that such examinations are inappropriate for overseas trained specialists with years of experience, and do not accurately reflect their level of competence as a specialist in their chosen field.[81]

4.113 In a joint submission to the inquiry, Associate Professors Michael Steyn and Kersi Taraporewalla, told the Committee:

> The level of expertise examined is that of a trainee completing the training program rather than at someone with experience beyond this point.[82]

4.114 Associate Professor Steyn expanded on this point during a public hearing, observing:

> My insight to answering a question for an exam was that of a registrar—a trainee. When I answered it is like a trainee, I passed; when I answered it like a specialist, I failed.[83]

---

80 See for example: RANZCR, *Submission No 43*, p 6; Royal Australian College of Surgeons (RACS), *Submission No 74*, p 3.

81 Dr Christoph Ahrens, *Submission No 66*, p 2; Dr Michael Galak, *Submission No 31.1*, p 2.

82 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 10.

83 Associate Professor Michael Steyn, *Official Committee Hansard*, Brisbane, 10 March 2011, p 42.

4.115 Dr Christoph Ahrens told the Committee that a specialist's knowledge of a chosen field evolves and deepens over time. He noted that during this period, general knowledge which is not directly applicable to the specialist's practice may not be retained. He added:

> I am supposed to sit the orthopaedic registrar's examination. This may seem fair at first sight, as all Australian Orthopaedic Surgeons have to sit this exam at the end of their training. It is however an inappropriate assessment tool to assess a senior surgeon. The exam is designed for the purpose to test the knowledge of trainees before they are allowed to work independently. It is unable to test surgical skills or ability of clinical judgement including the very vital judgement of surgeons owns limits.[84]

4.116 A South African trained ophthalmologist with over 20 years specialist experience overseas, seeking Specialist Registration in Australia after several years working in an Area of Need (AoN) position, observed:

> The college assessment is inappropriate for the age of the specialist: - no other Australian ophthalmologist at my age (50 years old) is required to write the exam, nor are they likely to pass if they did without studying.[85]

4.117 The South Australian Government Department of Health also noted:

> In some cases, highly qualified specialists from overseas have failed to gain specialist qualifications because of college requirements that they sit a fellowship exam, despite the fact that they work within a specific sub-speciality and will not realistically practice within the full scope of the fellowship.[86]

Committee comment

4.118 The Committee understands why many specialist IMGs feel frustrated when they find they are required to complete a graduate-level assessment, particularly when they are practising a sub-specialty within their chosen field, sometimes for many years. The Committee is of the view that specialist medical colleges should consider taking a more targeted approach to the assessment of IMGs who have been deemed substantially

84 Dr Christoph Ahrens, *Submission No 66*, pp 2-3.

85 Name withheld, *Submission No 39*, p 4.

86 South Australian Government Department of Health, *Submission No 96*, p 5. See also: Overseas Trained Specialists Anaesthetists Network (OTSAN), *Submission No 38*, p 2; Dr Frank Quigley, *Submission No 14*, p 1.

or partially comparable to an Australian-trained specialist with an increased focus on WBA and reduced reliance on college examinations.

4.119 A more targeted approach should include the ability for IMGs with substantial experience in particular sub-specialities to be assessed on the basis of the skills and experience required for that sub-speciality rather than on facets of the speciality which the IMG is unlikely to utilise during the practise in their chosen sub-speciality. Consideration should be given to an IMG's qualifications, level of experience and skills accumulated during their overseas practise. In particular, it would appear that this type of assessment would be appropriate for IMGs who have attained significant specialist experience in niche sub-specialities.

Recommendation 8

4.120 **The Committee recommends that specialist medical colleges adopt the practise 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.**

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.

4.121 The Committee also understands that the Australian Health Workforce Advisory Council (AHWAC) has been commissioned by the Australian Health Workforce Ministerial Council (AHMC) to inquire into and report on the assessment requirements for Fellowship of each of the medical specialist colleges in relation to the recognition of qualifications and management of assessment processes for overseas trained doctors.[87] The Committee anticipates that this review will include further recommendations for improving specialist college assessment processes for overseas trained specialists seeking Specialist Registration in Australia.

87 IMG Inquiry Recommendation Working Group, *Submission No 168*, p 6.

Reconsideration, review and appeal of college decisions

4.122 An IMG seeking recourse following a specialist medical college's decision regarding their application is required to follow the review mechanisms stipulated by that college. From evidence provided to the Committee, it appears that a number of colleges employ a three stage process for appeals.[88] In the first instance, an IMG may seek review from the original decision makers, usually an internal committee or board of the college.[89] Where a decision is upheld, an IMG may then seek review from a higher-level committee of the college.[90] Where such a review is upheld, many specialist medical colleges have the ability to convene a formal Appeals Committee.[91]

4.123 Generally, an Appeals Committee may only be convened through a decision by the college's Chief Executive Officer, if an IMG has exhausted all other avenues of review.[92] An Appeals Committee is usually convened with a majority of non-college members.[93] With the agreement of the Appeals Committee, an IMG may be entitled to have legal representation present during the appeal.[94]

4.124 The Committee's inquiry has taken evidence which highlights a negative perception of the clinical dispute resolution mechanisms available to IMGs seeking specialist accreditation. Dr Chaitanya Kotapati, submitting in a private capacity, told the Committee that there is an urgent need to regulate the appeal processes of the AMC, MBA and specialist medical colleges to improve accountability and transparency.[95]

4.125 Dr Anatole Kotlovsky told the Committee that based on unverified information, adverse findings were made by a specialist medical college in relation to his application and he was not aware of any right of appeal:

> No opportunity to present my perspective regarding the subsequent adverse decisions against my professional recognition

88 See for example: Royal Australasian College of Physicians (RACP), *Submission No 65*, p 23; Royal Australian College of General Practitioners, <http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Assessment/Assessmentpolicies/AppealsPolicy.pdf> viewed 3 February 2012.

89 RACS, Policy, <http://www.surgeons.org/media/55600/pol_2011-06-02_appeals_mechanism_v3.pdf> viewed 3 February 2012.

90 RACP, *Submission No 65*, p 23.

91 Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 11.

92 ANZCA, *Submission No 87*, p 11.

93 RANZCOG, *Submission No 45*, p 7.

94 RACP, *Submission No 65.1*, p 1.

95 Dr Chaitanya Kotapati, *Submission No 21.1*, p 4.

> or advice of my right to appeal these decisions was ever provided to me.[96]

4.126 Another IMG, who wished to remain anonymous, stated:

> I submitted an appeal to RANZCO which was supposed to be heard within 3 months and surprisingly was allowed to be re-employed and re- registered until the date of the expiry of the appeal. Shortly afterwards RANZCO requested that the appeal should be held in abeyance whilst RANZCO re- assess my clinical, surgical and academic abilities over a further year. I had no choice but to accept this additional assessment, as my registration which had been coupled to the appeal period was about to expire. If registration expired I would have 28 days to leave the country.[97]

4.127 Some contributors to the inquiry expressed concerns with the independence of the appeals process, with the Committee receiving evidence calling for a process entirely independent of college structures to conduct final determinations.[98] For example, Dr Viney Joshi told the Committee:

> I feel it is time that the government stepped in and created some sort of an ombudsman which sat above the colleges and the regulatory bodies—that is, AHPRA, the medical board and all these organisations—where at least people could go and get a fair deal.[99]

4.128 Dr Christopher Hughes from RANZCOG expressed some reservations about such a process:

> ... if it was for an external independent body to be making those decisions, I am not sure that the intimate professional expertise and knowledge to reverse or come up with an alternative decision is necessarily there, if it is going to involve people outside the specialty area. I guess you can take them from the specialty area but outside the college process.[100]

4.129 Dr Jennie Kendrick, Fellow and Censor-in-Chief of Royal Australian College of General Practitioners (RACGP) told the Committee that

---

96 Dr Anatole Kotlovsky, *Submission No 47*, p 3.

97 Name withheld, *Submission No 39*, p 3.

98 IMG Inquiry Working Group, *Submission No 168*, p 6.

99 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, p 13.

100 Dr Christopher Hughes, RANZCOG, *Official Committee Hansard*, Melbourne, 18 March 2011, p 58.

determining whether an IMG has reached the appropriate clinical standard should be assessed by appropriate clinical experts.[101]

Committee comment

4.130 It is apparent that the nature of many specialist medical college assessment grievances could be deemed as subjective, as often it is one clinician assessing another in a supervisory capacity. An example of this might be an IMG not receiving a favourable report during the peer review period. Despite a large number of submissions being received with respect to appeals, the Committee has received evidence that the number of reviews subject to a formalised appeals process by an Appeals Committee is relatively small.[102]

4.131 The Committee understands that specialist medical college Appeals Committees fulfil the function of providing a final process for the determination of decisions made by colleges. However, that there are aspects of college Appeals Committees which could be improved in the interests of transparency. The first of these is the discretion of the Chief Executive Officer of a relevant college to determine whether an Appeals Committee should be convened. The Committee is of the view that following the completion of the second-stage of appeal regarding a decision of a college, IMGs should have automatic grounds to appeal to the college's Appeals Committee. The Committee is also of the view that IMGs should have the option to retain an advocate to represent them in an appeal to the relevant specialist medical college's Appeals Committee.

4.132 The final aspect the Committee has considered in relation to the specialist medical colleges Appeals Committee is its membership. The Committee understands that Appeal's Committee's constitute a majority of independent members. However, the Committee is concerned about the perception of many IMGs who have made submissions to this Committee regarding their belief that the appeals processes of the specialist medical colleges are not independent, impartial or transparent.

4.133 The Committee is of the view that the colleges should provide clear and detailed information on the Appeals Committee and its membership on its website, including profile information on each member of the Committee to inform IMGs of each member's impartiality. The Committee also

101 Dr Jennie Kendrick, RACGP, *Official Committee Hansard*, Melbourne, 18 March 2011, p 59.

102 See for example: Mr Ivan Thompson, RACS, *Official Committee Hansard*, Melbourne, 18 March 2011, p 59; Dr Jennifer Alexander, RACP, *Official Committee Hansard*, Canberra, 25 February 2011, p 54; Dr Richard Willis, Australian and New Zealand College of Anaesthetists, *Official Committee Hansard*, Melbourne, 18 March 2011, p 57.

recommends that the Appeals Committee of each college should also comprise of an additional member who is an IMG and member of the college's international medical graduate committee.

Recommendation 9

4.134 **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:**

- **an automatic right for an international medical graduate (IMG) to undertake the next stage of appeal, following completion of each preceding appeal;**
- **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**
- **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.**

4.135 The Committee is also concerned about submissions to the inquiry from IMGs who advised that were not informed regarding the relevant college's appeals process and therefore did not avail themselves of the process. To rectify this issue, the Committee suggests that the colleges provide a two-pronged approach to ensure IMGs are informed about their right to appeal a decision made by the college, during their assessment process:

- by providing clear and detailed information on the relevant college website regarding the appeals process, including timeframes for lodging an appeal, the stages of appeal and how the appeals operate; and
- by providing relevant information on the next stage of appeal, including deadlines for submitting an appeal, in writing to all IMGs, in the same document advising the IMG of the decision the college has made in respect of their application for specialisation.

Recommendation 10

4.136 **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 application for specialisation:**

- **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**
- **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.**

4.137 During the inquiry, the Committee also canvassed the concept of developing an overarching independent appeals mechanism with respect to decisions of clinical competence made by specialist medical colleges. Although independent appeals processes are available for administrative decisions made by the MBA/AHPRA (through the National Health Practitioner Ombudsman as outlined in Chapter 6), where matters of clinical judgement arise no independent mechanism exists beyond the Appeals Committee process discussed above. The Committee believes that such a mechanism, discharging its functions independently, is paramount to providing reassurance in relation to the integrity of clinical competence assessments.

4.138 While evidence to the Committee was in general terms supportive of an overarching independent appeals mechanism to review decisions relating to clinical competence, there was a paucity of detail on the composition and functioning of an independent review mechanism. However, the Committee proposes that an overarching independent appeals mechanism for the review of clinical competence decision should comprise an appropriately selected panel. Composition of the panel will need to allow for the necessary perception of independence, in particular independence from the specialist college subject to review. Importantly, composition of the panel also needs to preserve the integrity clinical decision making through the involvement of medical practitioners with the requisite

knowledge and expertise to review college decisions relating to clinical competence. While not wishing to impose a structure, the Committee proposes that necessary balance between independence and clinical expertise could be achieved by a panel comprising:

- an independent Chair familiar with either administrative or clinical matters (eg National Health Practitioner Ombudsman or Commonwealth Medical Officer or their independent nominee);
- medical practitioners familiar with the particular speciality, with an equal representation of nominees made by the IMG and by specialist medical college subject to review; and
- medical practitioners from specialist medical colleges other than that subject to the review, with familiarity in clinical assessment. It might be that these panellists could be drawn from a pool of nominations made by specialist medical colleges, selected at the discretion of the independent Chair.

Recommendation 11

4.139 **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.**

4.140 In making its recommendations to improve the transparency and independence of appeals processes relating to assessments of clinical competence, the Committee recognises the need for colleges to ensure that specialist IMGs are appropriately qualified, skilled and experienced. Ensuring that the community continues to receive health care that is safe and high quality remains paramount.

Perceptions of assessment and accreditation authorities

4.141 Evidence has been provided to the Committee suggesting that specialist medical colleges are often not held accountable for their decisions, with a

perception that some specialist colleges are 'boys clubs' with a 'closed shop' mentality which discriminate against IMGs. Dr Joshi told the Committee of his concern regarding the specialist medical colleges, saying:

> I am going to make a very controversial statement here, but colleges are degenerating into old boys' clubs sadly enough. Instead of becoming centres of quality education they are becoming bastions of power and absolutely like an exclusive club, whether you are part of that club or not. Even when you become a part of the club through getting your fellowship whether you can pervade into the inner sanctum sanctorum depends on how good your manipulative skills are. If you are not slick enough then you get left out.[103]

4.142 Dr Michael Galak submitted to the Committee:

> The registering bodies or a body now, are not answerable to anyone with the political clout to change their decisions. The hypothetical possibility of going to the Administrative Appeals Tribunal or Human Rights Commission is useless because these organisations, having tackled Medical Boards before, learned the awesome power of the legal protection these registering bodies enjoy. Who would wish to squander the limited resources on a hopeless quest? In the end OTDs are left unprotected.[104]

4.143 Dr Jonathan Levy of the Australian Doctors Trained Overseas Association (ADTOA) told the Committee that many IMGs were scared to contribute to the Committee's inquiry as a result of their perceptions:

> ... they are all scared of the taskmaster on the ground and will not raise their heads above the parapet ... If everybody who wanted to put a submission in had put a submission in, you would have had two, three, four or five times the number that you received.[105]

4.144 The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) submitted to the Committee that it should be made clear that registration decisions are the responsibility of the Medical Board of Australia on advice from the AMC, and not by the College itself. RANZCO noted that there was a tendency to demonise the College and

---

103 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, p 15. See also: Dr Michael Galak, *Submission No 31*, p 1.

104 Dr Michael Galak, *Submission No 31*, p 2.

105 Dr Jonathan Levy, *Official Committee Hansard*, Canberra, 25 February 2011, p 44.

accuse them of restricting entry of doctors to their speciality.[106] RANZCO also stated in this regard that:

> The College takes pride in the fairness and transparency of its decisions made in good faith, and feels that the MBA and the AMC should be public in defending such processes undertaken at their request.[107]

4.145 Chair of the MBA, Dr Joanna Flynn responding to a question about whether the accreditation processes were susceptible to being manipulated to deliberately restrict IMG entry, observed:

> The way that it is dealt with structurally is to make sure that the standards that the colleges are using to assess are published, that they are clear, that there are appropriate reports written of the basis on which decisions were made and that there are appropriate appeals processes. I also believe that most people working as a doctor, which I do, recognise that there is a significant workforce shortage across the whole medical workforce— that there is more than enough work for everyone. So whereas 20 years ago the issue was about, 'Don't stay on my patch; there's not enough work for both of us,' I really do not believe there is anyone who believes that now.[108]

Committee comment

4.146 The Committee has heard evidence, particularly from IMGs themselves, suggesting that the AMC and specialist medical colleges lack transparency and fairness when performing their roles of assessing and accrediting IMGs qualifications, prior skills and experience for the purposes of registration.

4.147 The Committee is particularly concerned that some IMGs assert that these entities have acted with a degree of bias and/or discrimination. The Committee trusts that the AMC and specialist medical colleges aim to carry out their functions in an impartial, fair and transparent way, as affirmed by their representatives who gave evidence before the Committee during the course of this inquiry.

---

106 Royal Australian and New Zealand College of Ophthalmologists (RANZCO), *Submission No 73*, p 3.

107 RANZCO, *Submission No 73*, p 3.

108 Dr Joanna Flynn, Medical Board of Australia, *Official Committee Hansard*, Canberra, 25 February 2011, p 22. See also: Dr Andrew Pesce, Australian Medical Association, *Official Committee Hansard*, Canberra, 25 February 2011, pp 33-34; and RANZCOG, *Submission No 45*, p 6.

4.148 With regard to the specialist medical colleges, the Committee has already referred to the outcomes of the 2004-5 Review of Australian specialist medical colleges conducted by the Australian Competition and Consumer Commission (ACCC) in conjunction with the Australian Health Workforce Officials Committee (AHWOC). The review focused on four principles - transparency, accountability, stakeholder participation and procedural fairness – making 20 recommendations to improve college assessment and accreditation process. The Committee understands that since 2005 the colleges have made considerable progress in implementing many of the recommendations.[109]

4.149 Nevertheless, noting continuing concerns raised and perceptions held by IMGs and associated health stakeholders throughout Australia, the Committee encourages the AMC and specialist medical colleges to continue to take further steps towards achieving a high level of transparency and accountability in its dealings with IMG candidates seeking accreditation and/or registration as specialists in Australia.

4.150 As recommended by the Committee earlier in this Chapter, transparency should include the dissemination of clear and concise information regarding assessment processes, including explanatory information on how assessment processes are undertaken and the criteria used to determine levels of comparability.

4.151 IMGs should also be afforded access to appropriate independent and efficient appeals processes when they object to a decision made regarding the assessment their clinical competence. The Committee notes that there is further discussion on MBA/AHPRA appeals processes in Chapter 6 which deals with IMG registration processes.

109 Mr Scott Gregson, Australian Competition and Consumer Commission, *Official Committee Hansard*, Canberra, 20 September 2011, p 2.