



**Submission to the Parliamentary Inquiry into Registration Processes
and Support for Overseas Trained Doctors**

Submitted by: Dr. Johannes Wenzel, MD, FACEM



There are several reasons why I have sufficient experience to comment on the terms of reference for the 'Inquiry into Registration Processes and Support for Overseas Trained Doctors by the House Standing Committee on Health and Ageing'. First, I am an international medical graduate (IMG or OTD) from Germany who has lived in Australia for thirty years. I was the Director of Emergency at Dandenong Hospital in Melbourne from 1982 until 2005, always working with OTDs and since then worked as Director of Clinical Training for IMGs in Southern Health

I have been an AMC examiner since 2002, I work with the Victorian Medical Postgraduate Foundation and teach in their bridging courses and I am a member of the Postgraduate Medical Council of Victoria IMG subcommittee. Finally, I have supervised a PhD through to completion at the University of Melbourne, which addressed the social, cultural and political aspects of IMGs' experiences in Australian hospitals. These roles have provided me with significant insight into the registration process for IMGs, from a variety of perspectives.

Although the "Terms of Reference" do not clarify if the Committee will only review the colleges' role or if a wider approach and a review of the Australian Medical Council's (AMC's) role is planned, I believe that it is mandatory to review the registration process of all overseas trained doctors, because one of the big problems is the fragmentation and the lack of coordination of the registration processes in the extremely complex situation OTDs find themselves in and because many OTDs who start off in a college program later revert into the general pathway process. I therefore concentrate my comments on the second and mainly the third point of reference by first highlighting the current issues and then recommending improvements.

My comments are based on personal experience as well as the experiences of approximately 600 IMGs whom I have consulted in preparation of this submission. I have provided some of their remarks at the end of the submission.

I am very keen to appear as a witness at a Parliamentary committee hearing to provide more details about the IMGs' comments and to expand on my submission.

1. ROLE OF THE AUSTRALIAN MEDICAL COUNCIL (AMC):

- ISSUE: waiting time for the AMC clinical examination

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 conducting unlimited MCQ examinations locally and overseas at a time where they cannot provide AMC clinical examination positions within a reasonable time!

RECOMMENDATION: Drastically reduce the AMC MCQ examinations or increase the AMC clinical examination numbers to alleviate the inappropriate waiting time between the two examinations.

- ISSUE: allocation of positions for the clinical examination

The recent change of the rules from previous, where IMGs who completed a bridging course got preferential allocation of examination positions, to now abandoning this rule and giving everybody the same opportunity, was disappointing for IMGs who had enrolled in bridging courses but welcomed as a correction of injustice by other IMGs who had no access to bridging courses and were clearly disadvantaged.

RECOMMENDATION: Review of AMC's approach to fairness and equal opportunity for all OTDs.

- ISSUE: feedback about examination performance

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 form of a global tick box approach which does not relate to individual stations.

From an educationalists point of view this is inappropriate!

RECOMMENDATION: Introduce constructive feedback for each station, so that candidates have an opportunity to understand their weaknesses and improve their performance in the future.

- ISSUE: poor performance

Some candidates achieve very low results in the clinical AMC examination, sometimes even on repeat occasions, raising serious concerns about the candidates' clinical ability. Some of these doctors find work or already work in an Australian hospital but there is no feedback concerning their low clinical exam results to the relevant Medical Board or hospital because AMC does not see that as their responsibility.

RECOMMENDATION: Create a central agency (see under point 4/D/c) whose role could include tracking the progress of OTDs and possible to liaise with Medical Boards.

- ISSUE: safe practitioners

The AMC examination process does not ensure that OTDs are fit to practice safely in the Australian health care system. In comparison to the Australian Universities' medical graduates, a much higher number of OTDs who have passed the AMC examinations are considered by the hospital and general practice system as unfit to safely practice in the Australian system.

Identified problems vary widely, including clinical competence, proficiency in procedural skill, cultural understanding, communication issues, critical thinking, decision making etc.

RECOMMENDATION:

- a) Strengthen and evaluate the work place based assessment pathway, as this seems to have a much better chance of "producing" safe doctors because it assesses doctor's performance in real practice with real patients.
- b) Transfer the assessment and examination process to the universities because this is part of their core business.

2. VISA REGULATIONS:

The different visa classes lead to competing interests and can have some disturbing consequences:

- ISSUE: temporary working visa (457)

OTDs on temporary work visa are dependent on hospital sponsorship. This can lead to a situation where the OTD is exploited by the hospital and if the hospital is dissatisfied with their performance (rightly or wrongly), OTDs can often be left in a vulnerable position. Many OTDs feel that they have little recourse in such a situation (See below under "system culture").

RECOMMENDATION: to ensure that OTDs understand their rights including performance review and grounds for dismissal.

- ISSUE: permanent residency or Australian citizenship

There are many OTDs with permanent resident status or Australian citizenship who are struggling to obtain employment. Many of these doctors feel that OTDs on temporary work Visa are given employment preferentially.

RECOMMENDATION: A system needs to be in place where hospitals are required to prove that they cannot find an appropriate qualified OTD with permanent residency status or with Australian citizenship for a vacant position, before offering this position to an OTD on a sponsored work Visa.

3. BRIDGING COURSES:

ISSUE: availability of and access to bridging courses

There are not enough positions in bridging courses, mainly due to limited exposure to bedside teaching facilities and many OTDs cannot afford the high cost of these courses.

RECOMMENDATION: Funding of dedicated bridging courses, clinical attachments and trial examinations with the aim not only to assist OTDs through the clinical examination but to prepare them to be 'safe' doctors who are familiar with the Australian health care system and who can demonstrate clinical and cultural competence.

4. TRAINING/ HOSPITAL POSITIONS:

- ISSUE: access to training positions in major hospitals

It has always been difficult for OTDs to obtain a position in major and or tertiary teaching hospitals because OTDs are implicitly considered to be of inferior standard or will require extensive and expensive supervision and up-skilling. It is of concern that many OTDs who are unsuccessful in applying for jobs in city hospitals finish up in peripheral or country hospital positions where they have even less supervision!

RECOMMENDATION: Expose OTDs to appropriate training positions in city hospitals to familiarise them with the Australian health care system in well supervised environments, before they are relocated to peripheral hospitals!

- ISSUE: observerships

For a variety of reasons it has become almost impossible over the last 10 years for OTDs to obtain observership positions in the Australian health care system to help them to learn about the Australian health care system.

RECOMMENDATION: Create and fund specific observership positions. A good example of how this can work, is our program in Southern Health, where OTDs (IMGs) are offered a six months, unpaid program to prepare them for safe practice in our hospitals. This program provides them with hands-on experience under effective supervision with appropriate assessments, regular tutorials and simulation centre sessions, making sure that the OTD is "fit for safe practice" at the end of the course.

- ISSUE: work experience

After passing the AMC MCQ and an English language examination OTDs are entitled to work in a hospital with limited registration. They are often employed in the most unpopular positions to fill in where Australian doctors do not want to work. Many hospitals do not provide effective supervision for OTDs, nor support to prepare them for the AMC clinical examination.

RECOMMENDATION: To guarantee an effective training program for OTDs who are employed with limited registration who still have to pass the clinical AMC examination through accreditation and inspection similar to what PMCV does with intern positions in Victoria.

- ISSUE: internship positions
OTDs who have passed the clinical AMC examination find it extremely difficult to obtain an intern position. OTDs usually have to start at the level of 'hospital medical officer year 2' where they have more responsibility than interns, often beyond their experience.

RECOMMENDATION: Establish internship-equivalent training positions (12 months) for OTDs who have not worked in Australia and need a supervised introduction into the Australian health care system.

- ISSUE: "recency of practice"
The introduction of the "recency of practice" requirements by AHPRA have led to widespread confusion and often misinterpretation even by hospital managers, thus excluding OTDs from hospital positions if they haven't worked for the last 3 years and/or have no Australian experience. At this stage it takes often more than 3 years for an OTD to negotiate the AMC examination process, considering that many OTDs have to improve their language skills before they can embark on the MCQ and/or clinical examinations.

RECOMMENDATION: clarification and review of application of the recency of practice regulation to OTDs.

- ISSUE: rotations
After passing the AMC examinations, OTDs are expected to work for 12 months in supervised positions including general medicine, surgery and emergency medicine before they become eligible for general registration. Currently it would be very unusual to gain access to these rotations in 1, often not even in 2 years. Many OTDs feel that hospitals abuse the situation to force them to work for more than 12 months in a given institution. Experience shows that OTDs traditionally receive the most unpopular rotations like psychiatry, rehabilitation, emergency medicine, often working longer and more unsocial hours (i.e. night shifts) than their Australian colleagues and that they are often deliberately excluded from the rotations they need for general registration!
Many OTDs "get stuck" for example in psychiatry for several years without ever having been given the opportunity to work in the required rotations.

RECOMMENDATION:

- a) Establish internship equivalent training positions (12 months) for OTDs who have not worked in Australia and need a supervised introduction into the Australian health care system before general registration.
- b) Hospitals should need to demonstrate, during the application process for limited registration, a clear plan to enable exposure to rotations required for general registration within a reasonable time frame. Relatedly, hospitals should also need to outline the career progression for the individual OTD!
- c) Establishment of a centralised (state or nation based) agency to provide a matching service similar to the PMCV match in Victoria to avoid OTDs having to apply to hundreds of hospitals with often no response at all. This would also alleviate the workload of hospital managers.

- ISSUE: supervision
There is generally a lack of funding and capacity for ongoing assessment and training of OTDs in our hospital system.

RECOMMENDATION: Fund dedicated supervisor positions with improved training for supervisors concentrating on cross-cultural and communication skills training.

- ISSUE: access to specialty training positions
OTDs find it much more difficult than local doctors to be accepted into specialty training programs, except psychiatry, general practice and emergency medicine.

RECOMMENDATION: review of role of colleges regarding transparency in the college application process

5. English language testing:

- ISSUE: lack of effectiveness
The quality of the IELTS and OET is controversial in so far that many OTDs who have successfully passed the language test struggle to communicate effectively in the Australian health care system.

RECOMMENDATION: Establishment of advanced cross-cultural communication skills programs for OTDs who need more support.

- ISSUE: variability in results
Many OTDs experience astonishing variability in the IELTS and OET assessment achieving good pass rates in one exam and for example 2 years later an insufficient result in the same subject whilst having lived in Australia and having spoken English all the time.

RECOMMENDATION: Review of the consistency of the examination.

- ISSUE: two year limitation
The two year limitation of a language certificate creates huge problems for many OTDs in light of the time gap between MCQ and clinical examination which often exceeds 2 years and forces them to repeat the language examination. Many OTDs can't understand why they have to repeat the language test having passed the test and lived in an English speaking country!

RECOMMENDATION: Abolish the time limitation of the language test 'currency'.

6. Medical system culture:

- ISSUE: medical system culture of discrimination

For decades the medical system has maintained a two-tier culture where OTDs are treated inferiorly to their Australian trained counterparts. It is very common to experience derogatory remarks by medical and nursing staff about OTDs which they would never dare to express about Australian trained doctors, often based on cultural misunderstandings but often demonstrating blatant discrimination, racism and prejudice. 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!

This culture is already partially explained in above points and often leads to great uncertainty for OTDs with many negative consequences:

Job insecurity (discussed above)

Financial hardship

Fear to speak up

Exploitation

Discrimination

Frustration, despair and often manifest depression

RECOMMENDATION: Acknowledging and directly addressing discriminatory attitudes, at both the personal and institutional level, would help to alleviate the above listed problems and improve the plight of OTDs. Real change would require a significant culture shift in many hospitals in Australia.

7. General practice: general practice is probably the area where most OTDs finish up to work, although it is probably the area of most confusion with many different organisations involved and available for OTDs like the Royal Australian College of General Practitioners (RACGP), the Australian General Practice Training (AGPT), the Australian College of Rural and Remote Medicine (ACRRM), the Rural Workforce Agency (RWA), the Rural Locum Relief Programme (RLRP), Accredited Medical Deputising Services (AMDS) and Aboriginal Health Centres, complicated by “area of need” regulations, different rules in different states, PESCI requirements and the planned introduction of work place based assessment pathways at least in ACRRM.

- ISSUE: confusion

The multitude of organisations involved in engaging OTDs in general practice is a very confusing labyrinth and difficult to navigate for most OTDs.

RECOMMENDATION: Urgent review of the role of these organisations with the aim to simplify the process of entrance into general practice.

- ISSUE: exploitation
There is clear exploitation of OTDs in some practices and clinic organisations by coercing them to work long and unsocial hours. Practice managers often require commitment to long term contracts which do not explain the unfavourable working conditions and then threaten the OTD if they try to break the contract. There are also questionable practices by some migration and recruitment agencies persuading OTDs into expensive contracts.

RECOMMENDATION: a centralised agency which provided appropriate information would help to prevent the exploitation of vulnerable and poorly informed OTDs and could provide support for vulnerable OTDs when they meet difficulties.

- ISSUE: 10 year moratorium
The 10 year moratorium is considered by many OTDs as discriminatory and unfair practice in comparison to their Australian colleagues.

RECOMMENDATION: review of 10 year moratorium.

8. GENERAL INFORMATION FOR OTDs:

- ISSUE: fragmentation of information
Sources to obtain information are currently very fragmented and there is no single web site or organisation which provides comprehensive information for OTDs including warnings of the pitfalls and potential difficulties and time delays regarding the whole process.

RECOMMENDATION: creation of a single point of comprehensive information (central agency) similar to the Victorian trial with setting up the 'International Health Professionals Victoria' office.

9. CROSS-CULTURAL UNDERSTANDING:

- ISSUE: cultural misunderstandings
The current system does not appreciate the importance of the extent of cross-cultural misunderstandings compounded by the complexity of OTDs being an incredible heterogeneous group which is not recognised by the examination process, the health care system and the OTDs themselves.

RECOMMENDATION: consultation with experts in cross-cultural issues and inclusion in all aspects of the immigration and integration process.

COMMENTS FROM OTDs SENT TO ME IN E-MAILS:

Re. 1. Role of the Australian Medical Council (AMC):

-what's most frustrating for me is the very long waiting time to sit the Clinicals. Like I passed the MCQ July 2009 and still I haven't been allocated a place. I prepared very well for it, so I think my ranking was okay (49/522). The long waiting period even adds to the time I have been out of practice.
- The AMC clinical exam was a disappointment! Not my result, but the exam. The actors were poorly trained and examiners attitude varied, not one as encouraging as the gentlemen in the official AMC video.
- ...at the end they don't give you a proper feedback to give you some insight about your weak points.
- The AMC FEEDBACK broadly categories yr performance under various subheadings like history/ examination/communication/ Diagnosis and management etc. In how many station u did this or that . BUT WORSE THING IT DOESN'T PINPOINT YR MISTAKE /CRITICALERROR ON THE BASIS OF WHICH YOU FAILED THAT STATION, WHICH I THINK IS RIDICULOUS.

Re. 2. VISA REGULATIONS

- we don't dare to say anything because we don't have permanent residency we all are on work visa if we resign we have to leave Aus in 4 weeks!
- the biggest problem for me is to get the permanent residency, and as the policy has been changing all the time and I feel really frusutrated and to me, it is kind of unfair that those international students who study cooking or other courses can easily get their permanant residency, and for the IMGs, who studied much longer than those students, and it is more difficult for us to get PR.

Re.3. BRIDGING COURSES

- There are currently very few courses available for IMG's,if they want to take up any. and the ones that r available,are not supported by the commenwealth so they r really not affordable by everybody.
- As bridging courses are expensive for most of the IMG's some financial help will go a long way in helping the IMG's
- If we could enroll in bridging course training and then 3 months hospital based training program or observer-ship to everyone then I am sure we would nicely fit in without any problem.

Re. 4. TRAINING/ HOSPITAL POSITIONS

- In one particular occasion, I went to see a HMO manager, the person was very reluctant to even take the resume. At last she took the resume, told on my face "we receive at least 30 of these kind of resumes everyday and threw it into bin in front of me". On that day, I felt that I made a wrong decision coming to Australia.
- Since I started working in May last year, I haven't stopped requesting surgical rotation, but I just found it's so difficult and so frustrating for IMGs.....
- IMGs always get the marginal rotations or the least popular rotations (like nights, relieving, psychiatry, palliative care, ED, rehab).
- They can't pay us less than the minimum salary for HMO1 because it is not legal but on the other hand they just abuse us by giving the most difficult and unpopular rotations and lots of night shifts and at the end of the day they create lots of stress for us.....
- If we complain no one will give us a job!
- Although the psychiatry doctors can manage any amount of work load or service issue , they are not given the opportunity to work in medical or surgical jobs which is essential for general registration with the board.
- As there is a matching for Australian doctors similar thing should be for IMG's rather than calling each and every hospital as it will become more streamlined and easier for doctors, HMO Managers and hospitals.
-but I feel if i had just a bit more supervised support in Base hospital then I would have passed the exam in first go. I was working for about 6 months as an ED HMO with absolutely no supervisor on floor with me- just myself and a nurse; seeing about 15-20 patients per shift.
- My brother (he is a surgical reg with), was told initially by his bosses and the RACS that they will assess his overseas surgical training and let him appear for the Basic surgical training exam directly, and he need not bother about AMC exams. This was way back in 2005. However, after nearly two years of working as unaccredited surgical registrar, he was told that the rules have changed and the BST-AST model has been replaced by SET training. Moreover, he was then told that he has to pass his AMC exams (both MCQ plus clinicals) if he intended to enter the SET training. This took him another two and half years before he could get General registration and then get into SET training; i.e total of nearly 5 years since he first came to Australia.
-all friends says don't dream to be a pediatrician or urologist or ENT or any surgical specialties because you will waste your time.

Re. 5. English language testing

- In 2004 when I sat for the OET exam I obtained 3 B's and 1C. Thereafter, I basically lived mostly in Australia and attempted the OET exam and obtained A, B, C, D etc. Every time I attempted the OET exam my results sometimes went from "A" to "C" and some times from "C" to "A". There was no rationale in results at all. It is impossible for someone to obtain an "A" for writing and then when the exam is held on the following month to obtain a "C" for writing.
- I wish to ask from OET how come someone's "A" changes to a "C" at the next exam? Does that mean the applicant has lost the English touch in a short time frame living in a English speaking country?
- I came here four years ago with an over-all IELTS band score of 8. I took the OET in March 2008 and got A on all subsets. That OET result was valid until May 2010. I got my MCQ pass result in June 2010. Unfortunately, I fell victim to the so called "Expired English Club" which I think a lot of IMG's have found themselves in at some point in time. Realistically, I think this is one area which most of the IMG community find challenging.
- I agree it is good to expect you have reasonable understanding of English, before you work here, by the IELTS exam, but I do not understand why should it EXPIRE after 2 years even if you are living and working in Australia? I doubt if 50% of the Aussies would be able to score 7 in IELTS, academics!!!! I myself have done IELTS twice and scored more than 7 each time however, after passing the AMC and required to apply for a permanent residency, I was told that my IELTS again EXPIRED and I needed to do again fresh.

Re.6. Medical system culture

- The introduction of Competent Authority Model of the AMC is actually discriminatoRy and an insult to IMGs who are already an Australian Citizens, working in the Australian Health Care system as a doctor on a limited registration and couldn't get a Full registration because of the flaws and problems arising with the current AMC Examination the Clinical Examination in particular.
- ...even though I perform as best as I can , still there's a feeling of if I make a mistake, I might have to go back.....when local graduate make mistake, the publications are not as full on as if the IMG's make it.
- Whilst in process of getting a job, I used to see many HMO departments. In one particular occasion, I went to see a HMO manager, the person was very reluctant to even take the resume. At last she took the resume, told on my face "we receive at least 30 of these kind of resumes everyday and threw it into bin in front of me". On that day, I felt that I made a wrong decision coming to Australia. I hope you can understand the intensity of trauma. And almost all of the occasions, when I give a resume and meet them again to follow up in a week, they dont have my resume. So, it already went into bin but the good thing in these occasions is that they didnt throw in front of me.

- I would like to emphasize on the HMO office and nurses are the main problem for the IMG
- Some of the nurses are so much dominating that sometimes advising any treatment is a challenge for me, even some nurses talk with us in a rude way. They will make complaints to our supervisor behind us. this is like a back-stabbing. I must say local graduate interns could be very bossy to HMO2 IMG. I did prove myself to be competent to them and they stopped treating me like an alian afterwards. I have seen many of IMG colleagues who were bullied by ED nurses and some even shed tears. It will take at least a few months to endure all of these working environment.
- when I come to Australia thinking I will live in a civilized community and multicultural but from beginning of my work I faced and still facing harassment from three places

- 1- Nurses
- 2-HMO office and people who arrange roster or rotation
- 3-Few Australian doctors who hates the IMG.

Re.7. General practice

I had a couple of meetings with Dr. "ABC" ("XYZ –a migration agent" told me that Dr. "ABC" was a professor in Monash University). In the first meeting he had a bit of a chat with me regarding my Australian experience and about gp experience back home. He took my CV and promised me to help get my overseas general practice experience assessed by RACGP. In the second meeting with Dr. "ABC" he offered me the position. He said that I will have to work 45 hours a week and these hours I have to work after 5pm. He offered me \$ 85000 per year. He said if I am happy talk to "XYZ" and proceed with her. He also said that I have to sign the contract for five years. "XYZ" said she will arrange another meeting with prof and then I can sign the contract with prof and her. I then asked her to send me the contract so that I can go through it thoroughly before signing. Then she sent me that letter (see below). Then I said that is not what I want and i asked her to send me contract which explains my job conditions, including salary, leave, what hours etc. Then she said prof is unable to give such a letter because he is just trying to help me. Then I said I cannot proceed this without a written job letter.

Agreement for the client to assist in the recruitment & visa process

This agreement is between

.....
 Of
 Contact.....
 Email.....
 Hereafter referred to as 'Client'.

and
 "XYZ" n on behalf of "EFG" Migration
 Hereafter referred to as 'Agent'.

1. Who will act for you
 "XYZ" is a registered migration agent (MARN), regulated by the Migration Agents Registration Authority (MARA) of Australia.

**** Fees and charges:**

Government fees as required at different stages will be notified via telephone or email. *Please note that government fees may change at any time without prior notice.*

Total service and consultation fee – \$10,000.

Consultation fee is payable in any of the following plan.

1. 25% of the total amount when signing agreement
Remaining 75% be paid after commencing work fortnightly in 3 months
2. 25% of the total amount when signing agreement
Remaining 75% be paid after commencing work fortnightly in 4 months
3. 10% of the total amount when signing agreement
Remaining 90% be paid after commencing work fortnightly in 2 months
4. \$..... upon signing agreement
Remaining \$..... paid after commencing work fortnightly in 3 months

J.Wenzel: This OTD had considerable overseas GP experience and within 3 months of the above episode got the overseas general practice experience assessed by RACGP as having GP experience of more than five years. Based on that the IMG was offered another position in another medical group. The OTD found they were very genuine and they offered a very good salary (\$ 80 per hour) compared to the previous!!!

Re. 8. GENERAL INFORMATION FOR OTDs

- I think the most difficulty of being an IMG is lack of support and resources. More specifically, is lack of direction. Without knowing whether we are needed or not, and where we will be needed are very frustrated.
-because I believe they don't have a proper support here in Australia... I believe To make a committee or even a Web site for the IMG to make our voice more effective and powerful

Re. 9. CROSS-CULTURAL UNDERSTANDING

-furthermore, there are the new set of system, of values, language, laws, routine and culture as a whole that has, in one way or another, affected each one of us psychologically, physically and emotionally.