6

Improving administrative efficiency

6.1 One of the key messages received by the Committee throughout the inquiry was that much inefficiency and duplication exists within the system of accreditation and registration. Given this complexity, it is not surprising that some of the issues which have caused the most frustration for IMGs and others are those which require coordination between agencies. This frustration is compounded by the apparent duplication or confusing requirements of the various bodies involved.

6.2 While the Committee recognises that some of these inefficiencies are as a result of the transition to the new National Registration and Accreditation Scheme (NRAS), it seems that others may be legacy issues arising from previous systems which were operating under state and territory medical boards.

6.3 This Chapter considers the main administrative issues which impact on the amount of time it takes for an IMG to become registered. The Chapter considers firstly the time taken for IMGs to navigate the system and the impact on recruitment timeframes and maintaining Limited Registration.

6.4 The Chapter then proceeds to examine evidence relating to inefficiencies and inconsistencies in the administration of the NRAS, and concerns relating to the costs associated with obtaining full medical registration. The Chapter concludes with an examination of the mechanisms available to address systemic and professional conduct grievances.

Recruitment timeframes

6.5 Before examining some of the administrative inefficiencies which exist, it is useful to outline evidence regarding the delay between an IMG being

offered employment and actually taking up that appointment. Evidence indicates that the complexity and inefficiencies of the accreditation and registration system, and related processes, can lead to a delay of up to two years before an IMG qualifies for Limited Registration and can commence employment.[1]

6.6 This prolonged delay not only impacts on the IMG and their prospective employer but also on the IMG's family which faces uncertainty about relocation to Australia. Further, the delay can have flow on effects for the communities that rely on IMGs to fulfil local requirements for medical practitioner services. The Association of Medical Recruiters of Australia and New Zealand told the Committee:

> Under 2011 rules and regulations, it is difficult to predict when any doctor will be registered. When asked to predict a timeframe, we generally quote a figure for a Registrar of anything up to 9 months depending on the pathway and 12 months for a Specialist. A GP (again depending on qualifications and pathway) can take anything from 8 to 12 months.[2]

6.7 The Government of Western Australia Department of Health, Western Australia reported experience of even longer timeframes, reporting:

> Experience demonstrates it may take 5-24 months for an IMG to commence working in WA. This is exacerbated by the many professional and legal requirements required to obtain medical registration, with delays and inefficiencies at each step of the process. When an IMG is appointed to a position, the service is forced to employ locum practitioners to fill the gap whilst the IMG progresses through the process.[3]

6.8 Similarly, the New South Wales Rural Doctors Network noted:

> It is not uncommon for it to take 18 months to 2 years to recruit an OTD. Even then they will likely have limited registration and be required to work in an AoN, and will most definitely require District of Workforce Shortage (DWS) practice location and will require further education and/or undergo a period of supervised practice. This is an extensive time period and often gives rise to no

1 Government of Western Australia (WA) Department of Health, *Submission No 82*, p 3; NSW Rural Doctors Network, *Submission No 37*, p 10.

2 Association of Medical Recruiters of Australia and New Zealand (AMRANZ), *Submission No 139*, p 3.

3 Government of WA Department of Health, *Submission No 82*, p 3.

> medical services being provided to communities or interruption to services for periods of time.[4]

6.9 For IMGs intending to follow a Specialist Registration pathway, the need for specialist college assessment can also add to the time it takes to achieve accreditation. As noted by Queensland Health:

> The involvement of specialist colleges in the assessment of OTS may increase the recruitment and registration time of an OTD by three to six months. This highlights the need for review and enhancement of the policies, practices and processes of OTS assessment and registration within the specialist pathway.[5]

6.10 Expressing the level of frustration with accreditation and registration timeframes, an individual involved in recruiting IMGs for the Mater Hospital in Rockhampton informed the Committee:

> The process is so slow that I always apologise in advance. The delays are frustrating for specialists who have the qualifications and the skill to work anywhere internationally and equally frustrating for private hospitals with substantial workforce problems. We have experienced many highly qualified specialists withdrawing their application. Some of the withdrawals relate to delays and other withdrawals relate to assessment.[6]

Committee comment

6.11 The Committee is concerned by reports of extended periods of time taken to recruit IMGs. Clearly these lengthy timeframes are frustrating for IMGs and their families, prospective employers and communities in need. Worryingly, the Committee understands that the apparent complexity of Australia's accreditation and registration systems and associated prolonged timeframes have acted as a deterrent for some IMGs, with some IMGs withdrawing their applications prior to achieving registration.

6.12 While it is understandable that assessment and screening processes need to be robust to ensure that IMGs are appropriately qualified and skilled to practise medicine in Australia, it has become apparent to the Committee during the course of this inquiry that there are a range of administrative inefficiencies which hinder this process unnecessarily. Many of these inefficiencies seem to arise as a consequence of poor communication and coordination between the key organisations involved in assessment,

4 NSW Rural Doctors Network, *Submission No 37*, p 10.

5 Queensland Health, *Submission No 126*, p 4.

6 Mater Hospital Rockhampton, *Submission No 92*, p 1.

accreditation and registration. These issues are considered in more detail later in this Chapter.

6.13 While the ultimate aim is to streamline the system to achieve maximum efficiency, the Committee considers that more transparency regarding timeframes is needed. To provide IMGs and prospective employers with some indication as to how long the various processes can take (understanding that a high degree of variability exists), the Committee believes that there is a need to establish benchmarks for timeframes with regular reporting on performance against these benchmarks. Succinct and clear data should be published on at least a quarterly basis. This not only assists IMGs and prospective employers to understand the average length of time certain processes will take, but will also provide key organisations involved with accreditation and registration with an understanding of how their processes impact on the overall timeframes.

6.14 In the Committee's view, IMGs and others should be aware of the expected average timeframe for undertaking each step of a particular accreditation and registration pathway. For example, information should be available on the time it may take for Primary Source Verification, or the expected waiting time to undergo the Australian Medical Council (AMC) Structured Clinical Examination (SCE) or the Pre-Employment Structure Clinical Interview (PESCI). Overall completion times should also feature in data publication and this information should be regularly updated.

Recommendation 28

6.15 **The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes. Information published on websites should be updated on a quarterly basis.**

6.16 The Committee is aware that under the National Law, AHPRA must submit an annual report to the Australian Health Workforce Ministerial Council (AHWMC). The report must include financial statements regarding the activities of AHPRA and each National Board (including the MBA). A report on the functions of AHPRA's activities under the National

Law must also be made. AHWMC is then responsible for ensuring that the annual report is tabled in the Parliament of each participating jurisdiction including the Commonwealth Parliament.

6.17 In the interests of increased transparency, the Committee views that AHPRA's annual report with respect to the functions carried out by the MBA must also include a number of other key performance indicators relating to IMGs. In the Committee's view, these indicators must include (but should not be limited to):

- the country of initial qualification for each IMG applying for Limited Registration;
- the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and specialist medical colleges; and
- the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:
  - ⇒ AMC Multiple Choice Question Examination;
  - ⇒ AMC Structured Clinical Examination;
  - ⇒ AHPRA's Pre-Employment Structured Clinical Interview (PESCI);
  - ⇒ the MBA's English Language Skills Registration Standard;
  - ⇒ other MBA Registration Standards including Criminal History Registration Standard; and
  - ⇒ processes of specialist medical colleges including college interviews, examinations and peer review assessments.

Recommendation 29

6.18 **The Committee recommends that AHPRA's annual report, with respect to the functions carried out by the MBA must also include a number of other key performance indicators providing further information to IMGs. In the Committee's view, these indicators must include (but should not be limited to):**

- **the country of initial qualification for each IMG applying for Limited Registration;**
- **the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and**

specialist medical colleges; and

- **the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:**
  - ⇒ **Australian Medical Council Multiple Choice Question Examination;**
  - ⇒ **Australian Medical Council Structured Clinical Examination;**
  - ⇒ **AHPRA's Pre-Employment Structured Clinical Interview (PESCI);**
  - ⇒ **the MBA's English Language Skills Registration Standard;**
  - ⇒ **other MBA Registration Standards including Criminal History Registration Standard; and**
  - ⇒ **processes of specialist medical colleges including college interviews, examinations and peer review assessments.**

Maintaining Limited Registration

6.19 As outlined above, the timeframe needed to obtain registration can be considerable. In view of this, it is not surprising that some IMGs submitted evidence to the Committee expressing concern that under the National Law, Limited Registration may only be renewed a maximum of three times. On each occasion that renewal is sought, IMGs must demonstrate that they have made progress towards either General or Specialist Registration. The MBA provides guidance on how IMGs can comply with the latter requirement.[7]

6.20 As detailed under the National Law, once the limit of three renewals has been reached, IMGs who have not yet obtained full registration need to reapply for new Limited Registration:

> If an individual had been granted limited registration in a health profession for a purpose under this Division, had subsequently renewed the registration in the profession for that purpose 3 times and at the end of the period wished to continue holding limited registration in the profession for that purpose, the individual

7 Medical Board of Australia (MBA), FAQ and Fact Sheets, *Limited Registration - Information on how IMGs can demonstrate satisfactory progress towards gaining general or specialist registration*, <http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f4987&dbid=AP&chksum=lXhzMQ8%2baH95CmOzL4aYjQ%3d%3d> viewed 1 February 2012.

> would need to make a new application for limited registration in the profession for that purpose.[8]

6.21 As result of this, IMGs effectively have four years to progress from Limited Registration to General or Specialist Registration. A number of IMGs have expressed concerns that this four-year period is not long enough to complete the requirements to obtain full registration, particularly in the case of IMGs seeking specialist recognition. For example, Dr Chaitanya Kotapati told the Committee that:

> Some of the key issues I think are the difficulty with the four-year time restriction for doctors already in specialist training in Australia, as mandated by the Medical Board of Australia for attaining general registration. It makes it impossible to meet the competing demands of AMC on the one hand and the Medical Board of Australia on the other hand. It literally becomes impossible to meet all of these requirements. This places us in a very vulnerable position.[9]

6.22 Similarly, Dr Sunayana Das told the Committee that:

> There is an urgent need to recognise that this period of four years maximum for registration is arbitrary. It is unjustifiably too short a time for anyone to achieve specialist registration from the time of their first receiving registration.[10]

Committee comment

6.23 The Committee understands that obtaining full registration to practice medicine in Australia is a rigorous process, often requiring IMGs to pass professional examinations and undergo periods of supervised practise. Fulfilling all of these requirements often takes a number of years, and involves periods of intensive assessment which may pose difficulties for IMGs attempting to balance heavy workloads and study.

6.24 Nevertheless, the Committee does not believe that amending the current model of three annual renewals for Limited Registration under the National Law is warranted. The Committee understands that under some earlier state and territory registration systems there was no limitation on the number of times IMGs could apply for renewal of Limited Registration. During the inquiry the Committee received evidence from IMGs who had apparently been practising medicine in Australia under

8 *Health Practitioner National Law Act 2009* (Qld) s 72 (note).

9 Dr Chaitanya Kotapati, *Official Committee Hansard*, Brisbane, 10 March 2011, p 20.

10 Dr Sunayana Das, *Official Committee Hansard*, Brisbane, 10 March 2011, pp 21-22.

Limited Registration for many years, even decades without progressing to full registration. While recognising that the limit on the number of times that Limited Registration can be renewed under the National Law may be viewed by some as inappropriate and overly restrictive, the Committee considers this will encourage IMGs to work toward achieving full registration. The Committee supports this objective, particularly as the majority of IMGs should be able to progress to either General or Specialist Registration within this period.

6.25 Furthermore, the Committee understands that IMGs that have renewed their Limited Registration three times are not precluded from making a new application. If Limited Registration is granted under these circumstances, the four year period begins afresh. The MBA should further ensure that where Limited Registration is due to expire, particularly where a fresh application is required, that a renewal or expiration notices are sent to IMGs in a timely manner complete with full details of the next steps to be taken.

6.26 The Committee is aware that any new application for Limited Registration will require IMGs to demonstrate again that they meet all of the accreditation and registration standards. IMGs affected will need to provide proof of identity documents, undergo primary source verification through the AMC, demonstrate that they comply with the English Language Standard, and provide updated documentation relating to their work practice and registration history. The Committee is of the view that some of the concerns expressed by IMGs would be alleviated with the implementation of some basic administrative enhancements to document handling and archiving. These enhancements, in particular the development of a central document repository, are considered in more detail later in the Chapter.

Administration of the National Registration and Accreditation Scheme

6.27 As outlined in Chapter 1 of this report, in 2009-10 legislation was introduced in each state and territory of Australia to support the establishment of the NRAS. The Medical Board of Australia (MBA) was established under the *Health Practitioner National Law Act 2009* (Qld) the 'National Law' to develop the NRAS, with its administrative functions supported by the Australian Health Practitioner Regulation Agency

(AHPRA). The NRAS, under the auspices of the MBA as administered by AHPRA, commenced operating in July 2010.

6.28 In replacing previous state and territory based systems, the aim of the NRAS was to provide health professionals, including medical practitioners, with a simpler and more streamlined process of obtaining accreditation and registration. However, it is clear that the transition to the NRAS had not been without challenges and has presented further overall complexities. For example, Western District Health Service advised that:

> The registration and qualification process for overseas trained doctors (OTD's) is burdened with overzealous administrative and accountability processes which are uncoordinated thereby increasing the complexity and risk of extraordinary delays.
>
> Typically an OTD is required to go through the processes of the Australian Medical Council, the relevant Specialist College, AHPRA, Immigration and Department of Health and Ageing, and Medicare for a provider number.
>
> Each of these authorities has its own administration and accountability systems that are uncoordinated, unwieldy and often duplicated or replicate the process system of each other. Each requires its own individual application based upon its own criteria.
>
> The reality of the situation is that whilst applications from OTD's are caught up in the myriad of processes regional and rural communities are suffering.[11]

6.29 In addition, evidence to the inquiry also indicates that a range of issues have emerged relating to the operation of the NRAS itself. Transitional issues and issues with the new NRAS itself have both contributed to inefficiencies and delays with accreditation and registration. The main issues identified are:

- difficulties experienced by IMGs transitioning from state and territory systems of accreditation and registration to the new NRAS;
- poor communication with applicants seeking information on the progress of their applications or advice on NRAS processes, including:
  - ⇒ long waiting times for responses to inquiries; and
  - ⇒ concerns with the consistency and quality of advice provided;

11 Western District Health Service, *Submission No 184*, p 2.

- frustration with documentation requirements based on poor communication and coordination between key agencies resulting in unnecessary duplication of effort, and exacerbated by inappropriate validity periods for some documents; and
- concerns with the fees and costs associated assessment, accreditation and registration.

Transition to the National Registration and Accreditation Scheme

6.30 Although this issue arose prior to the advent of AHPRA, evidence to the Committee suggests that communication from the MBA on the transition from state and territory medical boards was deficient. This was particularly apparent with respect to communication with IMGs who held registration with former state and territory medical boards in relation to the implication of their transition to the NRAS and their registration status under the National Law.[12]

6.31 For example, in his submission to the inquiry Dr Chaitanya Kotapati also commented on the issue of transition, noting:

> The transition process from regional medical boards to Medical Board of Australia has not been a smooth process for many candidates. ... The level of communication process between the colleges and the Medical Board of Australia is very poor and the candidates are being pressurised by the newly established national regulatory authority for submitting support documents from college in time. The candidates or the employing authorities most of the times does not seem to have a clue about any such required documents due to the lack of communication from the Medical Board of Australia in the first place.[13]

6.32 Based on feedback from its members the Australian College of Rural and Remote Medicine (ACRRM) identified the following transitional issues:

- Poor communication and transparency by medical board of policies regarding new requirements (e.g. IELTS) and progression timeframes to gain Australian qualifications;
- Policies and processes did not provide adequate allowance for time required to meet new requirements at same time as meeting employment commitments;
- Increased costs for new requirements;

12 See for example: Dr Piotr Lemieszek, *Submission No 118*, pp 4-5; Dr Salahuddin Chowdhury, *Submission No 178*, p 1.

13 Dr Chaitanya Kotapati, *Submission No 21*, p 3.

- Lack of willingness by boards to communicate personally with OTDs impacted by these changes;
- No apparent ability to apply discretion in how to manage individual cases/applications;
- Failure to introduce supported transitional learning plans including increasing opportunities to study and re-skill particularly in the Area of Need/limited;
- registration status context;
- Limitations on OTD to be able to access requisite assessment (e.g. time delay incurred in gaining place on AMC Clinical exam); and
- Poor understanding by recruiters regarding expectations of boards.[14]

6.33 ACCRM also told the Committee:

> The change management process between the old and new registration arrangements was not smooth but does seem to be improving. ACRRM is aware that many organisations and individuals were significantly affected at both a professional and personal level by the lack of clear, consistent and correct information about requirements, lack of communication channels and lack of ability to escalate urgent matters for resolution. For OTDs the ineffectiveness of the system had the flow on implication of compounding other highly significant issues such as immigration decisions/arrangements, employment offers, confidence in decisions to relocate their families etc.[15]

Committee comment

6.34 The Committee acknowledges that the transition from state and territory Medical Boards to form a single national entity was a complex and difficult undertaking, and it is not surprising that the NRAS has experienced some teething problems. One of the more challenging issues has been managing registration of medical practitioners who had previously been registered under the disparate state and territory systems. It is also clear that some IMGs are concerned by the way in which transition to the NRAS was handled. In particular it seems that the implications of the transition were not fully explained to IMGs themselves. This lack of communication was unfortunate, and has undoubtedly contributed to the confusion and angst experienced by some IMGs.

14 Australian College of Rural and Remote Medicine (ACRRM), *Submission No 103*, p 9.

15 ACCRM, *Submission No 103*, p 9.

6.35 In addition, some IMGs who were well advanced in the process towards full registration under state and territory medical board processes, have suggested that they have been disadvantaged as a result of the commencement of the National Law. The Committee has already noted in Chapter 1, that in June 2011 the Senate Finance and Public Administration Committee reported on the administration of health practitioner registration by AHPRA. The Senate Committee's report dealt extensively with transitional issues, as well as reviewing AHPRA's administration more generally.[16] In particular the Committee notes the Senate report's first recommendation which directed AHPRA to compensate practitioners who had been de-registered as a consequence of administrative problems. The Committee supports this recommendation as a means to address any losses that IMGs may have incurred when it can be established that they were without registration due to maladministration by AHPRA.

6.36 On the whole however, there is little evidence to suggest that IMGs have been disadvantaged in this way. Rather, as outlined earlier, it is evident that some accreditation, assessment and registration requirements (such as English language proficiency assessment and the need to achieve full registration within essentially a four-year timeframe) are more stringent under the NRAS than under previous state and territory based systems. Although the Committee realises that the increased stringency has been a cause of discontent for some, it is an unavoidable consequence of amalgamating different systems and establishing a national system that ensures standards are sufficiently robust and IMGs have the necessary qualifications, skills and experience to practise in Australia.

6.37 Nevertheless, the Committee believes that where an IMG considers they have been significantly disadvantaged by the transition from the old system of registration to the NRAS, the MBA/AHPRA should ensure that the circumstances are investigated, and if necessary, rectified. The process and procedure for review should be clearly outlined on the MBA/AHPRA website. Any review should also be conducted in a timely and transparent manner.

16 Parliament of Australia, Senate Finance and Public Administration References Committee, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, June 2011.

Recommendation 30

6.38 **The Committee recommends that where an international medical graduate considers that the processes prescribed under the National Registration and Accreditation System have placed them at a significant disadvantage compared to their circumstances under the processes of former state and territory medical boards, that the Medical Board of Australia investigate the circumstances, and if necessary rectify any registration requirements to reduce disadvantage. The process and procedure for review should be clearly outlined. Any review should be conducted in a timely and transparent manner.**

Responding to inquiries

6.39 The Committee has received evidence in relation to responses to inquires made in relation to inquiry services operated by the MBA/AHPRA state and territory offices, as well as the AMC. The key concerns cited were that there were:

- delays in responding to e-mail inquiries;
- lengthy on hold wait times for telephone inquiries; and
- discrepancies in the quality and consistency of the advice given.

6.40 For example, the Australian Medical Association (AMA) noted:

> If the applicant wishes to discuss the process, it is possible to wait 1 hour on the telephone and then receive an incomplete answer. It seems that everything takes 10 days. If an applicant lodges a form and wants to discuss it, a wait of 10 days is required. If an agency wishes to make enquiries on behalf of an applicant an authority to act is lodged which takes 10 days to process.[17]

6.41 Alecto Australia noted in its submission that:

> The AMC call centre is often unavailable due to technical difficulties making it impossible for candidates to check on the progress of their application. There was recently a period of more than a week where it was impossible to call the AMC. The only method of communication was by email and then we had to wait for a call back. Similarly the AHPRA call centre is still unable to provide good information on any issue. It is quite common to get

17 Australian Medical Association (AMA), *Submission No 55*, p 7.

> different advice from different members of staff on the same day. It is also seldom the case that the telephonist can answer a query. Typically, the caller is put on hold while the telephonist asks a manager for information.[18]

6.42 It has been suggested that insufficient training for call centre staff and high staff turnover rates could contribute to the poor quality and inconsistent advice provided in response to queries. Melbourne Medical Deputising Service's submission stated:

> Since the commissioning of AHPRA in July last year we have found the processing of national registration extremely slow and while the staff on the help lines are always polite and do try to assist they field calls in a generic manner. On some occasions information provided has been found to be inconsistent and inaccurate.
>
> On more than one occasion, when necessary information was not available from the AHPRA website, MMDS personnel have experienced 'I can't give you that information because of privacy reasons' - central call centre staff did not seem to know that a doctor's registration status is public information.[19]

6.43 Challis Recruitment also observed:

> Communication with AHPRA is still very difficult via the 1300 #. There have been a number of technical issues with this telephone line and even when operational, it is very difficult reaching a member of the appropriate state medical team. Often the call is screened by the operator (who often cannot assist with the query or gives incorrect advice).
>
> There seems to be a frequent turnover of personnel at most of the regulatory bodies which means that advice given can be sometimes incorrect due to lack of staff training/knowledge.[20]

Committee comment

6.44 The Committee considers that that the transition to the NRAS should have improved the process for IMGs to obtain information pertaining to their individual circumstances. However, based on evidence provided to the

18 Alecto Australia, *Submission No 85*, p 5. See also: Western NSW Local Health Network, *Submission No 49*, p 4-5.

19 Melbourne Medical Deputising Service, *Submission No 15*, p 15.

20 Challis Recruitment, *Submission No 88*, p 11. See also: Government of South Australia Department of Health, *Submission No 96*, p 3.

inquiry it seems that current systems do not have the capacity to deal effectively with the volume of inquires from IMGs and other organisations wishing the clarify specific information regarding accreditation and registration. This has resulted in lengthy waiting times for telephone inquiries and delays in responding to e-mail inquiries.

6.45 In the interests of reducing waiting times and increasing efficiency, the Committee recognises the need for relevant agencies to ensure that all staff dealing with inquires have at their disposal relevant information in electronic form. This will help to ensure that queries are answered promptly and with minimal need for additional information to be sought elsewhere. Where computer-based information management systems are used, the AMC and the MBA/AHPRA should ensure that appropriate case notes detailing advice given and actions taken are entered by staff in the event that later clarification is required. To enhance the utility the AMC and MBA/AHPRA should ensure that information regarding the each IMG's accreditation and registration status is available to the relevant agencies in an appropriate and compatible form, bearing in mind the need to comply with the Australian Government's Information Privacy Principles and *Privacy Act 1988* (Cth). This matter is considered in later in the Chapter in association with a proposal to establish a central repository of documentation.

Recommendation 31

6.46 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency ensure that computer-based information management systems contain up-to-date information regarding requirements and progress of individual international medical graduate's assessment, accreditation and registration status to enable timely provision of advice.**

6.47 In addition, the AMC and the MBA/AHPRA should ensure that staff members are given adequate training in understanding the overall system of assessment, accreditation and registration so that any information provided to IMGs is reliable and consistent. The Committee also understands the frustrations of those IMGs who feel that they do not have access to an identified individual in a case management capacity

regarding either their accreditation or registration applications. The Committee will consider these options in Chapter 7.

Recommendation 32

6.48 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency implement appropriate induction and ongoing training for all employees responsible for dealing with inquiries. This training should include among other things, an understanding of the overall system of accreditation and registration so that referrals to other organisations can be made where necessary.**

Documentation requirements and processing

6.49 Providing documentation to verify that IMGs are suitably qualified, with the skills and experience to practise in Australia is a fundamental requirement of the NRAS. However, evidence to the inquiry has highlighted the difficulties faced by IMGs in dealing with their documentary evidence obligations. Adding to these difficulties, a large number of submissions have identified frustration with documents processing, apparently as a result of poor communication and coordination between key agencies. Applicants are frequently required to provide copies of the same document to multiple agencies, or even the same information, but in a different format again leading to duplication and wasted time and effort. In addition, some inquiry participants also expressed concern about the unreasonably short validity of some documents, meaning that if there are any delays documents expire and new versions have to be obtained.

6.50 Table 6.1 is a summary of the type of documentation which an IMG may need to provide as part of the accreditation and registration processes in order to obtain Limited Registration for an Area of Need.

Table 6.1 Documents required for an initial application for Limited Registration

▪ certified copies of all academic qualifications including examinations and assessments undertaken
▪ certified copy of primary medical degree certificate
▪ proof of internship
▪ evidence of specialist qualifications
▪ certificate of registration status or Certificate of Good Standing from previous jurisdictions
▪ curriculum vitae outlining full practice history
▪ possible criminal history in Australia and overseas
▪ details of any proposed supervised training positions
▪ proof of continuing professional development requirements and a continuation plan if required
▪ details of any relevant training and assessment
▪ details of any physical or mental impairment
▪ details of any registration or suspensions
▪ proof of any previously refused or cancelled registrations
▪ proof of any scope of practice restrictions
▪ proof of any disqualifications
▪ proof of any conduct performance or health proceedings
▪ AMC Certificate
▪ letters of recommendation from specialist medical colleges
▪ details of successful completion of AMC Multiple Choice Question Examination
▪ outcome of any PESCI assessment
▪ intended position description
▪ area of need declarations

Source: MBA, Application for limited registration for an area of need for Specialist Practice as a Medical Practitioner, <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f1330&dbid=AP&chksum=n0YXjs4TPKZ8PWVFJRNffQ%3d%3d> viewed 3 February 2012.

Duplication

6.51 In addition to supplying these documents to the AMC, specialist medical colleges and the MBA/AHPRA, some of the same documentation may also need to be supplied to prospective employers and to the Department of Immigration and Citizenship (DIAC) as part of the visa application process. The process of obtaining the required documentation from overseas educational institutions and employers can also be costly and time consuming for IMGs, while adding an additional burden on IMGs who are already navigating a complex system.

6.52 Outlining the enormity of supplying all of the required documentation to the key agencies involved in accreditation and registration, Challis Recruitment told the Committee:

> OTDs are asked to supply documentation detailing their basic training, advanced training, papers written, basic and advanced college exam results (not just evidence of the qualifications awarded when successfully passing an examination). Most specialist assessment submissions run into hundreds of pages (and most of those documents must be correctly certified, and duplicated at least 3 times which is hugely expensive) so that each individual regulating body (AMC, College, APHRA) receives a copy for their files.[21]

6.53 With regard to IMGs seeking specialist recognition, the AMC submitted:

> The specialist assessment pathway is open to criticism that an IMG has to submit the same documents to as many as four different authorities, including a certified set to AMC, a certified set to the College (if requested), a certified set to the Medical Board and possibly a certified set to an employer.[22]

6.54 Ms Charlie Duncan, Recruitment and Locums Manager, Health Workforce Queensland outlined administrative inefficiencies associated with demonstrating English language proficiency, explaining:

> There are problems with the process, and that is because to become registered you have to deal with multiple agencies. I will give you an example which might help. As you know, you apply through the AMC, the AMC do their step and then you apply to AHPRA. Those are two departments—and there are others involved as well—both asking doctors to provide a copy of their English language test. The AMC comes first, and they are happy to take a copy. AHPRA comes second and they have to have an original, and that original has to come directly from IELTS. So the doctor cannot even get their original so they can send a copy to the AMC and then send the original to AHPRA. They have to get an original to get a copy to the AMC, and then get another original sent directly from IELTS to AHPRA.[23]

6.55 Individual IMGs have also told the Committee about their experiences with documentation and the effect of organisations losing some documentation or having multiple requests to provide the same documentation. Dr Susan Douglas told the Committee:

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21 Challis Recruitment, *Submission No 88*, p 8.

22 Australian Medical Council (AMC), *Submission No 42*, p 25.

23 Ms Charlie Duncan, Health Workforce Queensland, *Official Committee Hansard*, Brisbane, 10 March 2011, p 67.

> I contacted the AMC and asked what information I needed to submit because I had already submitted all of the documentation in the past, which should be in my file. The representative informed me that they didn't keep a lot of the information in their records! They also wouldn't tell me what information they actually had in my file. I couldn't believe that they expected me to repeat the process which had taken me over six months to do the first time![24]

6.56 Dr Chellam Kirubakaran outlined his experience as follows:

> During the process of getting my initial assessment by the AMC and later by the College of Physicians, I had to submit my curriculum vitae five times. At one point I was asked to provide an 'expanded curriculum vitae' although I had given a very detailed write up, taking 27 pages in all. It appeared that the organisations kept losing my file repeatedly and there was no co-ordination between the two institutions. The 'source verification' of my qualifications was done twice and I had to pay for the second time as well.[25]

6.57 Acknowledging administrative inefficiencies in its submission, the AMC noted:

> One option being considered by the AMC is a possibility for it and the Medical Board of Australia to share access to electronically scanned documents along similar lines to the process that currently applies to primary source verification of medical documents. If successful this could be extended to participating Colleges.[26]

Committee comment

6.58 Given the volume of documentation required in the accreditation and registration process, a reduction in the cost and time associated with the provision of these documents by IMGs will have an impact on the overall processing times for applications by IMGs. It is unclear to the Committee why the key organisations involved in accreditation and registration do not appear to have established a coordinated and streamlined system for processing of documentation.

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24 Dr Susan Douglas, *Submission No 111*, p 17.

25 Dr Chellam Kirubakaran, *Submission No 122*, p 2.

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

6.59 Therefore the Committee proposes that the MBA/AHPRA and the AMC develop a centralised document repository which will enable all relevant organisations, including specialist medical colleges, to access authorised copies of documentation provided by IMGs for accreditation and registration purposes. In the Committee's view, this would greatly reduce the time and costs currently incurred by IMGs and increase the efficiency by which relevant agencies could manage accreditation and registration of IMGs.

6.60 The Committee anticipates that such a system would form a perpetual record of documentation submitted by individual IMGs, and that this documentation could be accessed by the relevant organisations to fulfil future accreditation and registration documentary requirements where necessary, subject to relevant validity periods. Importantly, it would negate requirements for IMGs to resubmit non time-limited documentation to relevant organisations multiple times.

6.61 In establishing a central document repository however, the Committee is of course aware that access by organisations involved in the accreditation and registration processes would need to comply with the Australian Government's Information Privacy Principles and any requirements under the *Privacy Act 1988* (Cth).

Recommendation 33

6.62 **The Committee recommends that the Medical Board of Australia, in conjunction with the Australian Medical Council and specialist medical colleges, develop a centralised repository of documentation supplied by international medical graduates (IMGs) for the purposes of medical accreditation and registration.**

The central document repository should have the capacity to:

- **be accessed by relevant organisations to view certified copies of documentation provided by IMGs;**
- **be accessed by relevant organisations to fulfil any future documentary needs for IMGs without the need for them to resubmit non time-limited documentation multiple times;**
- **form a permanent record of supporting documentation provided by IMGs; and**
- **comply with the Australian Government's Information Privacy Principles and *Privacy Act 1988* (Cth).**

Consistency

6.63 Several submissions have noted inconsistencies in the documentation requirements of the different accreditation and registration agencies even though ostensibly validating the same aspect of an IMG's application. For example, the AMC and AHPRA have different requirements for documents to establish proof of identity. To prove identity, the AMC requires IMGs to provide a certified copy of their passport, and one of the following:

- a certified copy of your driver's licence
- a certified copy of your credit card (front and back)—only bank-issued cards will be accepted; cards for internet/electronic use only are not acceptable
- a certified copy of your International English Language Testing System Test Report Form (IELTS-TRF) (with photograph)
- a certified copy of your current registration or certificate of good standing from a relevant medical regulatory authority.[27]

27 AMC, Assessment and Examinations, Document standards (Proof of identity), <http://www.amc.org.au/index.php/ass/apps/id-proof> viewed 1 February 2012.

6.64 In contrast, the MBA/AHPRA has more stringent proof of identity standards which require IMGs to produce at least one document from each of four categories, these being:

- Category A: Commencement of Identity
- Category B: Link between the identity and the person by means of photo and signature
- Category C: Evidence of identity operating in community
- Category D: Evidence of identity's residential address.[28]

6.65 While there is capacity for some overlap in the proof of identity documentation required, IMGs must provide all supporting documents again to the MBA/AHPRA irrespective of what has already been submitted to the AMC.

6.66 Furthermore, in some cases the acceptable form of documentary evidence differs. For example, as noted earlier in relation to provision of English language test results, organisations involved in accreditation and registration have different requirements with regard to the need to supply original documents versus appropriately certified copies.

6.67 Another example of inconsistency is the differing versions of curriculum vitae (CV) required by the AMC, specialist colleges and the MBA/AHPRA.[29] The AMC provides a template for CVs along with some additional guidance on its website.[30] The MBA/AHPRA also provides IMGs with a standard format for a CV, which is different to that used by the AMC.[31] As a result IMGs have to present different versions of their CVs, containing essentially the same information. As explained below by AMC:

> A common CV document was developed by JSCOTS and well supported by the Specialist Colleges. However the MBA also has a standard CV document. As a result an applicant may submit the AMC/Specialist College approved CV document and complete the assessment only to find that he or she must complete the MBA

28 Australian Health Practitioner Regulatory Authority (AHPRA), *Proof of Identity Requirements*, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f1973&dbid=AP&chksum=H7xVC2W%2bm57CqcCbJbUQrg%3d%3d> viewed 1 February 2012.

29 Association of Medical Recruiters Australia & New Zealand, *Submission No 139*, p 4.

30 AMC, Assessment & Examinations, Specialist Pathway (Specialist recognition), <http://www.amc.org.au/index.php/ass/apo/spp/spfr> viewed 1 February 2012.

31 AHPRA, Standard Format for Curriculum Vitae, <http://www.ahpra.gov.au/Registration/Registration-Process/Standard-Format-for-Curriculum-Vitae.aspx> viewed 1 February 2012.

> standard CV document when applying for registration. [The AMC/Specialist College CV document was developed and approved prior to launch of MBA so this was not an issue at the time]. This process is open to criticism for unnecessary duplication and should be addressed.[32]

Committee comment

6.68 The Committee has already commented on unnecessary waste of time and effort resulting from administrative inefficiencies in processing of supporting documentation for IMGs. To address these concerns the Committee has recommend the establishment of a central document repository accessible to the relevant agencies. To streamline processes for document lodgement and handling further, the Committee also understands that the key agencies involved in accreditation and registration will need to develop more consistent requirements for supporting documentation.

6.69 While recognising that not all organisations will have identical requirements for documentation, where overlaps do occur steps should be taken to ensure that these documents need only be lodged once. It is unclear to the Committee why organisation under a national system of accreditation and registration should have differing requirements on the form (i.e. original or certified copies) and format of supporting documentation which they will accept. The Committee is concerned that such minor differences not only add to the administrative burden for organisations, but also lead to unnecessary cost and time impositions on IMGs.

6.70 Therefore the Committee recommends that the MBA/AHPRA, AMC and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible, with a view to further reducing duplication by preventing the need to lodge information on more than one occasion and in different forms and formats.

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

Recommendation 34

6.71 **The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, the Australian Medical Council, and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible. These requirements should be developed with a view to further reducing duplication by preventing the need for international medical graduates (IMGs) to lodge the information more than once and in different forms and formats.**

This documentation should form part of an IMG's permanent record on a central document repository.

Document validity

6.72 The Committee has heard that it is not uncommon for IMGs to encounter unexpected delays for a variety of reasons and at different stages of the accreditation and registration processes. Where supporting documents are only accepted as valid by agencies for a limited period, these delays may extend beyond that period, requiring new documents to be produced by the IMG. The Committee received a range of evidence relating to document validity, and in Chapter 5, has already recommended extending the validity period for English language test results so that they are more consistent with accreditation and registration timeframes.

6.73 In addition, one of the issues most frequently raised relates to the three month validity period for Certificates of Good Standing (or work practice history). In order to demonstrate an IMG's medical registration history, both the AMC and the MBA/AHPRA require IMGs to provide Certificates of Good Standing from each employer. The AMC requires IMGs to provide Certificates of Good Standing from all employers over the previous two years[33], while the MBA/AHPRA requires these Certificates from all employers over the previous 10 years.[34] The MBA's application forms for Limited Registration state:

> You must arrange for original Certificates to be forwarded directly from the licensing or registration authority to the relevant state office of the Medical Board of Australia. Certificates submitted to

33 National Rural Health Alliance, *Submission No 113*, pp. 13 -14.

34 Medical Board of Australia (MBA), Registration Standards, <http://www.medicalboard.gov.au/Registration-Standards.aspx> viewed 1 February 2012.

> the Board must be dated within 3 months of the application being lodged with the Board.[35]

6.74 Dr Joanna Flynn, Chair of the Medical Board of Australia explained the purpose of this requirement to the Committee:

> We now require anyone coming into Australia for registration to provide direct evidence to the board from the jurisdictions in which they have been registered at any time in the last 10 years that they do not have any adverse disciplinary history.[36]

6.75 However, as noted by the Western NSW Local Health Network, the short period of validity for Certificates of Good Standing frequently results in IMGs having to obtain new documents part way through the accreditation and registration process:

> The 'certificates of good standing' which OTD's must obtain from their home registration board (or any board they have been subject to in the last ten years) only have a life of three months. Because of delays, these certificates frequently expire mid-process causing further, unnecessary hold-ups.[37]

6.76 In addition, noting that Certificates of Good Standing are required by both the AMC and the MBA/AHPRA, but at different stages of the accreditation and registration processes, the AMA observed:

> Some of the documentation such as letters of good standing are repeated for AMC and MBA but by the time it is needed the second time, a new letter of good standing is required due to delays.[38]

6.77 Similarly, Alecto Australia submitted:

> The requirements for gaining a Certificate of Good Standing differ for the AMC and AHPRA and the processes mostly have to be conducted separately as there is often a substantial time delay in the process so that the initial [Certificates of Good Standing] may be invalid by the time the applicant is dealing with AHPRA.[39]

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35 MBA, Registration Forms, *Application for limited registration for an area of need*, p 5, <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f1330&dbid=AP&chksum=n0YXjs4TPKZ8PWVFJRNffQ%3d%3d> viewed 1 February 2012.

36 Dr Joanna Flynn, MBA, *Official Committee Hansard,* Canberra, 25 February 2011, p 18.

37 Western NSW Local Health Network, *Submission No 49*, p 10.

38 AMA, *Submission No 55*, p 7.

39 Alecto Australia, *Submission No 85*, p 4.

Committee comment

6.78 The Committee views that the requirement for the provision of Certificates of Good Standing should form part of the centralised document repository as outlined earlier in this Chapter. However, the three month validity period appears to create an unreasonable burden for IMGs. The basis for the very restricted period of validity is unclear, and the Committee is of the view that the validity period should he extended to 12 months for a number of reasons.

6.79 In the first instance, an undue burden is caused to IMGs due to the possibility that the accreditation and registration process may not be finalised within the three month validity period, and fresh Certificates may have to be obtained part way through the process.

6.80 Secondly, the Committee views that it is unlikely that Certificates of Good Standing issued by a past employer will change, excepting under exceptional circumstances where there is disciplinary action or other decision pending, relating to an IMG's past employment or registration. Extending the Certificate's validity to 12 months should avoid expiration of the Certificate for administrative reasons only, but would ensure that any significant change in circumstance associated with previous employment which might affect the standing of the IMG would be taken into account.

6.81 The Committee is of the view that where there is a lapse of time of three months or more since the last Certificate was issued, IMGs should be required to certify that they have not been employed in medical practise during that time. Where an IMG has been employed in medical practise during that period, additional Certificates(s) will be need to be provided.

Recommendation 35

6.82 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Registration Agency amend requirements so that Certificates of Good Standing provided by past employers remain valid for a period of 12 months, noting the following:**

- **where there is a period of greater that three months since the last Certificate was issued, applicants must certify that they have not been employed in medical practice during that period; or**
- **where applicants have been employed in medical practice since issuing of the last Certificate, additional Certificate(s) of Good Standing must be provided.**

Certificates of Good Standing should also be available on a central document repository.

Application and assessment fees

6.83 The Committee has heard evidence relating to the fees payable to the AMC, the MBA and specialist medical colleges for IMGs who are undertaking their chosen pathway towards accreditation and registration as a medical practitioner in Australia.

6.84 The MBA told the Committee that assessment processes for IMGs are funded via a 'user pays' approach, which is an expensive process for applicants. The MBA provided a breakdown of indicative costs IMGs would usually pay to proceed down each registration pathway, including AMC fees, visa fees, MBA registration costs and relevant college fees (using the Royal Australian College of General Practitioners (RACGP) as an example). The MBA estimated that an IMG's total costs for pursuing a particular pathway is indicatively as follows:

- Competent Authority Pathway – approximately $4 165;
- RACGP Pathway (ranging depending on the categorisation of the IMG's comparability level) – approximately $3 615 to $11 900;
- Standard Pathway – approximately $8 730.

6.85 These estimates did not include provision for any visa or travel costs incurred by the IMG to travel for interviews, if required by the MBA or specialist medical colleges.[40]

6.86 Dr Sunayana Das told the Committee that the AMC's fee structure is unfair and burdensome:

> The excessive fees charged by the AMC at every stage of the process and draconian fee structure (including a $95 'document correction fee 'if any documents in an application are wrong or missing, and the fact that the AMC charges $1.95 per minute for the privilege of talking on the phone to someone there) together with the unnecessary red tape, is designed only to raise revenue for the AMC and support its bureaucracy. It is inefficient and places a considerable unfair financial burden on salaried doctors working in the public health system.[41]

6.87 IMGs and relevant stakeholders also told the Committee that fees charged to IMGs pursuing specialist accreditation through one of the specialist medical colleges vary significantly between colleges and these varying costs are often not justified or warranted.

6.88 The South Eastern Sydney Local Health Network submitted as follows:

> OTDs have also complained that, whilst the fees from the Department of Immigration, the AMC and the Medical Board are 'reasonable', Colleges are charging fees in the thousands of dollars, which OTDs feel does not reflect the amount of work required.[42]

6.89 In a joint submission to the Committee, Associate Professors Michael Steyn and Kersi Taraporewalla told the Committee that fee processes across colleges should be uniform and reasonable. Discussing the process IMGs must undertake to gain a position in an Area of Need (AoN), the Associate Professors told the Committee:

> There is no process which seeks justification of the amount of the fee charged and there is lack of uniformity between the colleges as to who should pay the fees.[43]

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40 For breakdown of the estimate of fees for each pathway, see AMA, *Submission No 55*, Attachment A, p 14.

41 Dr Sunayana Das, *Submission No 99*, p 3.

42 South Eastern Sydney Local Health Network, *Submission No 16*, p 2. See also: Illawarra Shoalhaven Local Health Network, *Submission No 17*, p 2.

43 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 7.

6.90 The Overseas Trained Specialists Anaesthetists Network (OTSAN) highlighted what it saw as a financial burden imposed by specialist medical colleges on overseas trained specialists:

> For example charges that are imposed by the Australian and New Zealand College of Anaesthetists include fees for Area of Need application, paper assessment, interview, clinical practice assessment, examination/workplace based assessment etc and amount to 13,500 AUD per candidate (relevant travel costs not included) or even more if more than one attempt for exams/assessment is needed.[44]

6.91 In response to concerns raised regarding the fee structure of specialist medical colleges, the Committee has heard arguments from colleges themselves justifying their fees.

6.92 Ms Dianne Wyatt, Strategic Projects Manager for the Australian College of Rural and Remote Medicine (ACRRM) noted that a staged fee approach allowed an IMG who was not assessed as substantially or partially comparable to avoid incurring further costs.[45]

6.93 ACRRM stated that if an IMG is assessed as partially or substantially comparable, the fees for each stage of assessment are discretionary, depending on what level of comparability the IMG is assessed at:

> If it is considered that they would be substantially or partially comparable, they go to interview and then there is a charge for the interview. It will depend on whether they are substantially or partially as to what the cost will be. If they are substantially, they have a year of peer review and they pay for multisource feedback. If they are partially it can be up to two years and they can have a higher level of assessment, which is also paid. So they pay for what is actually required. There is not an overall fee—for example, you are in or you are out. [46]

6.94 Dr Richard Willis, of the Australian and New Zealand College of Anaesthetists (ANZCA) told the Committee:

> As you know, the colleges are self-funded, and I guess it depends on the way that individual colleges divvy up the money that is available. Certainly the IMG process in our college is supposed to

44 Overseas Trained Specialists Anaesthetists Network (OTSAN), *Submission No 38*, p 2. See also: Queensland Health, *Submission No 126*, p 5.

45 Ms Dianne Wyatt, Australian College of Rural and Remote Medicine (ACRRM), *Official Committee Hansard*, Brisbane, 10 March 2011, p 59.

46 Ms Wyatt, ACCRM, *Official Committee Hansard*, Brisbane, 10 March 2011, p 59.

> be self-sufficient, and seeing there is no money other than from subscriptions and training fees there are differences from other colleges. It would be very nice if they were all the same.[47]

Committee comment

6.95 The Committee notes that the cost of pursuing a pathway towards accreditation and registration as a medical practitioner in Australia is significant for IMGs, particularly for those seeking specialist accreditation.

6.96 The Committee understands the need for colleges to itemise or stage their fees to ensure that IMGs are not paying for a stage of assessment they are not undergoing. However, from the evidence provided to the Committee it appears that the total fees applied to applicants can be significant and can be provided without appropriate justification as to why the fees for individual IMGs might vary and why there are differences between the colleges. The Committee is therefore not surprised that some IMGs are left feeling that the fees applied are inconsistent and unfair.

6.97 Accordingly, the Committee is of the view that the specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to IMGs seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the AMC and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should also be informed about possible penalties which may be applied throughout the assessment process.

6.98 The Committee is also of the view that the MBA, the AMC and specialist medical colleges should review the administrative fees and penalties which are applied throughout the accreditation and specialist assessment process to ensure that these fees can be justified in a cost recovery based system.

47 Dr Richard Willis, Australian and New Zealand College of Anaesthetists, *Official Committee Hansard*, Melbourne, 18 March 2011, p 56.

Recommendation 36

6.99 **The Committee recommends that specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to international medical graduates (IMGs) seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the Australian Medical Council and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should be informed about possible penalties which may be applied throughout the assessment process.**

Recommendation 37

6.100 **The Committee recommends that the Medical Board of Australia/ Australian Health Practitioner Registration Agency, the Australian Medical Council and specialist medical colleges review the administrative fees and penalties applied throughout the accreditation and assessment processes to ensure that these fees can be fully justified in a cost recovery based system.**

Grievances, complaints and appeals

6.101 During the inquiry the Committee received evidence from IMGs and from other contributors outlining individual circumstances and detailing specific grievances. This evidence has frequently included grievances from IMGs relating to the assessment of their clinical expertise, skills and experience. While these personal experiences have provided valuable insights, from the very start of the inquiry the Committee has been explicit that it does not have the authority to investigate individual cases or the expertise to question issues of clinical judgement. Rather the Committee's considerations in relation to grievances and appeals are directed towards identifying systemic problems or deficiencies.

6.102 In Chapter 4 of this report, the Committee has already commented extensively on reconsideration, review and appeal of specialist college decisions relating to IMG assessment, making recommendation to increase transparency and accountability. Therefore consideration below is confined to:

- processes for dealing with administrative complaints against the AMC and National Law entities (including the MBA, AHPRA and AHPRA's Management Committee); and
- processes for dealing with allegations of bullying or misconduct.

Administrative complaints

6.103 One area of concern for the Committee is that some IMGs appear to be unclear about the options available to them to pursue administrative complaints or appeal decisions made regarding registration.[48]

6.104 According to information provided by the Department of Health and Ageing:

> Appeals in relation to the AMC and its processes are made to the AMC Board of Examiners where there are grounds that procedural requirements were not followed in a significant way or that the applicant believes their performance was impaired by significant deficiencies in the examination procedures beyond the applicant's control.[49]

6.105 However, while information on the AMC's website indicates that all training organisations it accredits are expected to have processes for addressing grievances, complaints and appeals, there is no information provided on processes for handling complaints relating to the AMC's own processes.[50]

6.106 In contrast, AHPRA's Complaints Handling Policy is available on its website.[51] The policy advises:

> Any person may make a complaint. To enable the timely consideration of a complaint specific details of the incident, conduct or behaviour giving rise to the complaint should be provided.
>
> Complaints can be made over the phone, or in writing. AHPRA encourages complaints, where possible, to be submitted in writing (by email or letter).[52]

48 See for example: Dr Emil Penev, *Submission No 3*, p 2.

49 DoHA, *Submission No 84*, p 9.

50 AMC, Accreditation and Recognition, *Complaints about Training Organisations accredited by AMC*, <http://www.amc.org.au/index.php/ar/complaints> viewed 26 January 2012.

51 AHPRA, Complaints, <http://www.ahpra.gov.au/About-AHPRA/Complaints.aspx> viewed 26 January 2012.

6.107 APHRA's Complaints Handling Policy indicates that it is guided by the following principles:

- a complainant will be treated fairly;
- a complaint will be acknowledged promptly, assessed and assigned priority;
- a complaint handling officer will provide updates and information relating to the investigation of the complaint;
- where an investigation is required it will be planned with a timeline established;
- the investigation will be objective, impartial and managed confidentially in accordance with privacy obligations;
- the investigation will aim to resolve factual issues and consider options for complaint resolution and future improvement;
- the response to the complaint will be timely, clear and informative;
- if the complainant is not satisfied with the response, internal review of the decision will be offered and information about external review options provided.[53]

6.108 The policy also details how the response to complaints to AHPRA will be handled:

> The complaint will be acknowledged in writing within 14 days. Complaints will be promptly investigated, and in most circumstances a response will be provided within 30 days. More complicated complaints may require more time to investigate. AHPRA will communicate its expectations where a longer period is required.[54]

6.109 Where a complainant is dissatisfied with the outcome of the initial investigation, they have 30 days to write to the Complaints Officer outlining the reasons that for their dissatisfaction. The complaint may then

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52 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 3, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d> viewed 26 January 2012.

53 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 4, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d> viewed 26 January 2012.

54 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 5, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d> viewed 26 January 2012.

be referred to AHPRA's Chief Executive Officer who will prepare a response within 30 days.[55]

6.110 Where the result remains unsatisfactory to the complainant, there are a number of avenues that may be pursued. The first of these is that the complainant may contact the National Health Practitioner (NHP) Ombudsman.[56] The NHP Ombudsman investigates complaints from people who believe they may have been treated unfairly in administrative processes by the agencies within the national scheme.[57] The NHP Ombudsman can investigate complaints made about AHPRA, the National Boards (the MBA in the case of medical practitioners), AHPRA's Management Committee or the Australian Health Workforce Advisory Council (AHWAC).[58]

6.111 According to information provided by the NHP Ombudsman in its Complaints Handling Summary:

> The types of complaints that can be considered in relation to the 4 agencies after 1 July 2010 include:
>
> - allegations of an interference with privacy by one of those agencies breaching the National Privacy Principles under the Commonwealth Privacy Act 1989.
> - a complaint about action taken or not taken by one of those agencies that relates to a matter of administration.
> - a complaint about how one of those agencies dealt with a freedom of information matter.

6.112 If upon investigation the NHP Ombudsman finds that a National Law entity has acted wrongly or made a mistake it can recommend that the agency:

- reconsider or change its decision;
- apologise;
- change a policy or procedure; and

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55 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 5, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d> viewed 26 January 2012.

56 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 5, <http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d> viewed 26 January 2012.

57 Australian Government Department of Health and Ageing (DoHA), *Submission No 84*, p 9.

58 National Health Practitioner Ombudsman, <http://www.nhpopc.gov.au/docs/Complaint-Handing-Process.pdf> viewed 30 January 2011.

- consider paying compensation where appropriate.[59]

6.113 While noting that agencies usually act on the Ombudsman's recommendations, the NHP Ombudsman cannot force an agency to comply.[60]

6.114 The other avenue that may be pursued is with regard to decisions relating to registration or renewal of registration, is through the state and territory administrative appeals tribunal processes. Dr Joanna Flynn of the MBA told the Committee that following the process of internal review by the Chief Executive Officer:

> In relation to any decision that the Medical Board makes, if we want to not renew a registration or not grant registration or place conditions on a registration, the first thing we need to do is to issue a notice to the practitioner proposing to do that. Then we give them an opportunity to show cause by making a submission, we hear the submission and make a decision. If the decision then is adverse to the practitioner, their right of appeal is through the administrative legal structures in the states—so in Victoria it would be the Victorian Civil and Administrative Tribunal and so on. So there is a robust, proper, legal appeals process[61]

6.115 Notwithstanding these complaints and appeals mechanisms currently available, a number of submitters suggested there is a need to establish an overarching independent appeals body. For example, Rural Health Workforce Australia (RHWA) told the Committee:

> ... we believe that there is no option but to provide powers to either a 'Regulator' or 'Ombudsman' to oversee the system of OTD assessment. There are many mechanisms to do this through either existing legislation or new legislation but without this, nothing will change as each organisation will continue to work on its own with little regard to the impact on OTDs and rural communities.[62]

6.116 ACRRM also told the Committee:

> ACRRM would give in principle support to the establishment of an external appeals body such as an ombudsman and would

59 National Health Practitioner Ombudsman, <http://www.nhpopc.gov.au/what-we-do/office-of-the-nhp-ombudsman.aspx> viewed 30 January 2012.

60 National Health Practitioner Ombudsman, http://www.nhpopc.gov.au/what-we-do/office-of-the-nhp-ombudsman.aspx

61 Dr Joanna Flynn, Medical Board of Australia, *Official Committee Hansard*, Canberra, 25 February 2011, p 22.

62 Rural Health Workforce Australia (RHWA), *Submission No 107*, p 4.

> recommend the establishment of a national working group to investigate this matter and provide recommendations to government as to the feasibility, roles, functions and governance. Such an independent body should limit the cost of appeal for the OTD and speed the appeal process as it would take it out of the 'legal system'.[63]

Committee comment

6.117 It is understandable that IMGs and some of those involved in assisting them through accreditation and registration believe that there is a need for more independent mechanisms of review in relation to decisions of the AMC, specialist medical colleges and the MBA/AHPRA. Importantly, in this regard the Committee reiterates the need to clearly distinguish between complaints relating to assessments of clinical competency from complaints relating to administrative and procedural issues pertaining to assessment. accreditation and registration. As previously noted, the Committee does not have the expertise to comment on specific complaints relating to clinical judgement. The Committee views the AMC, specialist medical colleges and the MBA/AHPRA as the appropriate entities to set clinical assessment standards and to assess IMGs against these standards in a fair and transparent manner.

6.118 The Committee also believes procedures put in place by specialist colleges and the MBA/AHPRA with respect to handling of complaints through internal review are reasonable and appropriate. The Committee also notes the independent powers available to the NHP Ombudsman to review decisions made under the National Law by the MBA/AHPRA and further opportunities for independent appeal through state and territory tribunals. Given these options, the Committee does not believe that the addition of a further independent review process is warranted.

6.119 However, the Committee is unclear with regard to the options that are available to IMGs that might wish to make administrative complaint in relation to the AMC's processes. Despite the AMC requiring accredited entities to have fair and transparent complaints handling and appeals procedures, the Committee was unable to find evidence on the AMC's website of equivalent processes for handling administrative complaints relating to the AMC's own processes. The Committee believes that this situation should be rectified. Furthermore, the Committee believes that where IMGs are advised of the outcome of an internal review, whether

63 ACCRM, *Submission No 103*, p 13.

this is from the AMC or the MBA/AHPRA, the advice should contain information in relation to the next step in the appeal process.

Recommendation 38

6.120 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency increase awareness of administrative complaints handling and appeal processes available to international medical graduates (IMGs) by:**

- **prominently displaying on their websites information on complaints handling policies, appeals processes and associated costs; and**
- **ensuring when IMGs are advised of adverse outcomes of any review, that the advice contains information on the next step in the appeal process.**

Dealing with allegations bullying and harassment

6.121 It is implicit upon all medical practitioners to act with a high degree of professionalism not only with their patients, but also with their colleagues irrespective of seniority or any perceived advantage. Individuals have the right to work in a fair, supportive and productive workplace. For these reasons, evidence of allegations of workplace bullying is of great concern.

6.122 The inquiry has received evidence from IMGs regarding allegations of bullying and workplace harassment they assert occurred as they worked through accreditation and registration. Evidence was also received from individuals asserting that some supervisors have experienced instances of harassment as a result of decisions they have made relating to the accreditation of an IMG. This evidence is considered below, though it should be noted that the individual cases represent only one view, and an opposing view is not being presented and has not been sought by the Committee.

6.123 Dr Bo Jin, an IMG, expressed concerns that he was bullied by members of a specialist medical college prior to sitting a clinical examination. He was surprised that these same staff members were his assessors for the specialist college examination. Dr Jin believes that:

> They prejudged that I could not be able to pass the clinical examination because of shortage of clinical practice.[64]

6.124 Dr Piotr Lemieszek outlined allegations of substantial bullying by supervisors in his submission. During the course of his supervision he received a number of negative assessments from supervisors regarding his performance and alleges that he experienced a number of unsavoury incidents. On one occasion, Dr Lemieszek alleges he was advised by a supervisor that:

> ... top marks are reserved for the top 3% of best performers, and as you are overseas trained you can not belong to this group.[65]

6.125 On another occasion, Dr Lemieszek claims that the same supervisor told him that:

> We will keep you like a dog on a leash. If you are a good puppy we will extend your leash, if not we will tighten it ... If we trust you, we will let you progress, if we do not we will limit your progress and shut you up.[66]

6.126 Another IMG who felt he had been victimised, Dr Michael Damp, advised the Committee of his experiences when commencing work in the South Australian town of Whyalla:

> On the day of my arrival in Whyalla I was met at the front door of the hospital by an Adelaide Professor of Surgery and informed that I was unwelcome in South Australia and should not consider travelling to Adelaide to partake in Surgical Departmental meetings, ward rounds etc, as 'general practitioners' were not welcome at 'surgeons' meetings.[67]

6.127 Dr Damp added that prior to arranging several job interviews for him in Western Australia, the same Professor informed him that:

> I like you but we will never accept you as a specialist surgeon in South Australia.[68]

6.128 Dr Jonathan Levy stated that in relation to the Committee's inquiry:

> It may also be of note that many doctors who *should* come forward with submissions will not, due to fear for their professional

64 Dr Bo Jin, *Submission No 26*, p 3.
65 Dr Piotr Lemieszek, *Submission No 118*, p 2.
66 Dr Piotr Lemieszek, *Submission No 118*, p 2.
67 Mr Michael Damp, *Submission No 6*, p 2.
68 Mr Michael Damp, *Submission No 6*, p 3.

> position and, thus, visa eligibility and ability to remain in Australia.[69]

6.129 Dr Levy proceeded to observe that despite the vulnerability of IMGs:

> ... [IMGs] dare not complain, for fear of local xenophobia, institutional bullying and the threat of losing their job and, thus, visa to remain in Australia.[70]

6.130 The Committee understands that it is not only IMGs who feel that they have been subject to bullying in the workplace. Surveys have indicated that up to 50% of junior doctors in Australia have experienced workplace bullying.[71] Some evidence has also highlighted that those working in supervisory capacities may also be subject to intimidating behaviour from those being supervised, particularly in circumstances where they may be required to give negative feedback on aspects of clinical competency. As one contributor to the inquiry related:

> ... supervisors must show and discuss their recommendations and reports to the supervisee before they are submitted. At best, this is a further time drain on supervisors. But most importantly, at worst, this requirement makes it extremely difficult to provide negative feedback or reports, and leaves room for coercion, or worse.[72]

Committee comment

6.131 The instances of bullying highlighted are from a number made to the Committee, and are cause for serious concern. In addition, the Committee received a range of confidential submissions from IMGs, some of which contained significant allegations of workplace bullying. Furthermore, the Committee notes comments suggesting reluctance by some IMGs to contribute openly to the Committee's inquiry for fear of retribution.

6.132 While the Committee does not have the authority, or indeed the capacity, to investigate the circumstances of individual allegations, the fact that some IMGs feel that they have experienced bullying during accreditation and registration should be the catalyst for change.

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69 Dr Jonathan Levy, *Submission No 34*, p 1.

70 Dr Jonathan Levy, *Submission No 34*, p 11.

71 Rutherford A and Rissel C, 'A survey of workplace bullying in a health sector organisation', *Australian Health Review*, September 2004, Vol 28, No 1, pp 65-72.

72 Name withheld, *Submission No 158*, p 2.

6.133 In considering concerns relating to bullying and harassment however, the Committee understands that these issues are not confined to IMGs, but also extend to others in the medical profession, with surveys reporting approximately 50% of junior doctors have experienced bullying in the workplace.[73] Clearly all medical practitioners, including IMGs, should feel that they are adequately supported by their employers, colleagues and the organisations to which they are accountable.

6.134 In a Position Statement on Workplace Bullying and Harassment, the AMA emphasises the importance of raising awareness of bullying and harassment issues for medical professionals, and calls for employers and specialist medical colleges to implement bullying and harassment policies. While the AMA lists a range of behaviours which may constitute bullying and harassment (eg verbal threats, physical violence and intimidation, exclusion, vexatious or malicious reports), it also emphasises the need to distinguish between bullying and a supervisor's responsibility to address performance problems through the provision of constructive feedback.[74] The Committee recognises that managing professional interactions associated with supervision and peer review can be challenging both for those being supervised and for their supervisors. As recommended in Chapter 5 of the report, the Committee believes clinical supervisors will assisted in this regard if guidelines, educational materials or training programs include information on cross-cultural awareness communication.

6.135 For medical practitioners who believe that they are being bullied, the AMA provides the following advice:

- document threats or action taken by the bully;
- discuss your concerns with your supervisor (or someone equivalent if your supervisor is the bully);
- consider making a complaint under your employer's bullying and harassment policy. If your employer does not have a policy, consider using an informal/formal complaint procedure; and
- seek support from your peer network, colleagues, your local AMA and other organisations (eg the Australian Human Rights

73 AMA, Position Statements, *Workplace Bullying and Harassment*, June 2009, <http://ama.com.au/node/4788> viewed 30 January 2012. See also: *2010 AMA Specialist Trainee Survey: Report of findings*, October 2011, p 20, <http://ama.com.au/specialist-trainees-survey> viewed 30 January 2012.

74 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, <http://ama.com.au/node/4788> viewed 30 January 2012. See also: *2010 AMA Specialist Trainee Survey: Report of findings*, October 2011, p 20, <http://ama.com.au/specialist-trainees-survey> viewed 30 January 2012.

> Commission), who can give you advice on your options and rights and some of which may act on your behalf.[75]

6.136 In addition to pursuing these courses of action, the Committee also notes other avenues that maybe pursued through Commonwealth, state and territory jurisdictions under industrial and occupational health and safety legislation, and anti-discrimination laws.[76]

6.137 Although all of these courses of action are available to IMGs, it is unclear from the evidence provided, whether IMGs are appropriately made aware of the avenues they may pursue if they believe they have been bullied during the pursuit of accreditation and registration. Therefore, the Committee believes that employers of IMGs, and specialist medical colleges should actively take steps to ensure that the relevant information on workplace bullying and harassment policies is made available to IMGs. It is also of course equally important that all medical staff, including IMGs themselves, are also made aware of behaviour which may constitute bullying and harassment along with the sanctions which apply for proven contravention. Therefore the Committee believes that IMGs should be provided with general information on their rights and responsibilities in relation to bullying and harassment as part of a structured orientation to the Australian health system. This issue is addressed further in the Committee's comments on orientation for IMGs in Chapter 7.

6.138 Notwithstanding its observation above, the Committee is concerned that some IMGs are fearful of alerting relevant individuals or responsible organisations of bullying behaviour for fear of repercussions affecting their employment and immigration status. Assessing the scale of this problem is impossible, as there is no objective way to quantify how many IMGs who have experienced bullying, have been too afraid to pursue formal avenues of redress. Certainly anecdotal evidence to the inquiry indicates that some IMGs who believe they have been bullied do not feel in a position to take action. In particular temporary resident IMGs on 457 visa's whose continued residency in Australia is dependent on the continued support of their sponsoring employer. While recognising that IMGs in this circumstance may feel particularly vulnerable, the Committee trusts that the vast majority of employers, clinical supervisors and professional colleagues act with integrity.

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75 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, p 3, <http://ama.com.au/node/4788> viewed 1 February 2012.

76 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, p 2, <http://ama.com.au/node/4788> viewed 1 February 2012.

6.139 However, addressing the realities of bullying when it does occur requires a commitment from employers to develop and implement robust workplace bullying and harassment policies. As noted, employers and employees need to be aware of their rights and responsibilities, and need to be entirely confident that these processes are fair to all concerned. Increased transparency and accountability is a necessary part of the cultural change required if concerns regarding the existence of 'boys clubs' and 'closed shops' are to be addressed.

6.140 To effect this outcome, the Committee recommends that the MBA, as the national agency responsible for the registration of medical practitioners, extend the obligations it applies to employers, supervisors and IMGs in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent and appropriate standards of professional behaviour and act in accordance with workplace bullying and harassment policies.[77]

Recommendation 39

6.141 **The Committee recommends that the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.**

77 MBA, *Guidelines – Supervised practice for limited registration*, June 2011, <http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f5394&dbid=AP&chksum=iOgwjgGW%2f8qVcdN0yTaPxg%3d%3d> viewed on 1 February 2012.