Submission No. 101
(Overseas Trained Doctors)
Date: 23/02/2011

GUILTY UNTIL PROVEN INNOCENT

The system for the registration and accreditation of International Medical Graduates (IMGs) in Australia

The Inquiry into Registration Processes and Support for Overseas Trained Doctors
Prepared by the Australian Doctors Trained Overseas Association (ADTOA) for
The Committee on Health and Ageing
Australian Parliament – House of Representatives

February 2011

Acknowledgements: We would like to thank Marg Talliday and Dr. Robyn Iredale for their contributions to this submission. We would also like to thank all the overseas trained doctors and other Health Professionals who shared their stories with us.

EXECUTIVE SUMMARY

INTRODUCTION:

1. We thank the committee for engaging in this hearing but also ask that they reflect upon the question of why there have been so many prior investigations, with so little change – resulting in the need for these proceedings.
2. Overseas-born doctors / overseas-trained doctors / international medical graduates make up an estimated 25% of the overall medical workforce of Australia, rising to 41% of the rural/remote workforce – and as high as 52% in parts of W.A. We are truly the backbone of much of Australia's medical system.
3. As thanks for almost a decade-and-a-half of our work, we are still subject to discriminatory legislation and increasingly unfair procedures.
4. There is a requirement for greater transparency and oversight of the Australian Medical Council, alongside a comprehensive review of its current procedures and perceived role in the future.
5. Despite our representation in the medical workforce, overseas-born doctors are unrepresented in a meaningful way within AHPRA. This desperately needs to be corrected.
6. The Colleges currently have the dual role of both assessing overseas-born doctors' qualifications and taking responsibility for their members' interests – part of which involves limiting competition for members' medical services. This is a clear conflict of interest.
7. We contend that the AMC, Colleges and AHPRA act as a closed shop, when it comes to overseas-born doctors. Despite the anticipated arguments to the contrary, the facts, numbers and individual submissions speak for themselves.

PART ONE – BACKGROUND TO THE INQUIRY

HISTORY:

1. The historical treatment of immigrating doctors by the Australian authorities, colleges and associations has been openly xenophobic and racist.
2. Apart from the heavy moral, pragmatic and legislative onus on this Hearing to correct the system as it now finds it, there is also a responsibility to address this historical 'inheritance'.

3. Prior examinations of the current system facing immigrating doctors have failed to make substantial and positive changes. This has been deleterious to both the overseas-born doctors and the Australian (especially rural) public.
4. Official response to the 'Bundaberg/Patel' affair concentrated on the practitioner. This emphasis has informed both the systemic and public response, with a strong focus on the fact that he was overseas-born. This fact has been used as the basis for the argument supporting the current PESCE fiasco. However, the huge part played by Queensland Health in the tragedy has not received similar attention.
5. IMGs are at increased risk of professional mobbing where they are targeted by their peers for malicious purposes. Motives include greed, professional jealousy, and perceives threat to position of authority. Professional mobbing is not infrequently a death blow to a doctor's career.
6. The inbred nature of the Australian medical system ensures that a small cabal of influential people and organisations (who themselves suffer conflicts of interest) are able to influence an IMG's future at every level of the registration and accreditation system. This enables the ongoing prejudice, exploitation and abuse of IMGs.

THE CURRENT REGISTRATION AND ACCREDITATION SYSTEM FOR IMGs

1. Registration and accreditation of IMGs rests with three organisations: a) The Australian Medical Board b) The Australian Medical Council c) The Australian Specialist Colleges.
2. PESCIs were introduced in 2008. These "screening" tests were never intended to assess the competency and skill of IMGs already working in Australia.
3. A major concern about the Medical Board is the issue of its composition and membership, which has largely consisted of members of the AMA, AMC and Medical Colleges. This lacks of any independence of view that arises from such an enmeshed relationship between these organisations.
4. *I*n 1998, a report entitled *'The Race to Qualify'* described the treatment of IMGs by the NSW Medical Board as "...unfair, unreasonable, and prejudicial...". We can see no evidence, given the need for this hearing and the submissions received, of any change to this stance in the past thirteen years.
5. AHPRA represents a lost opportunity to improve the registration/accreditation system for IMGs and Australia. The spirit of an impartial registration and accreditation body as described in the intergovernmental agreement that laid the groundwork for AHPRA was not translated into the National law which governs the actual composition and processes of the Board. Hence Board composition is as incestuous as was previously seen with the state boards.
6. There are multiple concerns about the AMC, in terms of procedural and assessment fairness, validity of assessment methods, discriminatory practices and policies, lack of public accountability, complex and dysfunctional bureaucracy, and absence of independent view.

7. The *'Race to Qualify'* report voiced a number of serious concerns about the AMC processes for the assessment of IMGs. The report concluded that it was unfair in that it established harsher requirements for IMGs than Australian trained students. This remains unaltered since 1998.
8. Specialist Colleges determine the standards and processes for the assessment of IMG specialists including General Practitioners in Australia.
9. The Colleges - like the AMC - are private, member-based organisations. As such, their primary goal is to represent the interests of their members. Past reports have voiced serious concerns that the criteria and processes used to accredit IMGs have been largely influenced by organisational self-interest in contrast to professional standards.
10. Given that these organisations are private organisations, they are largely free to set their own rules. Consequently, there exists no meaningful avenue to challenge unfair and/or irrational policies and treatment.
11. College censors are not required to have any formal higher qualifications in Medical Education. This raises a critical question as to whether these people have the necessary knowledge and skills to be able to validly assess the complex issue of qualifications of doctors who have trained and been assessed in multiple different systems.

ENGLISH PROFICIENCY REGULATIONS AND OCCUPATIONAL ENGLISH TEST (OET)

1. Many IMGs and other health professionals need to put their careers on hold for many years while they struggle to pass the OET test
2. There is a lack of transparency regarding OET processes and results
3. The pass rate for IMGs increased in 2008 making it much more difficult to pass. A number of IMGs who passed the test prior to 2008, and or took another approved English test, have been deregistered because they cannot achieve the new standard.
4. The rationale for raising the test standard is unclear and has been proposed to be a backdoor form of quota to limit numbers of IMGs entering the workforce.
5. The reliability (reproducibility) and validity of the test are questionable.
6. Many Health Professionals are subject to degrading treatment and difficult testing conditions which have the potential to impair their performance
7. Many Health Professionals spend many thousands of dollars on the OET and other tests
8. Many Health professionals have reported unfair test conditions including poor audio and role-playing.
9. Candidates do not receive meaningful feedback on their performance
10. The listening sub-test is highly affected by factors other than English proficiency, particularly short-term memory
11. The OET policy discriminates against doctors with conditional registration who in contrast to IMGs with unconditional registration, need to continue to prove their proficiency in English!
12. The OET test is a revisit to the White Australia where immigrants were tested in Gaelic

s19AB & s19AA – HEALTH INSURANCE ACT, 1973

1. s19AB forms the legislative background for the ten year moratorium.
2. s19AB is discriminatory and contravenes s10 of the Racial Discrimination Act, 1975.
3. The ten year moratorium that results from s19AB has – perversely – served to *relatively harm* the provision of a regional medical workforce, in comparison to how rural health provision may well have appeared today had an alternative path to s19AB been pursued in 1996.
4. The effect of s19AA also contravenes s10 of the Racial Discrimination Act.
5. s19AB and s19AA both serve to restrain trade and, thus, contravene s2A of the Competition and Consumer Act, 2010.
6. New Zealand overturned an analogous system to that legislated for by s19AB in 1998 – for exactly the reasons above. Why is Australia lagging behind its neighbour by thirteen years?

ADTOA's PROPOSAL FOR A FUTURE RURAL MEDICAL WORKFORCE

1. Mass utilisation of IMGs as Australia's current workforce solution is in flagrant breach of our World Health Organisation commitment regarding the migration of medical practitioners. This moral issue, that is directly resulting in deaths in developing countries, *must* be resolved.
2. We recommend that s19AA is critically (and speedily) appraised and revised, in terms of its unequal effect on Australian-born and overseas-born doctors.
3. ADTOA advocates that s19AB be removed from the statute books in a graduated fashion, as an alternative rural workforce provision model is instituted.
4. We recommend that this workforce model be based upon a significant weighting in favour of the rural component in the ratio of rural:metropolitan postgraduate medical training places.
5. The building blocks for this have been in place for some time. There are a number of schemes that function exceedingly well and already deliver excellent quality rural training.
6. There are recognised and substantial clinical benefits for junior doctors who are exposed to rural/remote training – with enhanced opportunities for acquisition of knowledge and clinical upskilling.
7. The implementation of such widespread rural training of junior doctors may well provide a distinct 'flow on' boon to metropolitan practise – with an anticipated reduction in reliance on tertiary and Emergency Department care - upon the return of many of the practitioners from the bush.
8. There are also quite obvious rejuvanative rural community effects with the provision of a widespread, sustained and high quality medical workforce.

PART TWO – GUILTY UNTIL PROVEN INNOCENT – THE EXPERIENCES OF IMGS IN AUSTRALIA

The following describes the experiences of a sample (35) Australian IMGs with the Australian system. These doctors represented a wide range of specialists and primarily worked in rural and/or regional Australia.

1. **The majority of IMGs reported significant personal, professional and financial hardships as a result of their experiences with the Australian registration and accreditation system.**
    - Many described the devastating effect on their families, particularly their school aged children who perceived themselves as Australian.
    - A number had to leave the country after dedicating many years of service to rural Australia
    - Many were not in a position to appeal the Medical Board's decision because they were on temporary visas and/or could not afford the tens of thousands of dollars needed to appeal
    - Many described being out of work for months to years as a result of decisions made by the Medical Board(s), and/or Colleges.
    - A number described devastation of their career as a result of the system
    - A number described significant stress arising from feelings of uncertainty about their personal and professional futures.
    - A number described feelings of isolation and lack of support
    - Many described severe financial hardships as a result of their experiences, some spending all their life's savings
    - The financial costs involved in registration were considerable and exacerbated their financial hardships
    - A number expressed anger and disgust at Australia's uncaring treatment of IMGs, particularly given their contributions to rural and remote Australia
2. **Many IMGs reported the development of serious health problems that they attributed to extreme stress arising from their experiences to the system, including severe depression.**
    - Many described symptoms of mental illness particularly depression. At least one described suicidal ideation.
    - Two developed new chest pain that they had not had before they had difficulties with the system
    - A number described health problems in family members as a result of their experiences
    - A number described the stresses involved in needing to study for exams in relation to their age and their workload

3. **A number of IMGs described being the victims of discrimination and exploitation.**
    - A number described significant differences in working conditions for IMGs and Australian trained doctors (ATDs) where IMGs had to work much longer hours for considerable less pay than ATDs
    - Some described slave labour-like working conditions
    - Some were threatened with revoking visas if they did not comply with unfair work demands
    - Many described their inability to complain about working conditions because of their vulnerable position in Australia
    - Some described the condescending attitudes of Australian trained doctors with whom they worked
    - Some described feeling being used by Australia and then tossed aside when no longer needed
    - Many expressed the unfairness at the differences in standards expected of them and ATDs particularly with respect to the need to do exams and PESCIs
4. **Many IMGs expressed their frustration at what was described as the "shifting goal post syndrome".**
    - A number complained of having their conditions for registration change suddenly and without notice on multiple occasions since starting to work in Australia
    - Many believed that the changing rules were motivated by factors unrelated to standards particularly concerns about competition.
    - A number described feeling mislead about the conditions of employment which changed AFTER their arrival in Australia
    - A number complained about the Colleges changing their requirements for fellowship after they had applied and/or entered into employment contracts.
    - Many described the devastating impact of changes to the English language proficiency rules on their ability to gain access to the Australian workforce
    - Some believed that Australia was misrepresenting itself to the rest of the world, when it came to disclosing the requirements for registration for IMGs.
5. **Many described what they perceived to be seriously flawed and/or unfair assessment methods**
    - Many believed that the PESCI exam was an inadequate, unfair and invalid measure of their clinical skills and knowledge
    - A number complained about the lack of fair due process with regards to the PESCI in that they were not recorded and/or transcribed
    - A number complained about the lack of validation of the PESCI tool
    - Some reported serious mistakes made by the PESCI panelists. (I.e., panelists not the IMG were in error)
    - Many reported frustration at not being able to meaningfully appeal against unfair decisions with regards to assessment decisions.

- Some described failing their exams (esp. FRACGP) by very small margins and ever shifting pass marks
- A number reported inadequate feedback about their performance that would enable them to improve
- Some reported inappropriate questions did not reflect their clinical position (i.e. skin cancer doctor being asked question about unwanted pregnancy in an aboriginal girl)

6. **Many discussed a range of other problems with the Australian system including lack of fair due process, procedural fairness and access to a meaningful appeals process particularly with respect to the Colleges and Medical Board(s)**
    - A number of IMGs reported that the Colleges ignored their appeals (and/or failed to respond for unacceptable periods of time)
    - A range of serious irregularities were reported by IMGs regarding the Colleges accreditation processes including "missing documents" changing wording of key policies, major marking mistakes and frustration in being able to have these problems adequately addressed
    - A number reported being denied the opportunity to appeal
7. **Many expressed frustration at the lack of acknowledgement of their previous experience and qualifications**
    - A number of IMGs reported that they were not given any and/or minimal credit for their clinical experience (15-26 years) by the Colleges even when it involved working in Australia.
8. **Many reported being subject to unreasonably harsh and/or rigid rules**
    - A number of IMGs reported being deregistered for failing a PESCI even though they had passed all or parts of the RACGP exam
    - A number reported that the Medical Board insisted on doing PESCIs even though they were in the process of doing their fellowship exams.
    - A number of IMGs were deregistered and/or denied registration because of delays in sitting the OET (long wait lists) even though they had already passed an English test in the past and were working as health professionals in Australia. (See OET section)
9. **A number of IMGs reported a lack of educational support to achieve Australian qualifications as well as difficulties in taking time off to study and prepare for exams.**
10. **Many IMGs reported a wide range of obstructive registration/accreditation policies, processes and rules including:**
    - Needing to provide multiple copies of original documents and spending countless hours on paperwork.
    - Impossible requests for documentation – i.e. the need to provide certificates of good standing from dysfunctional war torn countries and proof of high school education in English from schools, which have since closed.
    - Needing to get original documents including those in Latin translated by "official translators"

- Catch 22 situations – i.e. unable to register with Medical Board until assessed by College, unable to apply to College until registered with a Medical Board
- Problems with attaining required clinical oversight
- Inability to acquire necessary training/procedures required by Colleges to attain fellowship

11. A number of IMGs have highlighted the inconsistencies and contradictions in the system including

- The fact that the Colleges defend the importance of maintaining their "standards' for public safety and yet it is extremely difficult for IMGs to get Australian specialists to adequately supervise and/ orient/mentor IMGs to the Australian healthcare system.
- That a doctor can be deregistered for failing a screening exam but at the same time has demonstrated their competency by passing an Australian fellowship exam
- That IMGs with conditional registration need to prove their proficiency in English every two years but those with unconditional registration don't.

11. A number reported workplace bullying, some of which interfered in their ability to be registered as well as causing significant psychological and/or physical distress.

12. Many IMGs described the valuable contributions they had made to Australian society from a professional as well as personal perspective

<u>Conclusions</u>

- **The experience of IMGs in Australia is one of being found guilty until proven innocent.**
- The experiences of IMGs reveals an unpredictable, dysfunctional and uncaring system which destroys careers and families
- Many of the concerns and/or problems reported by this sample of IMGs are similar if not almost identical to those described in previous government reports
- These problems have continued to fester because subsequent governments have failed to address the root causes of the dysfunction: lack of public accountability, conflicts of interest, and discrimination and prejudice.
- The evidence is overwhelming that the current system is largely shaped by organizational self-interests and dysfunction - not standards.
- The experiences of IMGs described in this submission do not support the Medical Board claims that a risk-based approach governs individual registration decisions. (I.e. experienced Australian GPs deregistered for marginally failing an English test)
- **What hurts IMGs- hurts rural Australia!**
- The health of rural Australians is being seriously impacted by the current system

- The government has a moral duty to take action to finally address the root causes and create a system that is fair for IMGs and rural Australia.

Introduction

The Australian Doctors Trained Overseas Association would like to thank the members of the inquiry committee for their participation in this important inquiry. This is a vital opportunity for international medical graduates (IMGs), which include overseas-trained doctors (OTDs) as well as overseas-born doctors (OBDs) to share their experiences of the current registration and accreditation system (hereby referred to as the system) and its impact on their professional and personal lives. While IMGs represent a diverse group of doctors, we all share the common problem of unfair discrimination based on our qualifications and/or our nationality.

We also appreciate the opportunity to propose our recommendations as to what we believe is needed to build a fairer and more effective system for IMGs and Australia. We want to stress to the committee that the problems, which have lead to this inquiry, are not new. The core problems with the system are well described in numerous other reports commissioned over the past twenty-five years. 1i 23456We would ask that the committee members carefully reflect on the reasons why these recommendations have been largely ignored.

Australia is heavily dependent on IMGs who make up at least a quarter of the Australian medical workforce, and as high as 50% in the rural areas. 7 IMGs constitute the backbone of the Medical system in rural and remote Australia. Hundreds of thousands of Australians are dependant on IMGs to provide critical medical services to Australians in areas where the vast majority of Australian-born doctors are unwilling to work. As thanks for their decades of invaluable service to Australia, IMGs have faced unfair discrimination, suspicion and exploitation for over a century. These problems are alive and well at the dawn of the twenty-first century. Not only has this unfair and discriminatory treatment caused widespread suffering for IMGs and their families, but has also put the Australian public at risk by denying them critically needed medical services.

One of the terms of reference of the present inquiry is:
"To help IMGs and the Australian public better understand the current standards, processes and policies that inform the current system."

One of the main goals in this submission is to provide a clear description of the forces which have shaped, and continue to shape, the current system. If we use the analogy of a tree, with the standards, processes and policies as the fruit of that tree, our goal is to show that the roots are rotten and why no amount of pruning and spraying will change the fact that the fruit will continue to be rotten. The only solution lies in digging up and destroying the rotten roots.

We will also show that the biggest victim of this tragedy is not the IMG group, but the Australian public who have been deprived of the services of highly skilled doctors at a time of critical shortage. In addition, the system has driven away or suppressed doctors with extraordinary skills and knowledge who could have significantly contributed to the advancement of Medicine in this country.

So what are the poisonous roots? The current pathology that has caused this sick system stems from four basic causes:

1. Unfair prejudice and discrimination
2. Lack of external accountability and external view
3. Conflicts of interest
4. Lack of IMG representation

Unfair Prejudice - Unfair prejudice has been the primary shaper of the current system. History has shown that IMGs have been unfairly labelled as incompetent and untrustworthy by the Medical establishment since before the outbreak of World War One. 8 The intentional spread of misinformation and suspicion by the Medical system has generated widespread fear and distrust of IMGs amongst the Australian public. This has enabled the ongoing discrimination and exploitation of IMGs in Australia. 9

Unfair prejudice has been a difficult problem to address because it goes unacknowledged and is widely denied by the Medical establishment who continue to propagate irrational fear and about the competence of IMGs in the public arena. The unspoken assumption is that IMGs, particularly those from non-English backgrounds, are inferior in skill, knowledge and character to Australian doctors. While there is some basis for concerns about the quality of education and training in some countries, this does not explain the irrational red tape and accreditation hurdles that IMGs are forced to navigate to prove their competence. 10

Lack of public accountability and external view *"Power corrupts: absolute power corrupts absolutely."*
The problems of a lack of accountability and external view are major contributors to the unfair treatment of IMGs in Australia. At present, the key medical organisations that make up the system - the Medical Board(s), Australian Medical Council (AMC) and Specialist Colleges - wield absolute power over the ability of an IMG to gain entry to the Australian medical workforce. Until very recently, this power was absolute and enshrined in legislation. Currently, there are no effective measures in place to ensure that these groups are accountable to the Australian public or IMGs for their policies or actions despite the fact that these policies significantly impact on the health of Australian citizens, particularly those living in rural Australia. Also, there is no independence of view as the members of the key decision making bodies are largely composed of representatives of the other groups. For example, in the past, many of the Medical Boards largely consisted of representatives of the Specialist Colleges and AMC. The system defends the lack of public accountability as necessary to maintain professional "independence". The term

"independence" is a misnomer, however, as there is no independence from the influence of these major medical power brokers on the professional lives of IMGs

Conflicts of interest -. There is a strong conflict of interest inherent in having these groups, particularly the Colleges, assess the qualifications of IMGs who are potential competitors. It needs to be acknowledged that Australian doctors see IMGs as potential threats to their income and positions of power. From a legal perspective, organisations like the AMC and Specialist Colleges are on par with a bowling club. As private member-based organisations they can set their own rules, with the government having no right to interfere in those rules, which are solely the clubs' business. Similarly, it is not against the law if a bowling club has silly unfair rules. There is no discernible legal difference between this, the AMC or specialist colleges.

A major goal of the Colleges is to ensure that their members' income and authority is protected. It is impossible in the current system to prevent these influences from directly impacting on the assessment of IMGs. The end result is that the assessment process reflects professional self-interests as much - if not much more than - professional standards. This is not a hypothesis but a statement of fact which has been repeatedly criticised11, 12 this problematic arrangement is quite unique to Australia. In countries like the UK, Canada, US and New Zealand, private based organisations do not play a direct role in the accreditation process. This role is designated to organisations that are under direct legislation. One of the key reforms, which must occur, is that any organisation that plays a significant role in registration/accreditation must come under legislative authority. It will also be critical to establish clear standards for accreditation to which these organisations must adhere.

Lack of IMG representation - These organisations' monopoly over professional power is enabled by the final root cause of the problem, the fact that IMGs have absolutely no voice in determining the processes and policies that dictate their professional future in Australia. Currently, there are no official IMG representatives on any of the major accreditation or political bodies including the Medical Board, AMC council or any of the College's Boards of Censors. We make this statement as the national body representing IMGs in Australia and the fact that we do not have any representation in these colleges, boards or councils. Given that IMGs make up fully a quarter of the entire medical workforce, there will be IMGs in positions of authority in these organisations but they do not represent the interests and views of IMGs as a group.

It is impossible for IMGs as individuals to meaningfully address problems with the system, as there are strong deterrents in place to actively dissuade IMGs from making any criticisms. Currently, IMGs who complain and/or stand up for their rights face the possibility of professional mobbing, de-registration and/or the destruction of their professional careers. Currently, workplace bullies can easily manipulate the system to discredit the competence of IMGs particularly in the absence of effective appeals processes. Fear of reprisals by powerful organisations and individuals is a major barrier to gathering information on the severity and scope of the problems. Not surprisingly, those that have been

subject to the worst treatment are also the most vulnerable, and the least willing to speak up about their experiences.

In the weeks to months to come you will likely hear from very senior and respected representatives of the various Medical Registration and Accreditation organisations including the Medical Board, AMC and Specialist Colleges. Many will argue that the current processes and standards and processes are necessary to protect the Australian public and that the role of their respective organisation(s) must be sustained and supported. Many will actually believe this to be true.

We argue that not only does the government have the responsibility to intervene in the matters of the Medical Board, AMC and Colleges based on the principles of fairness and human rights but that it would be in breach of its own laws not to act. We also argue that the evidence does not support allegations that the current system is necessary to protect the public but rather supports the contrary – that the system puts the public at unnecessary risk by denying them the services of doctors who provide critically needed medical services. We would argue that rural Australia has borne the brunt of these problems and that urgent action is needed to return those doctors who have been unfairly withdrawn from the workforce to their communities.

We will provide evidence that these organisations have already been given fair notice of these problems and have failed to satisfactorily address them. Also, we argue that the government *does* have options and does not need these political bodies to create an effective and safe system for the accreditation of IMGs – especially if these organisations continue to fail to address the key problems and issues raised by the public and IMGs.

Our submission is divided into three components. The first part provides important history and background information needed to understand what has lead to the current situation. The second part deals with the current problems and IMGs' experiences with the system. The third part summarises the evidence for the breaches in national and anti-discrimination law and ADTOA's conclusions and recommendations for the future.

In closing we would like to again thank the members of the committee on behalf of all international medical graduates and overseas born doctors for their time and efforts to improve the system for these doctors and Australia.

The History of IMGs in Australia

History shows that the current system has evolved to protect the professional interests of the Australian medical profession, not the health of the Australian public. Since the beginning of federation to the present day, the Medical Establishment has used its influence to spread fear and misinformation about IMGs in the public arena, which has created the current system, which continues

to enable the exploitation of, and discrimination against IMGs. The most influential Medical group in the early twentieth century was the British Medical Association, the precursor to the Australian Medical Association. The BMA wielded enormous political clout and was one of the most powerful political forces in early Australia. The leaders of the BMA were insular, xenophobic and protectionist. The BMA intentionally maintained a small number of doctors to protect their high income. They viciously attacked the character and competency of IMGs to block entry into the Australian workforce to maintain their small numbers even though the shortage was causing suffering for Australians. The first orthopaedic surgeon in Australia was expelled from the BMA for being of German descent despite the fact that he had lived in Australia for over 20 years. New South Wales maintained a ban on German doctors for over twenty years after World War One and, ironically/farcically only changed their policy after Nazi Germany protested Australia's "discrimination against its citizens" in 1938. 13

The treatment of Jewish IMGs fleeing Nazi Europe in the 1930s and 40s by the medical establishment has been described as "intellectual barbarism". Approximately 300 refugee doctors from Germany, Austria and central Europe fled to Australia. Australia was trying to increase its population at the time and advertised that it recognised the qualifications of foreign professionals to encourage skilled immigrants to migrate to Australia. Consequently, these doctors migrated to Australia under the impression that they would be able to practise their chosen profession in this country. The failure to disclose the barriers to entry to the Medical workforce to IMGs considering coming to Australia continues to be a major problem today. 14

This expectation could not have been further from the truth. The BMA used their influence to spread misinformation and fear about these "outsiders". They openly labelled these doctors as "incompetent, unethical and dangerous". The BMA refused to acknowledge any of their experience or qualifications as It was common knowledge that their qualifications could be purchased on the black market..."
Sir Raphael Cilento, president of the Queensland Medical Board, had this to say about the immigrant doctors:
"If refugee doctors were permitted to go taking jobs along the Queensland coast, they would create the same situation that caused them to be thrown out of Germany and Austria". 1

Not surprisingly, the BMA voiced no objection to these doctors working in a select number of posts where the work was extremely difficult and the pay low, including positions in New Guinea, Antarctica and some outback posts. The OTDs who worked in these hardship positions gained widespread respect for their knowledge, skill and work ethic amongst their Australian colleagues who worked alongside them. Still, the Australian Medical Boards who were controlled by the BMA at the time, refused to give them any credit for their

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1 Kamien, Max. "The History of Overseas Trained Doctors in Australia". 2007

experience. Of the 300 refugee doctors who emigrated in the wake of World War Two, only a small handful were able to work as doctors, most of who worked in immigration centres. Many more of these doctors ended up working in factories or as orderlies in hospitals. A number of these doctors committed suicide. 14

In the mid to late 1950s there was a relaxation in the registration of foreign trained doctors as a consequence of critical doctor shortages. Each state had its own criteria and processes for "conditional registration". In NSW, less than a third of the doctors who applied for conditional registration were able to pass the screening tests set by the NSW Medical Board. This significantly exacerbated the critical doctor shortage at the time. The NSW government took action by passing legislation that allowed the state government to overrule registration decisions made by the Board. The response by the BMA was swift and brutal. They launched a vitriolic campaign to vilify the foreign trained doctors calling them quacks and charlatans and used their political influence to get legislation passed in NSW to prevent government intervention in the matters involving the registration of IMGs in the future. This was the one and only time in the entire history of NSW that the government dared to challenge a ruling of the Medical Board.

Emergence of the Australian systems: 1930s to 1980s –

There were only 4 medical schools in Australia in 1938 and reciprocity agreements existed with Great Britain, NZ, South Africa and Italy. From then, each state and territory system developed separately and in an ad hoc fashion, often with one copying from another. For a history of the equivalent development of nursing registration systems see Diane Wickett's PhD thesis, University of Adelaide, 2006.

There were severe shortages in rural areas and the NSW government, for example, passed the Medical Act 1938, which allowed the registration of approved 'alien' doctors (i.e. other than the four countries) in certain country regions. A $1000 bonus was paid to such doctors.

In the late 1930s, a stream of refugee doctors began emerging from Europe but they were required to retrain (for three to five years) in Australia's medical schools. This was the predominant method of acquiring registration in the 1940s and early 1950s. A small number had their paper qualifications assessed and gained registration this way. The only other avenue to registration was via five years medical service in New Guinea, as the colony was short of doctors.

By the mid-1950s, public sympathy towards refugee doctors had begun to escalate and this, together with the growing shortage in rural areas, led to an expansion in the list of automatically acceptable qualifications (i.e. reciprocity arrangements) and the introduction of qualifying exams run by NSW medical schools.

A 1955 amendment to the 1938 NSW Medical Act enabled foreign doctors selected by the NSW MB and passing Sydney University exams to practice in certain places and under special conditions. But only 33% of candidates passed the Sydney University exams. This led the NSW Minister of Health to propose another amendment to the Act in 1957 as the NSW MB and the exam committees were 'frustrating the work of the Medical Act' Iredale, 1986: 2020). After much debate the amendment was passed, a fact that Kunz claims was the 'most important event in the long-drawn out battle to break the medical profession's opposition to the recognition of foreign medical qualifications in Australia'. As a consequence temporary registration became available to alleviate shortages.

In 1963, Section 21C of the NSW Act was amended to enable three years' supervised practice, followed by the satisfactory completion of an oral test, to be the route to registration for those without automatically recognised qualifications (i.e. not on the reciprocity list for NSW). Meanwhile each state/territory was expanding its list of automatically recognised qualifications and by 1970 the ACT had the longest list, with nineteen countries listed.

From 1970 the lists began to be reduced so that by 1983 Britain, Ireland, and NZ were the only ones remaining for most states/territories, except for Tasmania, which continued with Canada and South Africa for some time. Until 1978, therefore, the major mode of assessment for doctors with 'unrecognised' medical training was by means of supervised practice for a period of two to three years in the main teaching hospitals.

The inconsistencies and anomalies across the states and territories, together with public controversy, led to the Committee on Overseas Professional Qualifications (COPQ), newly established in the Immigration Department, turning its attention to medicine. Lack of agreement eventually led to a Joint Committee of all medical registration boards being formed as the Expert Panel in Medicine in late 1974.

Agreement was finally reached in June 1977 on the establishment of the Australian Medical Examining Council (AMEC), which would establish new procedures for assessment and issue certificates. The first national examination, adopted from the Victorian Foreign Medical Practitioners Qualifications Committee examination, was introduced in 1978. At the first two sessions in 1978-79, the pass rate was 18% but criticisms from a Commonwealth Committee of Inquiry (1982: 200) resulted in some changes and the pass rate reached 55% in 1984. The Australian Medical Council was formed in January 1986 and one of its two main functions became the assessment of overseas-qualified medical practitioners. (15-18)

<u>Government sponsored reports</u>

There have been at least seven government commissioned reports over the last 30 years, which have examined the system and processes for registration and assessment of international medical graduates including:
1982 – Fry report

1988 – Committee of Inquiry into Medical Education and Medical Workforce (Doherty report)
1989 – NSW report into recognition of overseas qualifications
Committee of enquiry
1991 – The experience of overseas medical practitioner in Australia; an analysis in light of the Racial Discrimination Act
1991 – AMC Report and Recommendations of the Working Party to review AMC examinations
1998 – Report on the committee for the review of practices for the employment of Medical Practitioners in the NSW Health System (Full report suppressed)
(The Race to Qualify)
2005 – Review of Australian Specialist Colleges – Report to the Australian Health Ministers

More recently the DoHA 2009 report on the Primary Care strategy has identified the current method of assessment and recognition of IMGs as a major barrier to the retention of IMGs in rural Australia!

These reports have described the system for registration and assessment of IMGs as:

"Racially discriminatory"
"Unfair"
"Unreasonable"
"Unlawful"

Direct quotes-

HREOC report concluded – *many overseas trained doctors have been the unwilling and undeserving victims of Australia's rigid medical registration system. No doubt the system operates to ensure the maintenance of high medical standards in Australia but it also deprives permanent Australian residents of proper recognition of their hard earned qualifications and experience and it deprives the Australian public of their skills and expertise.2*

The Race to Qualify report has stated

"Committee is concerned that the specialist college practices for the assessment of OTD specialists are frequently unjust, lack transparency and are racially discriminatory" 3

"The committee is also concerned that the policies of the NSW Medical Board and specialist colleges appear to be restrictive in nature"4

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2 Kerkyasharian, Stepan. *The Race to Qualify – The Report of the Committee for the Review of Practicesfor the Employment of Medical Practitioners in the NSW Health System.* October 2008, pg.46.
3 *Ibid pg. 203*
4 *ibid pg.* 208

"The committee is concerned that neither the specialist colleges nor the medical board are publicly accountable for their decisions" 5

There is "No public accountability and no independent view (AMC, Medical Boards and specialist colleges) because the boards are largely composed of members of the AMC and Medical Colleges. The make up of the Board by members of these bodies raises the issue of conflict of interest and collusion"6

The committee is particularly concerned about the lack of public accountability in the current arrangements and the lack of the separation of powers7

Discretionary decisions are made by the AMC and specialist colleges that are bodies, which are not constituted by legislation and have no public accountability8

There is no doubt that it is in effect a closed shop for local graduates9

The cases (in the report) make it abundantly clear that matters other than medical standards are imported into the assessment processes10

Summary of problems identified in these reports:

Regarding assessment methods and recognition of IMG qualifications:

1. Assessment processes which reflect professional self-interests not quality of training and education
2. Subjectivity and non-reproducibility of assessment practices for IMG
3. Discrepancy between criteria for satisfactory performance between IMGs and Australian Graduates
4. Inappropriate assessment processes for experienced doctors (i.e. unlikely that Australian doctors with similar experiences would be able to pass these tests
5. Absence of any input from IMGs regarding cultural appropriateness and content of assessment
6. Over reliance on "exams" rather than clinical experience and training
7. Inappropriate and culturally biased assessment processes

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5 Ibid pg. 206
6 Ibid pg, 202
7 Ibid pg. 202
8 Ibid pg.206
9 Ibid pg.86
10 Ibid pg.206

8. Lack of "independent" review and validation of assessment processes

9. Lack of major stakeholder input into assessment policies/processes

Sadly the vast majority of recommendations of these reports were never implemented. Some of the recommendations included the establishment of a national bridging course, improved standards with respect to accreditation standards with respect to transparency and fairness. Improved external accountability and increased stakeholder representation at the College levels. One of the primary reasons that the recommendations were not recommended was the lack of political will to challenge the medical establishment by both ruling parties. Also, in view of the current structure of the system there was no mechanism to enforce recommendations. For example, the report on the Specialist Colleges made a number of recommendations to improve fairness, accountability and transparency. However, there was no way to implement these recommendations. Basically it was left up to the good will of the Colleges to enforce them. The cases later on in this submission will show the obvious problems of allowing the Colleges to oversee themselves.

The Hunger Strikes

The perceived oversupply of doctors in the 1990s ushered in another era of discrimination and unfair treatment of IMGs. It became increasingly hard for IMGs who lived in Australia to gain access to the medical workforce through the AMC processes. In the mid-1990s there were approximately 3000 permanent resident overseas trained doctors in Australia. Only a small minority was successful (under 50%) in eventually getting into the Australian workforce. To add insult to injury, approximately 1200 doctors, many with similar or lesser qualifications would be brought in to Australia on temporary visas, to fill positions in areas of unmet need, which were not subject to the AMC screening exam. 19 A number of high profile cases occurred where doctors who had been working for many years as temporary residents had their registration revoked after they became permanent residents. One case was the cardiovascular surgeon Dr. Virdi who is described later on in this submission. 20

In December 1997, approximately 40 members of the Australian Doctors Trained Overseas Association (ADTOA) held a day's hunger strike at the parliaments of NSW, ACT and Victoria to protest the treatment of IMGs - particularly permanent resident overseas trained doctors. The purpose was also to lobby for changes to the system of recognition of IMGs. 19 The strike was the cumulative result of decades of overt discrimination, as well as the failure of governments who had repeatedly ignored the recommendations of multiple reports that advocated changes to the system for the recognition of IMG qualifications. The proverbial last straws, however, could be traced to three events:

1. Imposition of a quota on the number of IMGs allowed to pass the AMC exam AND time limits for completion of the process

2. Ten year moratorium on the provision of provider numbers for AMC graduates
3. Reduction of attempts at AMC to two attempts. 20

The Siddiqui case

Only one year after the Human Rights and Equal Opportunity Commission had found that the process for the recognition of OTD qualifications was discriminatory, the AMC imposed even harsher requirements on IMGs to obtain Australian qualifications in the form of a quota placed on the number of IMGs allowed to pass. The proposal was to limit the number of IMGs allowed to pass the written paper (and, thus, go on to take the clinical exam) to the top 200 scores. In addition, the AMC proposed a five-year limit on the total amount of time required to successfully passing both parts of the exam. This meant that candidates would need to wait for an opportunity to do both exams, which would not infrequently be months to years, not to mention score in the top 200 places. The specialist colleges initially proposed the initial proposal for a strict quota on iMGs. 21In the March 1992 'President Letter of the Royal Australasian College of Surgeons' the president wrote;

"The avalanche of foreign medical graduates is a more difficult problem (in comparison to the issue of medical students) and a formula has been proffered to the Government of a total registration of 200 foreign graduates per year!"1112

Interestingly ten years later the RACS would be charged with imposing restrictive practices on IMGs by the ACCC. 22

Dr. Burney Siddiqui - a doctor of Indian origin who had failed to gain registration in light of the quota - lodged a complaint of racial discrimination against the AMC to the Human Rights and Equal Opportunity Commission. On August 7 1995 the HREOC found in favour of Dr. Siddiqui that the quota was a case of indirect discrimination. The HREOC instructed the AMC to allow Dr. Siddiqui to take the clinical exam.

The AMC and the Commonwealth government appealed the decision and took the case to the Federal Court of Australia, which overturned the decision. The reason was not that the AMC exam did not disproportionately affect IMGs and those of minority races, which it obviously did; it was because Dr. Siddiqui had not proved that it unfairly affected doctors of Indian origin!! Not only did the court uphold the decision, but also it forced Dr. Siddiqui - an unemployed IMG - to pay the court costs of the AMC! 23

The report 'The Race to Qualify' had this to say of the Siddiqui case

"The AMC raising of the pass mark for the MCQ exam to admit only 200 of that cohort to the clinical exam has been regarded as acceptable in spite of the obvious inequities between groups of council candidates and local graduates"13

The Siddiqui case highlights the problems between what is obviously fair and what is legal in this country.

There is no question that the quota was a gross case of discrimination against IMGs but it was still enabled by the legal system in Australia. Whilst the AMC did remove the quota, legally the case outcome means that the quota could be resurrected at any time.

In 1997 the commonwealth government imposed a ten-year moratorium on the provision of Medicare provider numbers to PROTDs. As of January 1 2008 all IMGs who had successfully passed the AMC exams would be barred from obtaining a provider number which prevented them from working in the much more lucrative private system. This move was spear headed by the AMA. In 1996 a statement from the Victorian Branch of the AMA;

"Calls upon the Minister for Health to ensure that the number of OTDs entering the Australian Medical Workforce through the AMC exam is reduced to zero for a period of five years"14

The final straw occurred in May 1997 with the announcement by the AMC of a five-year limit allowed for OTDs to pass the MCQ and clinical exams. The stated rationale was to make it more comparable to what was required of Medical Schools. It is difficult to understand how the AMC could possibly compare a system whereby in one group, the pass rate if anything is scaled to limit numbers, to another group where pass rates are scaled downwards to ensure that only a small percentage fail regardless of how poorly an entire class may perform. Obviously the two groups are "not comparable".

ADTOA lodged a complaint against the AMC with the HREOC. Mediation with the AMC broke down and the doctors called the hunger strike

"Members had nothing to lose; they had already lost their possessions, income, dignity and frequently their families as a result of the stress caused by their predicament"15

The Hunger Strike ended on December 5 1997 after an agreement was brokered with the Hunger Strikers and NSW Department of Health. The conditions of the strike were as follows:

1. The government would commission a review into the employment systems for OTDs by members of the anti-discrimination board, ethnic affairs commission and equal opportunity commission.
2. Arrange meeting with the commonwealth Health Minister

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13 Ibid pg. 56
14 Ibid pg. 58
15 Ibid pg. 58

3. NSW support the establishment of a nationally accredited bridging course

Aftermath of Hunger Strikes and Lessons Learned

The Hunger Strike was the first time that IMGs had been able to successfully draw attention to the significant problems of unfairness and discrimination towards - and broker an agreement with - the governments that had the potential to create a better system. Unfortunately, the Hunger Strikes did not result in meaningful changes that would give rise to sustained improvements in the system. It is important to understand the reasons for why the hunger strike did not give rise to meaningful change if this inquiry is not to be condemned to the same fate. Both the government and OTDs themselves share responsibility for this failure.

The Race to Qualify Report –
On October 12 1998 the report The Race to Qualify – Report of the committee for the review of the employment of Medical Practitioners in the NSW Health system was released. It was by far the most comprehensive review and analysis of the barriers that IMGs faced in Australia. Many of the findings, views and recommendations of this report are described in other parts of this submission. One of the key concerns identified in the report was the structure of the accreditation system itself, which lacked external accountability, and an independence of view and was underpinned by the self-interests of the Australian doctors. The report could only issue recommendations pertaining to NSW Health at the time but did call for changes in legislation that enabled the Minister to direct the Board under specific circumstances. Most importantly however were the recommendations that reduced the unfair differences in the treatment between permanent and temporary resident overseas trained doctors, including providing permanent residents with the same qualifications the opportunity to work in areas of unmet need which previously they were prevented from applying for.

Sadly, The Race to Qualify report met with a fate even worse than its predecessors. Not only were the majority of recommendations ignored, the report itself was suppressed for over ten years!! Consequently, while the recommendations were available, the problems that lead to these recommendations (particularly the contributions of the Medical Board, AMC and specialist colleges) were suppressed. While the entire report is available now, it is extremely difficult to obtain and the argument can be made that these events occurred almost 15 years ago and therefore are no longer relevant. In fact many of the problems described in this report are unchanged and have directly led to the current inquiry. It is possible that if the report had been available in its entirety this inquiry may not have been necessary

Contributions of the IMGs themselves – IMGs also share responsibility for the long term-failure of the Hunger Strikes. This writer has identified two major mistakes made by IMGs. First and most importantly IMGs turned against themselves. There is no question that permanent resident OTDs (PROTDs) were the group that suffered the greatest hardships under the Australian system at the

time. Rather than lobby for changes that made the system fairer for all IMGs, however, IMGs lobbied for equity between the two groups. There is a huge difference between lobbying for fairness versus equity in an unfair system. In the next few years the AMC MCQ would be applied to all OTDs (with exception of competency authority) applying for AON positions, which was supported by ADTOA.

In some ways it has made it harder because PROTDs now need to compete directly with younger IMGs for these positions, with the latter much more likely to pass the exam and be offered the AON positions. From an international perspective, the AMC screening exams have made Australia a very unattractive destination for IMGs at a time of high international demand, which has exacerbated the doctor shortages. Also, the AMC has basically reintroduced the five preferred country scheme with the introduction of the competent authority program, which means that doctors from preferred countries are exempted from the AMC exam. In fact there is a valid reason for exempting doctors who have already passed exams like the US USMLE, Canadian LMCC and British PLAB from the AMC, as these exams are highly similar. In hindsight, a better approach would have been to look at the fairness and validity of the screening processes themselves.

This has not helped the PROTDs to gain meaningful access to the workforce. By focusing on equity not fairness, the system is now equally unfair for both temporary and permanent resident OTDs alike - as has been demonstrated in the last year.

The discriminatory and unfair treatment of temporary resident OTDs who have been actively recruited to work in Australia has finally dispelled the myth that the system, albeit difficult, is in fact fair. In the past it has been argued that OTDs who immigrated to Australia, many as family members, have been treated fairly as they should have known about the harsh conditions before they came. (24) In contrast temporary resident OTDs (TROTDs) have been recruited specifically to provide medical services. The evidence clearly shows that temporary resident overseas trained doctors are treated extremely unfair as well. In some ways temporary resident OTDs are subject to more exploitation than PROTDs as their presence is closely linked with their visa, which will be revoked if their employment ceases. Consequently, any complaint puts them at risk of losing their job and/or registration. Thus many are likely to suffer serious bullying and difficult work conditions in silence.

The argument that OTDs should know what they are getting into before they make the decision to move here is also invalid. The current system makes it impossible to make an informed decision about moving to Australia as the rules are always changing. There have been numerous IMGs who have been displaced from their jobs - and in some cases the country - because the rules have suddenly, and without notice, been changed.

The only way to avoid repeating these mistakes in the future is to make fundamental changes to the structure of the system otherwise we will continue

to be putting out one fire while the next one is brewing. The focus must be on the fair treatment of all doctors irrespective of country of birth and immigration status.

The Bundaberg Affair

The case of rogue doctor Jayant Patel had a significant impact on the reputation and treatment of IMGs. A summary of the case is as follows. Jayant Patel was chief of surgery at the Bundaberg hospital from 2003 to 2005. He had received his primary Medical education in India but had done most of his surgical training in the UK and the US. The Patel case paints a horrific picture of a highly dysfunctional registration and healthcare system, which allows rogue doctors to flourish. It is estimated that the combination of a rogue doctor and a highly dysfunctional system, were responsible for at least 13 deaths and much more morbidity and suffering. There were two government inquiries into the Bundaberg affair. The first inquiry, lead by Mr. Tony Morris, was suspended in 2005 because of allegations of unfair prejudice towards some of the government officials by Mr. Morris. The second inquiry was conducted by Mr. Davies and was published in November 2005.

Both enquiries lay the majority of blame for the Bundaberg tragedy at the feet of the Queensland Medical Board and Queensland Health. The inquiry uncovered a highly dangerous system, which put Australians' lives at risk. Patel lied about his qualifications and registration. For example, the Queensland Medical Board failed to check on his referees, references and even basic qualifications. A cursory check would have revealed that Patel's ability to practice surgery was limited in Portland and that he was banned from doing surgery in New York. A check of his qualifications would have also revealed that he had been asked to leave the surgical training program in the US. It is also noteworthy that – in a separate incident - during this time frame, the Queensland Medical Board had not only registered a man with a false Medical degree but had also issued him a certificate of good standing a year after his bogus medical qualifications had been reported to the board! Once Patel started to work at the hospital he was immediately promoted to the position of director of surgery, a position for which he was registered. (26)

In the course of twenty-four months there were more than twenty complaints made about Dr. Patel by numerous staff and patients including a number of IMGs working alongside Patel. Yet the Director of Medicine did not launch any audit or inquiry into Patel's actions/competence. The subsequent inquiries revealed a healthcare system driven by financial consideration in contrast to the quality of patient care. It also revealed the shocking absence of any form of credentialing system - which is critical for ensuring staff competence for their positions, and ensuring patient safety.

The inquiry also discovered that the hospital sacrificed quality of care in order to meet the financial bottom line. Hospital management was resistant to investigating a doctor who clearly served the best interests of the hospital from a

financial and operations perspective. He was a hard worker and significantly reduced the waiting list and provided a core medical service. There was the absence of any basic credentialing or peer review mechanisms in place to oversee competency of staff. Hospital management failed to address important concerns rose by employees and in fact punished those who dare to raise alarm bells. 26

Unfortunately, the media circus that was generated by the Patel case focused more on Patel himself rather than the equally culpable system. This fact is highlighted by the fact that while Patel serves time behind bars, many of the Australians who were directly responsible for the tragedy are still gainfully employed in their positions!! 27 The relative contribution of the dysfunctional system can be inferred by the fact that he was unable to leave a similar legacy of carnage in other countries where he worked. Patel was still registered to practice in the US albeit with restricted practice. If we assume that his knowledge and skills had not changed significantly over time obviously there must have been a significant difference between the hospital environments of the US and Australia that enabled the carnage.

This brings to mind the case the case of Graeme Reeves - also dubbed the 'Butcher of Bega' tragedy - where over 500 women were the victims of alleged sexual abuse, mutilation and death at the hand of a rogue doctor and dysfunctional medical system which clearly breached its duty of care. 28 Unlike Patel, this case did not trigger a backlash against Australian-trained doctors.

In contrast, IMGs were found guilty-by-association with Patel. The Medical system - rather than coming to the defence of its IMG Medical workforce - implicated that there were many more "unqualified" IMGs that had slipped through the accreditation system which made Australia at risk of another 'Dr. Death', particularly with respect to the AMC exams and specialist college assessment. 29 In 2006, Mr. Ian Frank (CEO of the AMC) was quoted as saying the following about IMGs:

"These people are not qualified to work unsupervised."16

He went on to say that OTD specialists are supposed to go through the AMC and specialist college pathways and that:

"Failure to comply with the assessment guidelines had allowed Patel to be employed."17

Sadly, statements like these totally missed the mark! **The evidence clearly showed that in the Patel case the problem was *not* an issue of differences between quality of training, competence and skills between overseas and Australian trained doctors. This was clearly an issue of a dysfunctional**

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16 Pirani, C. *Unqualified Doctors Working in Australia.* The Australian Sept. 22 2006.
17 Ibid

registration and credentialing system that enabled rogue doctors (Australian or overseas-trained) to inflict significant harm on the Australian public. Tony Morris (who conducted the initial inquiry) was quoted as saying; *"Perhaps the enduring tragedy of Jayant Patel is. he has become a scapegoat for everything that is wrong about Queensland Health. Patel is not and never was the problem..."18*

We would modify this statement to say that IMGs and not just Patel have been the scapegoats. We also argue that the statements like those made by the AMC in the wake of Bundaberg provide other examples of the Medical establishment once again using their considerable influence and position of authority to unfairly bias the Australian public against IMGs.

In the next few years, a number of new regulations were ushered in which made it considerably more difficult for IMGs to gain entry to the Medical workforce. These changes also resulted in many de-registrations of IMGs already successfully working in the system. In fact, it is the de-registration of these doctors - particularly in rural regions - that has largely prompted the current inquiry. Post-Patel, a number of "reforms" were implemented on a national scale. All OTDs had to obtain their Australian qualifications within a specified time period. The fact that these doctors had little free time to study and did not have access to key training required to obtain their Australian qualifications, (not to mention that they had to do this on their own in contrast to the registrars who received tens of thousand of dollars in government support), was not taken into consideration. All doctors applying for new positions including those who had already worked in Australia for many years would have to go back and study their old medical school textbooks as they would now need to pass the AMC exam. Again, the fact that many of these doctors were close to retirement and had not taken exams for many years wasn't taken into account. Many would also need to undertake a viva exam (PESCI) consisting of a few questions. There was no evidence that these measures were applied to Australian doctors of a similar cohort to ensure equity or fairness.

New English standards were also brought into effect. To be eligible for registration, IMGs had to have taken their English test within the past two years as these tests were only valid for two years and they needed to ensure that their language skills had not deteriorated over time in the Australian clinical setting. Also, the standards of English were raised - which required doctors to speak the same level of English as an English professor.

<u>Professional Mobbing – the case of Thomas Kossmann</u>

One of the most malicious forms of abuse for which IMGs are at an elevated risk is professional mobbing. Professional mobbing occurs when a group of professional peers act in collusion to discredit a peer. The motives are malicious

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18 Giles, D. *Patel is "fall guy".* Courier Mail. November 25 2006 Accessed athttp://www.couriermail.com.au/news/sunday-mail/patel-is-fall-guy/story-e6frep2f-1111112585088 February 11, 2011

- usually related to issues of competition and/or other self-interests. While Australian-trained doctors are not immune to professional mobbing, IMGs are at increased risk. This relates to their temporary registration, visa status and differences in medical culture.

One of the vehicles for professional mobbing is the peer review mechanism. Peer review is an important mechanism for quality assurance for all doctors. It involves auditing cases and discussing what could have been done to improve outcomes. It is important that the peer review process be protected and that participants be immune from fears of protection. Unfortunately, while peer review is a critical component of quality assurance it can be abused. The peer review process was not designed to take into account malicious motives other than improving professional practice and standards,

Peer review is a critical component of accreditation. The problem arises when an IMG is singled out for professional mobbing because their peers are financially and/or professionally threatened by IMGs. Individuals who make defamatory statements as part of the "peer review" process are not subject to the judicial process. Consequently, individuals can make untrue and defamatory statements without fear of legal repercussions. 30

Sadly, we have had a number of cases of "professional mobbing" brought to our attention in the last year. IMGs, particularly those who work in the public sector, can undermine the income of their specialist colleagues by drawing patients away from the lucrative private market. Additional factors like personality conflicts and professional differences can exacerbate tensions. Once a doctor is accused of impropriety/incompetence, a domino effect occurs, where one injustice triggers another. Almost inevitably the end result is the destruction of the IMG's career. 30

Most of the IMGs who have been the victims of professional mobbing (brought to our attention) have decided not to submit their stories for fear of further damage to their professional and personal lives. The following case of Professor Thomas Kossmann has been used as an example to illustrate a case of professional mobbing and its aftermath.

Dr. Thomas Kossmann

Dr. Kossmann was a young, highly accomplished specialist in trauma who was recruited from Germany to head up the trauma unit at the Alfred hospital in Victoria in 2001. Dr. Kossmann brought with him critical skills and knowledge. In Australia, surgeons were not trained in trauma surgery per se but rather were trained in specific areas of surgery like orthopaedics and vascular. This meant that multiple specialists from different areas had to be involved in severe trauma cases. A specialist in trauma itself brought an important new perspective to the field. This difference in training and perspective was a potential source of conflict. 31

Australia, however, did not have a history of treating those who were different graciously. The previous department head that was also from Germany, faced problems, as did a number of other IMG trauma specialists who had subsequently returned to their own countries because of their hostile treatment by the Australian medical establishment. 32

From 2001 to 2004 Professor Kossmann left an impressive mark on his profession. He proved his leadership and clinical skills in the treatment of many of the Bali Bombing victims. He was involved in over 4000 surgeries involving 2500 patients and did not have one patient complaint. In 2004 he invested hundreds of thousands of his own funds into the Foundation for Trauma Research Institute. However things were not going as smoothly as would outwardly appear. As director, Dr. Kossmann set about changing an entrenched culture and attitude. This caused significant tension and clashes between powerful egos. More importantly, however, many doctors perceived that Kossmann influenced their financial bottom line. Early in his appointment, Dr. Kossmann was quoted as saying that the biggest barrier to the progression of the trauma service was the greed of the visiting doctors. 31 A Brisbane based orthopaedic surgeon confirmed this view by also stating that visiting officers saw him as a threat to their income and comfortable lifestyle. 32

A group of surgeons were instrumental in having an external review launched against Professor Kossmann alleging unnecessary - and in some cases incompetent - surgery, and improper billing procedures. The media crucified Kossmann who was referred to on numerous occasions as the "disgraced trauma surgeon". The media treated him as if he was guilty and needed to prove his innocence from the start. An expert panel was convened consisting of "respected" orthopaedic surgeons to investigate the allegations. In 2007, one overseas trained doctor made the following prediction on one of the IMG websites in relation to the review:

"The chronology of events is going move like this: investigation – if there is anything that can be made to stick, the issue will be reported to the Victorian Medical Practitioners Board. Next step would be either a disciplinary or performance inquiry – either way Professor Kossmann's career will be ruined." 19

The contents of the expert panel were "leaked" to the press. The panel's report was extraordinarily damning. The panel accused Kossmann of serious flaws in his surgical ability and judgment. They went as far as saying that the nature of these practices and decision-making were beyond any level of accepted behaviour and standards of practice. They also concluded that he had "no concept of what constituted a moral approach to billing". As the vultures circled, more groups jumped on the anti-Kossmann bandwagon. Authorities from the College of surgeons came forward to say that they had been pressured into giving Professor Kossmann fellowship.33 34

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19 Posting to http://www.aippg.net/forum/viewtopic.php?t=70274&postdays=0&postorder=asc&start=0 accessed Feb 10 2011.

One colleague made the following particularly nasty quote to reporters:
"It was if God spoke to Thomas one day and said today you are a pelvic surgeon and went on to do surgery he was not qualified to do."20

The Victoria ombudsman was next to delve into the Kossmann affair. In October 2008 the Ombudsman George Brouwers released a report that not only condemned his surgical abilities but his character as well. The ombudsman report painted Dr. Kossmann as a greedy, ruthless and incompetent egoist. The ombudsman concluded that Professor Kossmann had failed to act with integrity and placed private interests ahead of his public duty. The ombudsman said he spoke to more than twelve of Kossmann's peers, all of whom were critical of the results of his surgery. The Ombudsman recommended further investigations by the police, Australian taxpayers office, TAC and the Medical Board.35

Throughout his ordeal, Professor Kossmann maintained his innocence and refused to let the accusations that had destroyed his career and reputation go unchallenged. While the reports, which contained the damning accusations, had been front-page news, the subsequent investigations that slowly but surely cleared Professor Kossmann of any wrongdoing went largely unreported or were delegated to the back pages of the papers. Over the next two years these organisations came to different conclusions to the Ombudsman and previous panel. WorkSafe investigated over 1900 claims by Dr. Kossmann and reported that it unequivocally found no evidence of inappropriate billing. 36 The Medical Board was the last organisation to clear Professor Kossmann in May 2009 where it concluded that it was satisfied that Dr. Kossmann had the skills and training to perform pelvic and spinal surgery and that he understood how to bill medicare for orthopaedic procedures. 36 The final chapter was closed recently when The Alfred Hospital and Professor Kossmann settled the defamation charges out of court and paid a sum estimated to be a few million dollars. As part of the settlement The Alfred made a public apology to Professor Kossmann and acknowledged that any billing irregularities had been the fault of the hospital, not Dr. Kossmann. Dr. Kossmann has signed a confidentiality agreement. 37

Unfortunately, one can only guess at the devastation that these events had on Professor Kossmann. We do know that he came to Australia as an internationally renowned leader in his field. He brought with him the energy, skills and vision to make a huge contribution to Australian society. We can only guess at the suffering of loved ones caused the ongoing public allegations of incompetence and impropriety. We know that other IMGs of the same specialty have been treated with hostility by their Australian peers and have returned to their countries because of their treatment here. We know that his professional life was basically put on hold for three years and that while he is back working somewhere in private practice, it is likely that Australia will never reap the full benefits of this highly gifted doctor particularly with respect to championing a new innovative approach to trauma. While he was finally vindicated, the events surrounding the clearance of his name were hardly mentioned in the press,

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20 Baker, R, McKenzie N, *Anatomy of a trauma.* The Age, April 12 2008.

unlike the vicious allegations of incompetence and dishonesty, which made the front pages. It is likely that Dr. Kossmann's career will never fully recover from the trauma.

The Kossmann case has raised many disturbing questions about the peer review and ombudsman process. It also highlights a frightening degree of collusion that can occur when Australian doctors feel threatened financially and/or professionally by IMGs.

In summary, the history of IMGs in Australia has been remarkably consistent over the last century in that, as a group, we have been the targets of unjustified prejudice and malice of peers who are threatened financially and/or professionally by their IMG peers. The Medical establishment has created a system that enables the ongoing prejudice, exploitation and abuse of IMGs. Historically the voices of IMGs have been ignored and their basic human rights denied. Those IMGs, who have dared to challenge the system and have refused to play the game, are the targets of collusion and professional defamation. The inbred nature of the system ensures that Australian stakeholders are able to influence an IMG's future at every level of the registration and accreditation system. Today it is the same as it was one hundred years ago – IMGs in Australia have no chance of a 'fair go' in this country.

The current registration and accreditation system for IMGs

Overview

First, what do we mean by the terms registration and accreditation?
In general, accreditation refers to the establishment of specific standards for professional education and training and assessment of the degree to which these standards have been met. Registration, on the other hand, largely involves assessment of fitness to practice, a vital component of which involves determining the degree to which an individual has attained the predetermined standards set out in the accreditation process. For the purpose of this paper accreditation will refer to the assessment of an individual's educational and professional qualifications whereas registration will refer to the process by which a doctor is granted entry into the Australian medical system.

In Australia, the responsibility for the registration and accreditation of IMGs rests with three organisations: 1. The Australian Medical Board 2. The Australian Medical Council 3. The Australian Specialist Colleges. It is critical to understand the relationship between these three groups to be able to understand why the current system is inherently unfair and why fundamental changes are needed. In general, the AMC and/or the specialist medical colleges have responsibility for accreditation, while the medical boards register as fit for practice those with accredited qualifications. The Australian Medical Board has only recently come into existence as of July 1 2010 as a result of the implementation of the new National registration and accreditation scheme for Health Practitioners or

AHPRA. Prior to the implementation of the scheme, the role of registration and accreditation of overseas trained doctors without Australian qualifications was largely the responsibility of seven separate state Medical Boards.

In Australia, the process of registration and accreditation largely depends on whether the doctor is applying for unconditional or conditional registration. An IMG has one of two avenues to obtain unconditional medical registration: the AMC or the specialist pathway. Currently there are two AMC pathways towards general registration, the standard and competent authority pathways. Doctors who undertake the standard AMC or competent authority pathway are not accredited as specialists.

In both pathways candidates must have their Primary Medical qualifications and workplace history assessed/verified by the AMC. The process involves numerous hours of work filling in multiple forms and providing certified copies of extensive documentation including certified English translations of degrees, passports and professional qualifications. In many cases this process will need to be repeated again when candidates apply to other accreditation organisations like the Medical Board.

All candidates must also prove their proficiency in English by showing evidence that they received their high school education in English or by achieving specific standards on the occupational English test (OET) or the *International English Language test (IELTs)* English tests. The standards for satisfactory levels of English are set by the AMC. An inverse association between the standards of English required by the AMC and the demand for IMG services in the Australian workforce has been noted and is discussed elsewhere in this submission.

The standard pathway involves a two part exam including a multiple choice and clinical examination. Candidates must also work for twelve months in the Australian system including a minimum of ten weeks in Medicine and Surgery and eight weeks in emergency or General Practice. In the competent authority pathway, candidates who received their Primary Medical qualifications in particular countries assessed as having similar standards to Australia are exempt from the AMC exams. They still need to complete twelve months of approved supervised practice prior to being granted general registration.

In the *specialist pathway,* the AMC assesses the doctor's primary medical qualifications but then refers the case on to the relevant specialist college for assessment. The role of the Specialist College is to assess whether that individual has the skills and knowledge to be deemed a specialist. In general the AMC will grant authority to colleges for their IMG accreditation as long as their policies seem "reasonable". (40) They also do not play a significant role in investigating IMG complaints against the colleges.

If the IMG is not successful in getting his or her specialist qualifications accredited by the specialist colleges, they must go through the standard or competency authority AMC pathways for general registration. The other option for IMGs to obtain registration is to apply for conditional registration in positions

designated as area of need or occupational trainee positions in the hospital. Historically, the state Medical Boards have had the responsibility for the registration and accreditation of IMGs applying for these positions. The inconsistencies and lack of clarity in the policies and processes for the assessment of IMGs for conditional registration between states was one of the drivers for the establishment of the National Scheme. In many parts of Australia, IMGs working under conditional registration make up the backbone of the Medical Services. These doctors provide an invaluable service to Australia.

In 2008 a number of important events occurred that would significantly impact on IMGs professional careers. First, on March 26 2008 COAG signed an intergovernmental agreement for the development of a national registration and accreditation scheme for the nine major health professions to take effect on July 1 2010. 41 From 2008 on, the vast majority of IMGs applying for conditional registration had to pass Part One of the AMC unless they were exempted under competency authority pathway. 42 In addition all candidates had to pass a pre-employment screening clinical interview or PESCI relating to their position. It is important to understand that these "screening" tests were never intended to assess the competency and skill of IMGs already working in Australia.

Another change that was implemented around this time was the requirement that IMGs working under conditional registration as GPs or specialists had to acquire their Australian qualifications within a specified time period, usually four years. While this requirement was in place for some of the states, it was not a national standard until 2008. This meant that in order to stay in Australia the vast majority of IMGs had to pass either the AMC exams or go through the specialist College system.

The Australian Medical Board(s)

Pre-AHPRA

A major concern about the Medical Boards is the long-standing problem of Board composition and membership. This has largely consisted of members of the AMA, AMC and Medical Colleges. There is a lack of any independence of view that arises from the enmeshed relationship between these organisations. In the first half of the twentieth century, the BMA controlled the membership and decisions of the first state Medical Boards. Consequently the Medical Boards were used as a tool for the BMA to exercise control over the entry of IMGs into the Medical workforce. 43 The position of power of the AMA in the Boards was challenged to some extent by the establishment of the separate Specialist Colleges in the latter half of the twentieth century. Over time, the specialist Colleges became the major representatives on many of the Boards. For example, in the late 1990s, the majority of members on the NSW Medical Board were representatives from the Specialist Colleges. Consequently, up until the establishment of AHPRA, the Medical Boards were extensively populated with official representatives of the Specialist Colleges. In contrast, IMGs had no official representation on the Boards. The composition of the state boards

enabled the Specialist colleges to exert their influence over the registration of IMGs applying for conditional registration.44

There is a long history of concerns about the unfair treatment of IMGs at the hands of the Medical Boards. The 1998 report *The Race to Qualify* described the treatment of IMGs by the NSW Medical Board as
"Unfair, unreasonable, and prejudicial to the career development of IMGs."
The committee was particularly concerned with the harsh and rigid rules in place for IMGs. The report cited evidence that the Medical Board was unfairly preventing IMGs from receiving the necessary training/clinical experience required to obtain their Australian qualifications - a fact, which was acknowledged by the Board. Another problem cited by the committee was the lack of access to a fair appeal system. The committee was very concerned that the board's actions were unlawful and denied the Australian access to an important source of culturally diverse and skilled medical practitioners. 45

Of particular concern to ADTOA are the recent reports of harsh and unfair treatment of IMGs at the hands of the Medical Board(s) which are very similar in nature to those described over ten years ago? These recent cases highlight the unwillingness of these organisations to change their attitudes and behaviours.

The National Scheme

In December 2005 the Productivity Commission and the Australian Health Workforce Advisory Committee tabled a research report on the Australian Health workforce to the Council of Australian Governments. The report identified a number of problems with the existing system of accreditation and registration, including fragmentation of responsibilities, difficulties in coordination, rigid regulatory arrangements and entrenched workplace behaviours. The Productivity Commission report recommended the establishment of a national Health Practitioner Regulation agency to improve efficiency and improve deployment of critically needed health professional manpower.46

On March 26 2008, the Council of Australian Governments (COAG) signed an intergovernmental agreement for the establishment of a national registration and accreditation system for the nine major health professionals including Medicine. Under the new system the national boards for the Health Professions, including Medicine, would be responsible for the registration and accreditation of overseas trained health professionals. The National Law supporting the intergovernmental agreement was to be first passed in Queensland and is in the process of being ratified by the other states. 47

The creation of a national scheme was an important opportunity to create a more effective and fairer registration and accreditation system for IMGs and Australia. This represented an important opportunity to start fresh and analyse the existing system from a new and impartial perspective. 48 The new system was supposed to be different from its predecessor in a number of important areas with regards to IMG registration/accreditation. First, in the new system,

the Ministerial council composed of the commonwealth and state health ministers, would ultimately be responsible for national IMG registration/accreditation standards. The role of the Board was to advise the council on these standards. Previously, the state Boards had uncontested authority over these standards and decisions which in some cases was enshrined in state legislation. This put the state and commonwealth governments in a difficult bind. On one hand they were responsible for ensuring access to high quality health care, which in turn was directly affected by the supply of doctors. On the other hand they were unable to intervene in accreditation decisions by the Boards that adversely impacted on their ability to provide this care.

A major improvement in the new system was that the new Australian Medical Board was not to be chosen from representatives of the major medical power brokers like the AMC and specialist colleges. As discussed, previously, the former Boards were largely composed of representatives of these private member based organisations The establishment of an impartial registration/accreditation body would significantly reduce the potential impact of self-interests unfairly influencing IMG registration/accreditation policies, processes and decisions. 48

Unfortunately, to-date the new system represents a lost opportunity to improve the registration/accreditation system for IMGs and Australia. The spirit of an impartial registration and accreditation body as described in the intergovernmental agreement was not translated into the National law, which governs the composition and processes of the Board. Rather than being a an impartial body, the new Board is a whose who of the elite and powerful members of the major medical power brokers particularly the specialist colleges and AMC!

Almost without exception every medical member of the new Medical Board holds or has recently held very senior and/or powerful positions in the AMC, Specialist Colleges and/or the AMA. 49 In addition, almost all the Medical members have held senior positions on the old boards including those who have been harshly criticised for their treatment of IMGs. For example, the new president, Dr. Joanna Flynn, was the former president of the Victoria Medical Board and the AMC council, as well as a senior official in the RACGP. The composition of the current Board has perpetuated the lack of independence as well as the prejudice and conflicts of interests that have plagued the old system for decades. The recent mass de-registration of many highly regarded IMGs by AHPRA despite their many years of high quality service to their communities, is strong evidence that these problems are alive and well in the new system.

The Australian Medical Council (AMC)

The AMC is the major accreditation body in Australia responsible for setting national standards for education and training. The AMC has three primary roles: 1. The accreditation of Australian and New Zealand Medical Schools 2. The accreditation of Specialist training programs and 3. Accreditation of qualifications of overseas trained doctors. It was established in 1986, replacing

its predecessor the Australian Medical Examining Council (which was established in 1978 as a consequence of a joint decision by the state Medical Boards). The AMC was incorporated under the Association Ordinance act of the ACT making it a private company but not publicly accountable.

The AMC receives its funding from a number of sources including the commonwealth government, medical boards, accreditation of Medical Schools and examination fees from AMC examinations. The council itself consists primarily of representatives of the medical boards who as previously noted also are often senior members of the specialist Colleges. This author was unable to obtain information about the current AMC members and their affiliations and organisational governance structure on their website. Similarly there was no information available on sources of funding on their web site. The lack of open access to this kind of information in this age of technology is a concern to ADTOA.

Historically there have been multiple concerns about the AMC in terms of procedural and assessment fairness, validity of assessment methods, discriminatory practices and policies, lack of public accountability, complex and dysfunctional bureaucracy, and absence of independent view. 50

One of the major concerns that has been voiced about the AMC multiple choice and clinical exams is the current benchmark for assessment which is the level of knowledge and skills expected of a final year medical student about to start their internship. The AMC MCQ exam tests both declarative and functional knowledge. Declarative knowledge consists of the basic medical sciences on which declarative or functional knowledge is based. An example would be that it is important for students to learn biochemistry, a form of declarative knowledge before they can understand the concepts of rational prescribing which is essential for being a competent doctor.

On face value this does not sound unreasonable. Why shouldn't we expect that overseas trained doctors have the same level of knowledge and skills as our Australian graduates? In fact this would not be an unreasonable expectation except for one major fact. The majority of overseas trained doctors are not new Medical School graduates - they are experienced clinicians! The educational research shows that there is an inverse relationship between clinical competency and basic medical knowledge when you compare experienced with new clinicians.

The research suggests that it becomes more difficult for experienced doctors to recall the detailed information they learned in Medical school because it becomes highly integrated into their extensive knowledge base. This is a bit like being unable to tell a friend the numbers to your combination lock that you use everyday. ***51***

This raises an important issue; given that the majority of overseas trained doctors are experienced clinicians, why has the AMC designed an exam for new graduates? It could be argued that there are similar exams in other countries

like the LMCC exams in Canada and the USMLE exams in the United States. A major difference between the AMC exams and these exams, is the that the latter are licensing exams that are administered to ***all*** new graduates prior to being registered to practice. This provides important comparative data on the failure rates for domestic versus international graduates and ensures that the standards for IMGs and domestic graduates, at least on face value, are comparable.

Another problem is that we don't have the evidence that the AMC is a valid assessment of the knowledge and skills expected of Australian graduates. Australian graduates do not take this exam. Consequently there is no definitive way of comparing the pass rates for the spectrum of Australian Medical students and IMGs who take the AMC. The fact that the reported failure rates for the AMC exams are higher for IMGs than for other exams like the Canadian LMCC where the Canadian students must also pass provides support for the theory that Australian medical students and IMGs are assessed at differing standards.

Other serious concerns the problems of lack of public accountability and lack of transparency. Of particular concern to ADTOA is the fact that the AMC has repeatedly failed to address these major problems despite the numerous reports on these issues.

And, to top it all off, once this unequal exam has been successfully passed and the entire AMC process navigated – there is still no equality for IMGs 'on the other side' of it. i.e. they have been assessed as 'equal" to Australian doctors at an intern level, but then do not enjoy the same rights as those doctors to whom they are 'equal'.

Under the new system, the Australian Medical Board is responsible for the accreditation of IMGs, however, it can contract out these responsibilities to an external agency if that agency meets certain standards. Specifically, the processes used to assess the qualifications must be fair, transparent and in accordance with National law. Currently the AMC has a three-year contract with the Medical Board to continue to assess IMGs applying for the AMC and the specialist pathways.

The Specialist Colleges

The Specialist Colleges determine the standards and processes for the assessment of IMG specialists including General Practitioners in Australia. The Colleges, like the AMC, are private member-based organisations, which lie outside legislative influence. As these organisations are member-based their primary goal is to represent the interests of its members. They are not responsible for ensuring adequate Medical services or public safety, which are the responsibility of the Government and Medical Board respectively. Past reports have voiced serious concerns that the criteria and processes used to accredit IMGs have been largely influenced by organisational self-interests in contrast to professional standards. 51

Given that these organisations are private organisations, they are largely free to set their own rules. Consequently, there is no meaningful avenue to challenge unfair and/or irrational policies and treatment. IMGs have no recourse to organisations like the Ombudsman. Politicians are largely helpless to intervene, as they have no legislative authority over these organisations Recourse to the judicial system is generally unhelpful because in many cases while the rules and processes may be grossly unfair, they are not necessarily illegal. Also, the vast majority of IMGs do not have the financial resources to challenge the Colleges in court.

Many of the specialist Colleges have argued that unfair treatment is effectively dealt with by their appeals mechanism. While Colleges do have appeals processes in place they are extremely limited and ineffective. First, the appeals process does not allow an IMG to challenge a College policy itself. Consequently if an IMG is unfairly treated because of an unfair/irrational College rule or regulation they have no recourse to seek justice. Also IMGs who are not members of these organisations may not even be eligible to appeal. (see part 2 of Submission)

Another problem is the failure of these organisations to follow their own appeals processes and rules. Consequently, while on paper their appeals processes may seem reasonable the reality is they are ineffective. This situation arises because of the lack of external accountability in which these organisations are allowed to police themselves. Currently there are no negative repercussions in place for breaking the rules. This is analogous to having laws in place for speeding and drink driving but no negative consequences in place for breaking these laws.

Another major problem is the governance structure of the Colleges. While governance structures do differ slightly between Colleges in the majority of cases decisions relating to the assessment of IMG qualifications is made by a separate college committee – the Board of Censors. Committee members are largely appointed except for the Censor in Chief who may be elected by the committee members. The Board of censors operates largely independently from the rest of the College in that other committees including the College council do not interfere in the Board of Censors' business, discussions and decisions. Given that the members are not elected this organisation is not directly accountable to the college membership for its policies and decisions.

Another major concern is the lack of formal qualifications of the College Censors. In Colleges like the RACGP censors are not required to have any formal higher qualifications in Medical Education or Higher Education. This raises a critical question as to whether these people have the necessary knowledge and skills to be able to validly assess the quality of IMG qualifications. We would argue that they do not have the requisite educational background to be able to judge the qualifications of doctors who have trained and been assessed in different systems.

Lack of educational expertise may be related to another key deficiency in the Specialist IMG assessment process. Currently, many Colleges judge IMG

qualifications based on the similarity of education and training, not quality. There are a number of different models of Medical education and training - the most widely known being the British and North American models. Both models have their advantages and disadvantages but there is no evidence that one system is better than the other. Concerns about the practice of using similarity as a benchmark for quality of training has been voiced in previous reports. 52 There are numerous examples of highly qualified specialists from developed countries whose qualifications have not been recognised because of differences in training models. This has been a particular problem for doctors who have trained in the North American system.

Another concern is the evidence that the assessment of IMGs is influenced by College politics, particularly with respect to reciprocal recognition of qualifications in countries where Australians may want to work. On the other hand, hard feelings may arise when countries do not recognise Australian qualifications and may react by not acknowledging the other countries' qualifications. This can result in the situation where an IMG is more likely to be judged on the basis of the relationship (or lack of relationship) of the respective Colleges rather than the quality of their training. Evidence for this hypothesis is reflected in the very few non-English qualifications recognised by the Colleges (also where reciprocal recognition would not be pursued) and instances where Australia recognises a country's qualifications in the absence of mutual recognition. This raises an important issue of the government allowing College politics to influence the deployment of qualified and competent IMGs.

Of greatest concern are the numerous reports of the Colleges failure to follow the principles of natural justice and due process, as well as the unfair and unreasonable, and unjustified barriers put in place by the Colleges in order for IMGs to gain fellowship. These barriers have been described in past reports and include requiring senior IMGs to do many years of training followed by examinations when they have already demonstrated their competence by practicing for many years without incident in Australia. 53 54 55

These problems are long standing and continue to inflict intense suffering on IMGs and deprive Australia of highly skilled and much needed specialists. One example of the treatment of IMGs by the specialist colleges is that of Dr. Virdi which is described in detail in ADTOA's submission to the ACCC application for authorisation of the RACS. While this case is now ten years old it highlights a number of important problems with the system and their impact on individual doctors. The Race to qualify and ACCC reports confirm that these problems were not uncommon in the system.

We ask the members of the committee to compare the treatment of Dr. Virdi from 1986 to 2001 and compare it to that described in the more recent cases described later on in this submission, as well as any independent submissions they may receive from specialist IMGs.

Dr. Virdi was a cardiovascular surgeon who had done many years of specialist training in the UK and was a member of the UK Royal College of Surgeons. Dr.

Virdi started working as a cardiovascular surgeon in St. Vincent's hospital in 1986. In the next few years he would perform over 160 coronary bypass and valve replacement surgeries. Initially he was supervised by a senior experienced surgeon who described him as being in the top five in the world who he had worked with. Later he worked independently.

In 1989 he became a permanent resident. In 1991 his registration was revoked because of his immigration status. The Medical Board refused to extend his registration until he started his next job in the UK and he went without work for the next eight months until he moved to the UK where he continued to perform advanced cardiovascular surgery.

Dr. Virdi had applied for membership to the RACS in 1989 but was denied fellowship. This was prior to the establishment of the specialist pathway where all permanent resident IMGs had to pass Parts 1 and 2 of the AMC exams. In 1993, one year after the establishment of the specialist pathway, Dr. Virdi received notification that he was eligible to apply for recognition under the specialist pathway. Later that year he received a letter from the College censor-in chief informing him that in order to be eligible for fellowship he would need to do at least four years of advanced surgical training and do the final FRACS exams. He was also advised that it was unlikely he would be able to get a training post because of the intense competition for these positions.

In 1993 Dr. Virdi appealed the decision not to grant him fellowship. Dr. Virdi travelled twice to Australia from the UK for two interviews, the first with the AMC where they said they would arrange a face-to-face meeting with the College and the second with the college. At the second meeting, Dr. Virdi met with the College president and Censor-in-chief. At the meeting he was chastised for ignoring their advice and accused of trying to cut corners and sneak in the backdoor. Dr. Virdi responded that he knew of at least two other overseas trained surgeons with less experience than himself who were allowed to sit the exams after only working a few months in Australia. The end result was that not only did Dr. Virdi need to do the training and the final exam, he would also need to do the entry exam. In 1994 Dr. Virdi appealed the decision. The College ignored the appeal.

From 1993 to 1999 Dr. Virdi worked in the UK and India where he performed over 1000 procedures and acquired an international reputation. In 1999 he was contacted by a reporter in response to the Race to Qualify report about his experiences in the system. It was as this point Dr. Virdi decided to find out what had happened to his appeal. He wrote to the College who initially told him that he needed to reapply. However, the AMC told him that he didn't need to apply as his application was still open with no final decision on the record. Dr. Virdi's case was extensively publicised in the wake of the Race to Qualify report. In 2001 Dr. Virdi was finally awarded fellowship.

Dr. Virdi's story is unusual in that he had the courage to challenge the unfair and unreasonable conditions imposed by the College and he actually went public with his story. The vast majority of doctors that find themselves in Dr. Virdi's

position are not willing to go public for fears of reprisals from the College even if they return to their native country.

The following is a quote from one highly trained specialist who did their specialist training in a developed country who has suffered extreme professional and personal hardships as a direct result of the College imposed barriers to registration, about their reasons for not putting in a submission to this inquiry.

"I apologise for my reluctance to take part in the inquiry but the College and Board, with support from destructive elements within the profession could easily prevent a doctor from working anywhere in the world ever again. I came here in my XX with a good career prior to coming here. Losing everything at this stage of one's life is too much to bear."

"It is all so very unfair with a system which is easily influenced by those who wish to lend further disadvantage to vulnerable foreign doctors. I still hope that something good comes of all of this. The wrongs my family and I have had to accept should never occur in a civilised society."

Another specialist wrote about their IMG colleagues who;

"I don't think X or Y are prepared to submit as they are intimidated beyond belief."

The loss of this specialist had a profound impact on the community and delivery of highly specialised care to a large area of rural Australia potentially affecting tens of thousands of patients.

These doctors are not alone in their concerns about the vindictive nature of the Colleges. The submissions reported later also report warnings from colleagues about the dire consequences of challenging the Colleges on their decisions. There is often little if no sympathy for IMGs from their Australian colleagues. The unspoken message is that those who complain about their treatment and do not defer to the authority of the Colleges will suffer the professional consequences. Those who do not acquiesce are the seen to be the authors of their own misfortune.

English Language Proficiency Regulations

"Many overseas trained health professionals have shown great courage in risking everything to make a fresh start in Australia, a country which needs their skills.
They would be the first to acknowledge that they need to be great communicators, empathic listeners and sensitive doctors, dentists and nurses. They do not need to be linguistic professors."
Marg Talliday OET tutor

Background

Currently all international medical graduates, including some who have attended Medical School in Australia, and those who have been born and raised in English speaking countries (i.e. UK, Canada and US), must prove their proficiency in English prior to being registered to practice. The vast majority of these doctors must take an English test regardless of their native language. In order to be considered for an exemption from an English test, an IMG must produce evidence that they received their High School education in English! Currently, IMGs have the option of taking the Occupational English Test (OET) or the International English Testing System (IELTS). The Occupational English test has the advantage that it tests an applicant's command of the language in their professional context. The IELTS test has the advantage that it has been subject to stringent quality assurance measures that make it a fair and valid test. While the ILETS test is very reliable and valid many IMGs prefer to take the OET test as they find it easier to be tested in a professional versus layperson context.

There is no question that all doctors must be proficient in written and spoken English. However, the current rules and regulations imposed by the Medical establishment impose severe and unnecessary barriers to IMGs from gaining access to the Medical Workforce. We argue that the majority of these barriers are harsh and are not related to ensuring that IMGs have an adequate standard of English. Rather the evidence suggests that the English language requirements are being used as another tool to restrict IMG access to the Medical workforce, similar to the manner in which the AMC quota was used to control IMG numbers in the 1990s. We will provide evidence that these barriers are causing widespread and unnecessary suffering amongst doctors and other health care professionals.

The Health Care Professionals

In the last year this writer has been contacted by thirty health professionals regarding problems with the English language regulations, particularly the OET test. Of shock to this writer is the fact that over half of the people that contacted her were other Health Care Professionals. These overseas trained Health Care professionals had heard of the inquiry into overseas trained doctors and wanted to share their experiences especially those relating to passing the OET. Of the thirty health care professionals who contacted the writer regarding the OET test, twelve were medical doctors, eleven were dentists, five were nurses, one was a pharmacist and one was a veterinarian. I am also aware of a large number (approximately twenty) female doctors from Afghanistan, some of whom have passed their AMC exams, who are unable to get registered because they have been unable to pass the OET exam. I have spoken to one of these women personally who has communicated that the others are too intimidated to share their stories. Some of these women may need to return to Afghanistan, where their lives are at risk, if they don't pass the OET test.

In addition, this writer was also contacted by two English language tutors who were extremely concerned about the unfair nature of the current English language assessment methods/policies and the devastating impact these were having on a large number of people. One of these tutors has prepared a more

detailed discussion of the major problems with the OET, which is part of this submission.

Recurrent Themes

While this writer has no background or expertise in language assessment, a number of recurrent themes of concern emerged with regards to the current English tests and/or policies. Following is a description of these themes as she has perceived them with some specific exemplary examples.

Lack of reliability

One of the most striking and concerning aspects of the OET test was the lack of consistency in results for individuals over time. A significant number of these Health Professionals had taken the OET test multiple times over a course of many years. An accurate and fair test needs to be reliable and valid. The results of the OET are wildly inconsistent for the same person. It was not an uncommon story for a person to do well in one area at one sitting, then poorly in another and back up and down for the next round of testing. The following is an example of one result over rounds of tests. This individual needed to get Bs in all areas at one sitting to satisfactorily pass the OET test.

It is difficult to understand how a person's English ability can fluctuate so wildly over time. The other surprising fact is that the scores don't seem to improve with ongoing tutoring and/or English training. Almost all of the respondents had been involved in some form of English language training. It seems odd that such a large number of individuals, who are intelligent enough to satisfactorily complete post graduate studies and who have actively engaged in English language training, are unable to improve their scores.

Need for repeated tests

Another striking harsh and unreasonable requirement relates to the need to continue to take English tests after a doctor has satisfactorily passed their English test. This author has been contacted by a number of doctors who have satisfactorily passed the required English tests and have had to repeat these tests because their "results had elapsed". This is supposedly because the results of the English test are only valid for two years. While this policy MAY be understandable for doctors who do not live in Australia, it seems unreasonable to continue to make people who are living and working in Australia, to need to take an English test every two years! I have spoken to three doctors who have all worked in Australia as GPs for ten years, who have been asked to take an English test in the last year. All of these doctors had already taken and satisfactorily passed their English tests before they started work in Australia over a decade ago. One of these doctors who passed her English Toefel test ten years ago, AND has been granted an English exemption by the AMC, AND has been working full time as a GP in rural Australia for almost a decade, is now out of work (and her 8000 patients have lost a GP!!) and is probably going to need to leave Australia because she is having difficulty passing the OET test. While the

devils advocate may argue that this woman should not be practicing anyhow because her language skills are inadequate, it would seem that her difficulties do not relate to her English ability as described in the next section.

Confounding variables affecting results of tests

There are serious concerns that variables other than English language ability unfairly affect the results of the OET test, particularly in the reading section. These concerns are echoed by the English language tutors that I have had contact with. A number of people have complained that they have failed the reading test because they have been unable to complete the task on time. This reader also talked to an English speaking investigative reporter from The Age about the OET test. She and a colleague (and also an English speaking reporter) took the reading test. She reported that they passed but "barely". She reported difficulty with finishing on time. One of the tutors also discussed the difficulties one health professional was having who was a naturally slow person, and simply could not meet the time limit. This tutor felt that they would perform similarly if the test was in their native language because it wasn't as much a language proficiency issue as it was a speed issue. This begs the question; how important is language speed for professional competence?

Another problem is that performance in the reading section is also highly related to short term memory ability. In order to perform well in the test, not only do you need to be able to read and understand the text but you also need to be able to remember specific details. Short-term memory is very sensitive to stress. The OET test is a high-stakes assessment and many of the health professionals have reported extremely high levels of anxiety related to the test. While Medicine does involve the need to be able to perform under stressful conditions, it is not necessary (in this writers opinion) to be able to recall numerous new items of information under stress. The doctor described above who has worked for many years as a GP, and had recently failed the test, was under extreme emotional strain at the times that she took the test, as her entire future in Australia was completely tied to the results of that test. She failed the reading section.

Unfair test conditions

A number of people have complained about the conditions at the time of the test and its impact on their performance. These include not being able to leave to use the toilet for a number of hours or for the duration of the test, which is tantamount to nothing less than torture! Also, anxiety increases the levels of hormones that act as diuretics and diarrhoeal agents; to prevent people from using the toilet under stressful conditions is totally unacceptable!

Another example was having people need to stand out in the rain prior to the test for an extended period because the test was late getting started. This is simply an affront to basic human dignity!

Others have complained about the poor quality of the audio used in the test or of having hearing problems affecting their performance. Others have complained about the behaviour of the invigilators in that they were disruptive.

Following is one doctor's experiences
"Exam hall conditions were real shocking, it was very very cold , and raining and we were made to stand outside [the building, in the street], not allowed to talk, couldn't have a cup of tea ,etc. People who were new to the City, travelled so they could arrive early, they got really frustrated. We were not allowed to wear sweaters in spite of pleading "I am cold" [intolerant etc.] Inside the building the AC was full on in very cold conditions. We were not allowed any pencil cases, not given any transparent bags either. We were not allowed pacer pencils, there was no mention of not allowing pacer refill pencils, {which save time in sharpening] So I took a second pacer pencil- very thin with a transparent barrel - but i wasnt allowed, even a mint lolly wasnt allowed inside. I said my throat goes very dry with anxiety & stress, but was told "no". We had to carry pencils,rubbers,sharpener.pens, passport & candiate number paper & bag in one hand go from ground floor to 3rd floor & then to 24 th floor in both hands, while pressing buttons etc. I had a hand injury & had had surgery done, and in the process of travelling to the 24th floor, dropped a pencil lead and had [only] 2 left somewhere, so I was left with only one defective pencil, which needed repeated sharpening - as they had taken all my pacer pencils."

Another IMG appealed based on the harsh test conditions

"I attended the OET on Saturday, the XX in XX. There are a few things I would like to report to you:

1) During the interval between the listening and reading tests, I was not allowed to use the restrooms until the last moment. If I knew I could resist the urge to run into the bathroom, I would not ask for permission to go. However, I was treated in this uncivilized, disrespectful and unnecessary way. This made me very distressed for the reading test since I had to rush around at the last minute and had not settled down for the test yet.

2) After the reading test, I requested to use the bathroom again, having thought I had given enough warning (15 minutes is surely enough!) I was only told AFTER the writing test commenced that I was given permission to go. This meant using my test time to go to the bathroom when I could've done so during the break time. Furthermore, a female member of your staff has not been watching her mouth properly and let it loose, saying things to me that are definitely disrespectful for anyone's standards. This led to further distress which led to not completing the task on time.

Please kindly think over these incidents and find a solution so that they DO NOT affect our, being the candidates', performance in these series of tests."

The response was as follows...

"The OET Centre Appeals Committee has met and investigated your request for special consideration received XX A final decision has been reached based on OET Centre policy, information provided by the test venue and comments and supporting documentation supplied by yourself.

After a thorough review of your comments, the OET Centre Appeals Committee has decided to decline your request for special consideration. As per OET Centre policy, candidates are not permitted to take breaks between the sub-tests or leave the test room at anytime. Results from the administration of the OET on XX will be available shortly."

Discrimination against doctors with conditional registration

Another irregularity is the discrimination against doctors who have conditional versus unconditional registration. Currently the only registered doctors who have been asked to take an English test that this writer is aware of, are those with conditional registration. It would appear that IMGs who have unconditional registration are not being asked to continually repeat or take another English test. This policy makes no logical sense. Registration status is not linked with proficiency in English. Why would you make a doctor who has conditional registration take an English test because two years has elapsed and/or they are applying for a different position and/or the test standards have changed and not apply the same rules to IMGs who have Australian medical qualifications? The only logical explanation is that the latter group is a far more politically powerful entity and would simply not tolerate such conditions.

Inconsistency in application of English language policy

Another problem is the lack of consistency in applying the English language policies and standards and the granting of exemptions. On the one hand we have doctors that have worked here for ten years and who have previously been granted an exemption for English test, being forced to take an OET test. On the other hand we have the case of a doctor who has been granted an exemption from taking an OET test because they took their nursing degree (x 3 years) in Australia. We have numerous examples of doctors who have been asked to provide proof of proficiency in English and many who have not been asked. The rationale behind who is asked to take the OET test and who is not defies logic.

Conclusions

These stories provide strong evidence that passing the OET test is a significant barrier to registration. The experiences of these Health Care professionals raises serious concerns about the fairness and validity of this test. We are particularly concerned about the irrational nature of some of the English language requirements such as the need to take an OET test every two years for IMGs who are living and working in Australia. We are also concerned that the standards are set at levels that are unnecessarily high in that many Australian born professionals would struggle to pass it. The following chapter presents a detailed description of the problems with the OET and the impact it has on doctors as well as other overseas trained health professionals.

The Occupational English Test

This paper relates anecdotal evidence received from overseas trained health professionals, all of whom have encountered months and years of frustration in trying to satisfy the requisite pass standard at the Occupational English Test.

It is asserted that there is much room for improvement to make the registration process a fairer one, thus enabling the backlog of highly skilled health professionals with very adequate English skills, the ability to move on with their professional lives and to ease the paucity of supply in rural and regional areas.

The OET Centre in South Melbourne is cloaked in secrecy: a candidate who seeks information must make an e-mailed request. Candidates cannot retrieve their writing material submitted at a test. They cannot obtain a copy of their recorded speaking test. If one wishes to learn *why* they did not gain a pass in speaking or writing, the only course of action is to request, and pay for, a written report. This *modus operandi* prevents failed candidates getting a second opinion on their writing and speaking performance. Natural justice is thus denied.

The OET is a high stakes test: without a pass in OET, a candidate's professional career in Australia cannot progress. Not only is the test itself a stressful event, the administration of the test on a given test day is designed to "ramp up" stress levels. Once seated in the test room, a candidate is not allowed to have a toilet break – unless accompanied by an Invigilator – and only when the test has started. During the short in-between breaks (between the listening, reading and writing subtests), candidates are not allowed to leave the room. Candidates are not allowed to eat candy or drink anything in cans or bottles – other than completely clear water, in a completely clear plastic container. Pregnant or menstruating female candidates find this 3-hour session particularly stressful. Speaking tests are carried out by appointment. Many candidates report having difficulty hearing the listening soundtracks and that their requests to turn up the volume are dismissed. Requests to move closer to a speaker are refused.

This paper focuses on "the administrative processes, assessment processes, appeal mechanisms and support programs" in relation to the Occupational

English Test. Ways on how "impediments could be removed and pathways promoted, to assist OTD's in achieving full Australian qualifications, particularly in regional areas, *without lowering the current standards as set by professional and regulatory bodies*" are also looked at. (AHR, Media Alert, 24 Nov 2010)

Candidates' personal comments are included throughout this paper in dark blue.

ADMINISTRATION & ASSESSMENT OF THE OET TEST

Candidates regularly report that they are **not allowed to go to the toilet** during the five minute break between subtests. They may be escorted to the toilet ***after*** the listening / reading / writing test has started – but not before. **This is a calculated ploy to diminish one's human dignity.**

At the October 16th (2010) test - a drizzling cold morning in Melbourne - candidates were congregating inside the building to get out of the weather - about 8.30am / 8.40am - there were about 50 at that point - someone from the OET testing centre came down to the ground floor (440 Collins Street) and told them - 'you can't wait here - we don't rent this part of the building - you will have to wait outside'. They shuffled out into the cold, bleak, windy morning - and slowly but surely got wet and frozen to the core. *Then* they were allowed inside the building - and into the examination rooms. **The rooms themselves were airconditioned further heightening the frigid conditions that had to be endured throughout the test.**

Some candidates have reported **not being allowed to sit the test** after paying all requisite application fees and receiving their candidate number - due to I.D. problems:

i) Sri Lankan nurse – who had sat the OET test several times before and *always* used her "common name" – had been registered – had been allowed into the test room on past occasions - yet **was not allowed into the test room** at the August 2010 test – because the name of her Passport was different to that on the test receipt. **This candidate had brought with her a Statutory Declaration signed by a member of the Victorian Police Force, attesting to the fact that she was the one and the same person as on the Passport. The OET official refused to look at the Stat Dec.** She was refused entry; she did not get a refund; the September 2010 test was cancelled by the OET Centre; this candidate has now given up on the OET.

ii) Sri Lankan dentist – applied for, paid for, and was accepted – to sit the July 2010 OET test. At the time his Sri Lankan passport was valid. By the time the test had rolled around his Passport was 7 days out of date. He was refused entry to the test; he was not given a refund. At the time of the test he was waiting on confirmation of his Australian citizenship.

Candidates can get **official feedback** on their writing and speaking tests - but not the reading or listening tests. What they cannot get, of course, is the actual writing they submitted in the test, or the soundtrack recorded during their speaking test.

- "There is qualitative feedback that we can ask from the OET Centre .. but the OET website says that this feedback *will not change the OET result.*"

The Listening Test has two parts: Part A is a consultation between a health professional and his/her patient. This takes 8 to 10 minutes. Candidates are required to fill in missing information on their question sheets. Part B listening is a monologue – a 25 to 30 minute long lecture – on a health-related topic. The last 2/3rds of this monologue is delivered at a fast pace (about the same pace as a news reader). Candidates must abbreviate their answers – otherwise they will not keep up. At previous tests candidates have been given "two minutes to go through the paper and complete your answers" - giving folk time to fill-out abbreviated forms. At the January 2011 test, candidates **were not given** this two minute time slot. Many papers will be handed in with abbreviated forms written on them - jeopardising those candidates' chances of a pass in listening.

Candidates must score an average of 65% over both Part A and Part B listening. **Assessment** is done by human beings who place a transparent template over the answer sheets which allows quick checking of answers.

The administration of the Listening Test leaves much to be desired:

- "... we are facing a lot of disturbances from the invigilators in the listening test ..."
- " ... they just used the computer speakers so it is very difficult to hear clearly."
- " ... in particular the listening [focuses on] one's short term memory rather than one's English proficiency. I believe most of native English speakers at the age of 50 will not have that kind of memory and therefore wont be able to pass the listening module ..."
- "... that's probably why they make the speaker talk faster, in some cases, almost "running out of breath" so candidates can't follow quick enough. That makes this test very difficult for other candidates. That's my conclusion!"
- "I found listening, which is the first subtest, very hard for me – then I felt stressed and couldn't concentrate in the other subtests as I know I have to repeat all of them."

The Reading Test requires candidates to read four pieces of text on the same theme – then, using those – fill in 30 gaps (known as a 'cloze' exercise) on the summary sheet. The time given for this entire Part A reading test is 15 minutes.

Part B reading requires candidates to read two longer pieces of texts – each one 1,000 to 1,100 words - each one having 10 multiple-choice questions. The time given for this entire Part B reading test is 45 minutes.

Each multiple-choice question has four options: a, b, c, d. Two of the options are usually quite clearly wrong answers. The remaining two are carefully worded with a slight nuance of difference – for example "The author expects ..... " compared to "The author anticipates that .... " .

Another favourite line of questioning is to select a word from the text – example:

> The prices could be regulated and affordable such that any black market dealing would be
>
> unviable; not illegal, just not worth the effort.
>
> Q. In paragraph 2, the author uses the word 'unviable'. Does this mean
> a. illegal
> b. legitimate
> c. unworkable
> d. legal

- "In the reading test, Section A, they did not give 15 minutes – they did not use standard timing – they used their watch. .... They only gave me 12 minutes."
- "The reading part is really hard and, of course, the first part there is not enough time. I know many people who tried OUT more than me and are still struggling with reading."

Assessment of the Reading Test is done by computer. Part A is worth 1/3 of the overall mark; Part B reading is worth 2/3rds of the overall mark.

The Writing test requires candidates to write a letter: a letter of referral, or a letter of discharge, or a letter to the owners of an animal - based on information contained in a " case study ". Criteria to be observed includes

1. good grammar and spelling
2. appropriate language (using correct pronouns, salutations, endings)
3. addressing the given tasks at the bottom of the case study notes
4. correct format

This latter criterion demands letters be dated, correctly addressed, correct salutation used, blank lines between paragraphs, correct punctuation, few abbreviations (*not ECG but electrocardiogram)* , concise and cogent information.

Candidates have failed in the past because they did not put a clear line between paragraphs.

If you fail the writing test the candidate can ask for feedback – at a cost of $85.

Original written work is not returned / available.

Assessment is done by English language tutors who read the letters for grammar, cogency, cohesiveness noting the letter's formatting style and formality of language style. [See scoring grid, next page].

Appendix B: Extract from scoring grid - writing sub-test

OVERALL TASK FULFILMENT

Completely satisfactory _ | _ | _ | | _ | _ | _ Unsatisfactory

APPROPRIATENESS OF LANGUAGE

Appropriate _ | _ | _ | | _ | _ | _ Inappropriate

COMPREHENSION OF STIMULUS

Complete _ | _ | _ | | _ | _ | _ Incomplete

CONTROL OF LINGUISTIC FEATURES (GRAMMAR AND COHESION)

Complete _ | _ | _ | | _ | _ | _ Incomplete

CONTROL OF PRESENTATION FEATURES (SPELLING, PUNCTUATION)

Complete _ | _ | _ | | _ | _ | _ Incomplete

McNamara, T. (n.d.) *Problematizing content validity: The Occupational English Test (OET) as a measure of medical communication*, Melbourne Papers in Language Test, University of Melbourne, p.40

The Speaking Test is, *prima facie,* to test a candidate's English speaking abilities requiring them to demonstrate -

1. good spoken grammar
2. ability to maintain "meaningful communication" throughout the test
3. their professionalism in the way they handle stressful (non compliant) patients
4. their "bedside manner" - sounding friendly and open towards their "patient"
5. they can complete all the given tasks in their role card

Candidates are given an appointed 20 minute time slot - some time is spent on –

"warm up" (which is recorded); [See note about the "warm up", p.6]
2 minutes preparation time for Role Play No.1 and
2 minutes preparation time for Role Play No.2.

That leaves about 13 to 14 minutes to do the two role plays.

Most candidates find this kind of testing quite confronting – they need to use imagination, dramatic flair, and to be able to handle roleplayers ("the patient") who remain mute – or nearly mute – when answering the candidate's questions.

A reliable source asserts that "roleplayers receive no training for this test. That has been the situation now for the past two years."

The recorded performance is sent **away for assessment by an unknown assessor who listens to the recording and marks the performance accordingly.**

If you fail the speaking test the candidate can ask for feedback – at a cost of $85.

Original soundtracks are not returned / available.

- "There is qualitative feedback that we can ask from the OET Centre but the OET website says that this feedback will not change the OET result. So I didn't try to ask for this feedback."

Scoring grid for the Speaking sub-test:

Appendix A: Extract from scoring grid - speaking sub-test

OVERALL COMMUNICATIVE EFFECTIVENESS

Near-native flexibility & range _ | _ | _ || _ | _ | _ Limited

INTELLIGIBILITY

Intelligible _ | _ | _ || _ | _ | _ Unintelligible

FLUENCY

Even _ | _ | _ || _ | _ | _ Uneven

COMPREHENSION

Complete _ | _ | _ || _ | _ | _ Incomplete

APPROPRIATENESS OF LANGUAGE

Appropriate _ | _ | _ || _ | _ | _ Inappropriate

RESOURCES OF GRAMMAR AND EXPRESSION

Rich, flexible _ | _ | _ || _ | _ | _ Limited

McNamara, T. (n.d.) *Problematizing content validity: The Occupational English Test (OET) as a measure of medical communication*, Melbourne Papers in Language Test, University of Melbourne, p.40

- I was really shocked and surprised when I saw my third OET result. I did not expect Grade C in Speaking. I thought I had done great in Speaking – as in the previous tests. I had a lot of confidence when I sat the Speaking module. I thought I would get a grade B in Speaking on the third attempt. If I'm not good at Speaking, why did I get Grade B in Speaking on the previous tests?"

---

* The "warm up" for the Speaking Test is, ostensibly, *not part of the test itself.* One doctor, when questioned about his current work commitments during the warm up, answered he was working at the Monash Medical Centre. A few weeks later

this same candidate (who did not clear all four subtests) was requested to leave his post at the Monash Medical Centre because "he had not yet passed the OET".

APPEAL MECHANISMS and SUPPORT PROGRAMS

From FAQ section, *www.occupationalenglishtest.org [accessed 18 Jan 2011]*

I don't know why I got this result. How can I get more information?
If you are not sure why you got a certain result, you can apply for **qualitative feedback**. Qualitative feedback is available for the Writing and/or Speaking sub-test and is provided only when the grade you got requires you to re-sit the sub-test. The feedback consists of a brief written report that provides information against the assessment criteria. **Applying for qualitative feedback will not change your result.**

You must order qualitative feedback within **three** weeks of the date of online publication of results. The cost of the service is **A$85** for each sub-test request. Your feedback will be sent to you within approximately four weeks from the date of your order. To order qualitative feedback, log into the OET website and go to My Details. Click on the 'Order Qualitative Feedback' link at the bottom right of the page and follow the instructions. Payment can be made by credit card only (Visa or MasterCard). Please note: qualitative feedback is non-refundable.

TYPICAL FEEDBACK REPORT

QUALITATIVE FEEDBACK 12 December 2010
Administration: 16 October 2010

Speaking
An analysis of your marks indicates that you were in the high C band. You were marked by two assessors, who awarded you very similar marks. The criteria against which the Speaking sub-test is assessed are as follows:

Overall Communicative Effectiveness – relates to how well the candidate maintains meaningful interaction

Intelligibility – relates to pronunciation, accent

Fluency – relates to repetition, self-correction, hesitation, speed of delivery

Appropriateness – relates to register, tone and lexis

Resources of Grammar and Expression – relates to effective use of vocabulary and grammar

Comments on performance
In general, lower marks were awarded for the criteria *'Resources of Grammar and Expression'* and *'Intelligibility'*.

The following comments relate to the areas of your performance that *most* affected the marks awarded.

Significant feature 1
While a range of grammatical structures are mostly used accurately, there are times when word order or word choice is inaccurate, affecting *'Resources of Grammar and Expression'*.

Specific examples
'We can not **only** *treat this tooth only with* **a** *filling, we should have a crown on this tooth* **as well**...'

'I'm afraid there **this** *is the only option you have here, you* **can** *only should have a crown...'*

In these examples, you need to be more direct as there is no real choice, so use other stronger modal verbs, such as 'have to'/ 'need to'.

'As I've seen on your mouth... **Now I've had a look at/examined your mouth** *...and you said that you...you didn't...you won't...you haven't go* **been** *to the dentist for two years...'*

'You should have routine dental care, you should brush your teeth at least twice a day and floss your teeth, that is the only thing you should **all you need to** *do...'*

Overuse of 'should' can be avoided with other choices such as 'It is important to' or 'have to' or 'we recommend'.

Significant feature 2 While most of your speech can be easily followed, there are occasional patches of strain for the listener, affecting *'Intelligibility'*.	**Specific examples** Pay attention to which syllable in a word is stressed. con**cern** alloy ceramic Also take care that no syllables are omitted. sens**i**tivity periodont**i**tis
Significant feature 3 Question forms can be inconsistent at times. Altering the word order of questions can be distracting, affecting *'Resources of Grammar and Expression'*.	**Specific examples** *'Do you know when did it happen* **it happened***?'* *'Can you a little tell me about your brushing?'*
General Comment Overall, your speech is clear and you are able to maintain the interaction well.	**Specific examples** Some inconsistencies with grammar and pronunciation need to be worked on to improve your performance.

For useful ideas on preparation for the Speaking sub-test, please refer to www.occupationalenglishtest.org

We hope this feedback is helpful and wish you success for the future.
Yours sincerely, Assessment Services The OET Centre

NOTE: An mp3 soundfile of this candidate's speaking abilities is being held for safekeeping and can be produced if required. He is clearly an accomplished English speaker.

SUPPORT PROGRAMS ASSISTING OTD's IN MEETING REGISTRATION REQUIREMENTS

- Doctors Connect, a government website helping those IMGs who have passed the
  English test (IELTS or OET) plus the AMC-MCQ exam, to find work.

- Rural Doctors Association of Victoria
  http://www.rdav.com.au/overseasTrainedDoctors.html

- Australian Overseas Trained Doctors Association www.aotda.org

MANY SEEK SUPPORT / HELP BUT ARE IGNORED

Many health professionals are facing financial disaster after spending thousands of dollars on preparation courses, application fees, clinical tests, the Medical Council's multiple-choice question test and bridging courses:

- "After arriving in Melbourne, I contacted the Dental Board to obtain registration and was advised that the rules had changed and I would now need to undertake a further course of study in order to register. This course is for one full year, conducted in Adelaide and costs $27,000. Having to undertake such a course is difficult for me for a number of reasons."

- "As a temporary resident, I am not covered by Medicare, am not eligible for Social Security payments, nor are my children eligible to go to State schools. I am not even in a position to apply for a bank loan ... "

- "My casual employment with my sponsoring employer provides a small amount of money which does not in any way cover our family expenses. As such, our family is relying on savings to meet all these expenses, including rent and living expenses. "

- "We have already spent over $2000 plus study materials and accommodation, because I live in Gippsland and have to travel to attend the test. We can't plan a baby until I pass all the tests and it feels like it is going to take ages to do so. "

- "It has cost me $15,000 in English preparation classes, bridging courses and test application fees."

- "I have spent nearly $6000 on OET (test fees and for preparation courses including private coaching). After I got my last results I was very depressed. My teacher was quite surprised because she was sure that I would get through it and said my standard of English was quite good."

UNBLOCKING PATHWAYS

Australia has a long history of not welcoming others – starting with the Chinese gold-diggers in the 1850s – through to Vietnamese 'boat people' – and before them, Jewish refugees on the goodship 'Dunera'. It continues today with asylum seekers and refugees from war torn countries and corrupt regimes.

The OET English test is social engineering and immigration filtering at its best. It is a revisit to the White Australia policy era where immigrants were tested in Gaelic.

Australia is a massive landmass, largely unpopulated, much of it environmentally hostile and (currently) uninhabitable. It's the "lucky country" - free from political oppression – where settlers can follow their choice of religion, have freedom to voice an opinion without fear of being incarcerated, where opportunities are plentiful for those willing to "give it a go", where the air is clean and the water is drinkable.

The OET Test has raised its passing standard – from a "C" a few years ago – to a "B" or an "A" today. **It may be time to relax the minimum standard from a "B" to a "C+"**

At one time, candidates had two years to complete all four subtests. Now they must gain passes in all four subtests *at the one sitting*. **Gaining passes in all four subtests *over a period of twelve months* – that is – being able to re-sit individual subtests rather than being required to sit all four subtests all over again – would seem to be a fairer way of doing things – and save the candidate money.**

If a candidate gets 3 B's and one C - they must re-sit the test – and pay another $540. **Being required to sit again and again, all four subtests, is financial draining.**

Many find themselves sitting the test over and over again:

- "We studied the 4 and ½ years course in English; referred to English medical books; all lectures were conducted in English. In January 2008 I got B, C, C, D; May 2009 got a B (instead of the D in 2008). Sat the clinical test in March 2010 – but OET had now expired. April 2010 got B, C, C, C. In July 2010 – not allowed to sit as Passport was one week out of date; August 2010 got B, C, C, C. "

- I can't participate in dental exams without passing OET. I started to sit OET in April 2010. I have done it four times – I keep getting A, B, B, C. My local MP, Darren Chester, wrote a letter to the OET Centre asking for feedback on my reading but we haven't heard from them yet. "

- "I have successfully completed all the AMC exams including the OET with four B's in May 2007. Since that time I have been unable to register with the NSW

Medical Board. I financial thousands of dollars to complete all the above exams . . . I have appeared in the OET exam 15 times and passed 3 skills with A or B grade several times but always fail the 4th subtest. It seems an endless exam and I have lost three years just because of the English which I did successfully and provided the result to the AMC. I have approached several authorities such as the Health Minister, several members of Parliament but they only show sympathy."

- "I know dozens of IMGs who passed the AMC exams in 2007-2008 including the OET with 4 B's and now they are unable to pass the same exam. These doctors are so afraid and do not take any steps in relation to getting registration. I have completed all my education in English including MBBS (Pakistan). "

Doctors, dentists and nurses who gained a pass in OET prior to 2008 are being called to re-sit the OET test and to show they can still pass the OET at the new "B" grade level. What if they can't ? Do careers fall apart ?

Careers are being putting on hold or in jeopardy:

- " I was working for three years at the Bendigo Base Hospital as an HMO (2007 to 2010). This year I couldn't work because of my bridging course and AMC exam (including an unsuccessful attempt). After a successful result from the exam, I wanted to continue my work in Bendigo. However the Medical Board rejected my registration application because of the expiry of my English test (OET)."

- "I have spent four months in Melbourne attempting to obtain registration as a Dental Hygienist, in accordance with my Visa requirements, to no avail. The Department of Immigration and Citizenship have expressed an intention to cancel my Visa and my family's Visa, if I am not able to obtain any form of registration in the near future.

- "I am a qualified Dentist, having graduated from Cairo University. I also hold postgraduate qualifications from Germany and USA. I have been practising for fifteen years and am registered in Egypt as a Dentist and Dental Hygienist. I arrived in Australia on a Temporary Business (Long Stay) – Standard Business Sponsorship (subclass 457) having met all the necessary requirements of the Visa, *including a positive assessment through Vet Assess* according to the Australian Qualification Framework for a Dental Hygienist. ... I am trying to comply with my Contract of Employment and to become familiar with the Australian standards of Sterilization and Infection control, and the role of a Dental Hygienist. Despite this, the Department of Immigration and Citizenship have advised me that if I cannot obtain limited or provisional registration, they will cancel my visa and require me to return to Egypt. "

There seems to be many anomalies with the current system:

Most health-industry jobs require the applicant to have medical registration. Overseas-qualified candidates need to be permanent residents or on a working visa, prerequisites which most cannot fulfil.

- "I have concerns about the OET. It is said that "B" means *able to use English with fluency and accuracy adequate for professional needs.* I think this definition is too obscure and impractical. How adequate is " good enough " ?

- "The doctors who have passed the AMC-MCQ as well as English can be offered help with finding a job. Why are IMGs like me, who have passed the AMC-MCQ and the clinical exam, [but not the English] not considered eligible? In my opinion, the government can set up an alternative pathway for these IMGs and **allow them to look for work while continuing their practice, but [make] English a requirement in order to gain full registration**."

Yes – health professionals need to be able to communicate clearly using English;
Yes – health professionals need to understand what their patients are saying;
Yes – health professionals need to be able to accurately read and interpret information.

But...they do not need to be linguist professors.

20 Jan 2011

<u>s19AA, s19AB and a Proposed Workforce Solution</u>

by Dr. Jonathan Levy MBBS FRACGP

The proximate reason for this hearing is the PESCI situation that we now face. However, it is vital that the *basis* for the current situation is examined. Ignoring the causes will ensure that we face exactly the same problems in the future.

The background to the current situation is s19AB of the Heath Insurance Act, 19731. This section was introduced into practise in 1997 and restricts Medicare provider number issuance to (so-called) overseas trained doctors and foreign graduates of Australian & NZ medical schools. Provider numbers are available to these groups only when working in a designated 'district of workforce shortage' (DWS), generally for a period of ten years from first gaining medical registration.

A further basis to the current PESCI problem is s19AA2. It is designed to promote general practice and to achieve long-term and widespread improvements in the quality of doctors. S19AA legislation applies to all doctors, but has had a

disproportionate and negative impact on overseas-born doctors compared to Australian-trained graduates.

Each of the above will be discussed below.

We will also present a potential solution to the current legislative and workforce situation.

s19AB

Precis:

1) s19AB of the Health Insurance Act, 1973 (HIA) is unlawful as it contravenes
   a) s10 of the Racial Discrimination Act, 1975 (RDA)3
   b) s2A of the Competition and Consumer Act, 2010 (CCA)4
2) s19AB has resulted in a *relative deterioration* in rural and remote health provision
3) Significant reform to the operation of s19AB was strongly recommended in 2006. Not only was this ignored by DoHA but the report itself (A Review of Section 19AB Guidelines and a Model for Revision, Dr. Eleanor Long, July 20065) was suppressed
4) s19AB defies international conventions on the specific human right pertaining to freedom of employment

s19AB is an anachronistic piece of legislation that was imposed as a stopgap measure to shore up the rural/remote medical workforce just after a period when it was mistakenly thought that Australia was 'over-doctored'. This assumption was later reversed, when it was realised that there was actually a workforce deficit.

s19AB has been in force for fourteen years, with minor alterations in 2001 and 2010. During that time, rural health has declined significantly. This is evidenced by an emerging and consistent picture, within which two facts stand out:

a) 62% of rural Australians are experiencing a significant shortage of health professionals in their area.6
b) There are 4600 more rural/remote death per year than would be expected in any major Australian city with the same mortality rate. This is, in part, due to the lack of access to medical staff.7

S19AB has strongly contributed to the inequity between service provision and workforce distribution, by placing a vast proportion of the burden of regional healthcare on the relatively numerically small number of immigrant doctors. The far greater number of Australian-born doctors has been left legislatively untapped, resulting in a maldistribution of practitioners in favour of the cities.

It is quite clear, after almost a decade-and-a-half of s19AB, that the policy simply has not worked. The best that can (and has) been said for it is that it has "....stopped a bad situation from becoming disastrous".8

It would be well worth considering – as a sort of mental experiment - how the situation might currently be if rural/remote workforce provisions had been catered for in a different manner; for example, by *routinely* utilising the vastly greater numbers of Australian-trained medical graduates in rural/remote roles. It must be agreed that the regional health workforce landscape would be vastly altered, and for the better.

The pragmatic reasons of 1) the relative failure of this legislation and 2) the inability to pursue a long-term course of supplying Australian workforce needs from abroad would be compelling alone. However, strong consideration should also be given to the legal and moral underpinnings to s19AB.

To divide a group of people based on an arbitrary factor is unethical. In this case, the group of doctors practising in Australia is divided into two groups – ostensibly by the place of undergraduate degree.

If this were taken at face value alone, it would be problematic. A doctor may have practised for many years since graduating – perhaps with the bulk of those in Australia. They may have numerous postgraduate qualifications. What relevance does the *place of undergraduate degree* have to the current practise of that doctor? It is an utterly arbitrary measure, with the sole intent of hiving off a portion of the medical workforce to fulfil a role that the majority of local graduates are unwilling to undertake.

However, the location of undergraduate degree is actually a way of hiding the truth of s19AB. It subdivides doctors based on *place of birth*. This is clear from the following:

1) Foreign-born medical students *in Australian universities* are subject to the very same s19AB ten year moratorium restrictions upon qualifying. They *trained* here – the same as all of their peers – and will *qualify* here. But they were not *born* here. This rather gives the lie to the premise that it is the place of training rather than place of birth that counts.

2) The fact that one attains their medical qualification in place X is obviously a direct consequence of having been born and raised in place X. This is overwhelmingly the case and it would be quite unreasonable to have expected one to undertake their undergraduate studies in Australia when born and raised abroad. I believe that it is similarly unreasonable to restrict ones practise now for not having done so.

And discrimination based on *place of birth* quite clearly contravenes the Racial Discrimination Act, 1973.

s10 of the RDA is pertinent. Its foreword lays the ground for the intent of the Act:

If, by reason of, or of a provision of, a law of the Commonwealth or of a State or Territory, persons of a particular race, colour or national or ethnic origin do not enjoy a right that is enjoyed by persons of another race, colour or national or ethnic origin, or enjoy a right to a more limited extent than persons of another race, colour or national or ethnic origin, then, notwithstanding anything in that law, persons of the first mentioned race, colour or national or ethnic origin shall, by force of this section, enjoy that right to the same extent as persons of that other race, colour or national or ethnic origin.

It is worth anticipating and answering the governmental defences to our allegation that s19AB is discriminatory.

1) s19AB legislation does not stop one practising, merely restricts ones patients from claiming Medicare rebates for ones service.

Rebuttal of this defence is clear. The RDA is concerned with the *effect* of a law – not its intent nor wording. This was clearly defined in the following three cases: *Gerhardy v Brown, Mabo v Queensland [no 1] & Western Australia v Ward* and is beyond contest.

To this, one should add the knowledge (as is known by all general medical practitioners), that if a patient is unable to access Medicare rebates for ones service, there will be a very severe restriction on ones ability to practise – to the extent where it may be impossible to generate an income at all.

When seen in this light, s19AB has the *effect* of restricting ones ability to practise as a doctor. This 'real life' effect is clear and, thus, unlawful.

2) Each doctor had foreknowledge of s19AB before deciding to practise in Australia.

This assumption is questionable – to say the least. The Eleanor Long Report of 2006 (which was only relinquished to me under FOI legislation with the threat of exposing its suppression to this hearing) makes it exquisitely clear just how convoluted and opaque the system for medical registration really is.

Add to that an incomplete grasp of English, possibly dire overseas current living circumstances and an Australian Medical Council who act more as a barrier than an aid and it is easy to see that many doctors would *not* have an understanding of just what they were letting themselves in for.

And, in any event, since when did foreknowledge of any discriminatory law make that law suddenly non-discriminatory?

The RDA is based upon the *International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)* and the *Universal Declaration of Human Rights,* to which Australia is a signatory.

To quote the former:

Article 5 (e)(i): *The rights to work, **to free choice of employment**, to just and favourable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favourable remuneration;*

and the latter:

Article 23. (1): *Everyone has the right to work, **to free choice of employment**, to just and favourable conditions of work and to protection against unemployment.*

Australia – by any standard - is a developed/first world/Western nation and has undertaken a duty to adhere to these universal conventions. Indeed, itself an example, the RDA draws heavily on both these and various human rights precedents and obiters from other countries. Why should one part of the legislation (RDA) so choose this path and another (s19AB, HIA) utterly ignore international convention?

It is recognised (as exemplified by modifications to s19AB and also the Citizenship Act in 2010) that Australia's medical system shares many similarities to our closest neighbour's – New Zealand.

It is perplexing, then, to note that New Zealand had a *very* similar system to s19AB and the ten year moratorium operating until 1998.....which was found to be discriminatory *(Northern Regional Health Authority v Human Rights Commission[1998] 2 NZLR 218).* Australia – despite analogous health systems, legislation and internal milieu – has chosen to ignore this precedent, made on our doorstep, for thirteen years.

To move from human rights to competition restriction.

It is fairly clear that the effect of s19AB is to restrain the trade of a subsection of the medical workforce, through restriction of provider number issuance.

The question is whether this is a lawful restraint of trade.

The relevant legislation is the Competition and Consumer Act (CCA) 2010, s2A(1 and 2b). To quote:

2A Application of Act to Commonwealth and Commonwealth authorities

(1) *Subject to this section and sections 44AC, 44E and 95D, this Act binds the Crown in right of the Commonwealth in so far as the Crown in right of the Commonwealth carries on a business, either directly or by an authority of the Commonwealth.*

(2) *Subject to the succeeding provisions of this section, this Act applies as if:*

(b) *each authority of the Commonwealth (whether or not acting as an agent of the Crown in right of the Commonwealth) in so far as it carries on a business*

The (anticipated) potential federal rebuttal stems from s2C(1b)9, where it may be contended that a Medicare provider number constitutes a licence and s2C(1c)9 DoHA is exempt as it is not a "business"

These may be refuted as follows:

A doctor is licensed by the medical board (AHPRA) to practise. DoHA does not provide this licence. The Medicare provider number relates to *the patient.* ie. his/her ability to reclaim all/part of their expenditure when seeing a particular doctor. A medicare provider number is not a licence and it does not, thus, provide an exemption to the law.

To all intents and purposes, DoHA *does* act as a business. When perusing DoHA documents or website, a reading of the terms, phrases, intent etc. are all redolent of "normal" (ie. private sector) business activity. DoHA budgeting for projects reads like a company department presenting a business plan to its board. What is the material difference between the financial actions of DoHA and a business enterprise?

When taken in the round, ADTOA would allege that DoHA utilises discriminatory legislation to illegally restrain trade, in a manner that has been detrimental to the workforce.

s19AA

This section of the HIA is ostensibly egalitarian and applies to all doctors – regardless of where they trained/were born. Its intent is admirable – to raise the standard of Australian medical practice across the board.

However, the numbers speak for themselves. Those who fall foul of s19AA are overwhelmingly overseas-born doctors. Indeed, this is the immediate backdrop to the PESCI debacle.

The reason for this is understandable when the following is considered.

An overseas born doctor must relocate to Australia. Even if not a refugee, there will be significant immigration barriers to smooth transition – involving dozens of forms (in complex English – a second language to most), physical examination and interview(s). There is also responsibility for the family, their immigration status and settling into an entirely new life.

Then there is the issue of medical board registration and the often vastly prolonged procedure of AMC verification that can take years. Each of these is festooned with (literally) kilograms of paperwork and forms and the examinations each require months of preparation.

Having undertaken all of the above, ADTOA members can testify to the logistical nightmare that it presents. (Perhaps, as an aside, this fact also goes to indicate

just how much we all desire to be Australians and, consequently, how much of a 'slap in the face' ss19AA & AB represent.)

All of the above is often exacerbated by a lack of English and family considerations – not least spousal and childrens' inability to access healthcare (ironically, the very system being propped up by the immigrating doctor), employment and education.

The process sets an immigrating doctor back *years*.

By way of contrast, an Australian-trained graduate has a clear, unimpeded and streamlined process to fellowship, thus satisfying s19AA – as a de rigueur part of ones medical career.

Again, the *effect* of s19AA legislation is discriminatory in its impact. s19AA of the HIA quite clearly contravenes s10 of the RDA.

s19AA also contravenes the CCA, in that there exists a difference in Medicare rebates payable to those doctors with fellowship (so called 'vocationally registered') and those without. If one cannot access that fellowship in as easy a manner as ones peers, the result is the loss of potential patients as they have to pay relatively more for ones service. Thus, the CCA is contravened.

Whilst ADTOA does not advocate that the *intention* of s19AA should be abandoned, we strongly advocate that its current form and application be closely examined and fundamentally changed. The *effect* of s19AA should be felt no differently by any group of doctors – all should enjoy the same opportunities to progress towards fellowship and no group singled out for additional hurdles.

We would like this legal critique of ss19AA and AB to be read and understood in conjunction with the individual submissions from affected practitioners. It is only truly possible to grasp the *reality* of the effect of this legislation by viewing it through their prism. Those effects have been breathtaking in some cases, not worthy of a modern, developed nation.

As individuals, the submissions of Drs. Sue Douglas and Jonathan Levy clearly illustrate the actual effects of s19AA and s19AB on specific careers and could usefully be taken in conjunction with this ADTOA submission.

A Proposed Solution

Introduction

Much as we profoundly disagree with the current s19AB legislation (and all that stems from it), the reality is that approximately 41% (52% in rural W.A.) of the rural/remote workforce is made up of overseas-born doctors and it is this unfortunate reality upon which regional medical provision has become based. To suddenly rescind s19AB would be to pull the rug out from under rural and remote healthcare, as many of the affected doctors would immediately relocate

to metropolitan areas. An untenable solution for workforce reasons both out bush and in town, and not one that we propose.

Legislative basis for change
We suggest that the ten year moratorium (encompassed within subsections 1 and 2 of s19AB) be *gradually* phased out. This can be accomplished under the legislation – *as it currently stands.*

s19AB legislation also contains subsection 3. This allows for exemption from the ten year
moratorium by dint of ministerial discretion. There is carte blanche within subsection 3 for the Minister for Health to exempt any practitioner for any reason.

Exemptions from s19AB and the ten year moratorium, using the discretionary provisions available under subsection 3, could be applied to successive groups of overseas-born doctors. The discretionary factors used to decide to whom this exemption applies might be related to the doctor's time spent in Australia, practitioner's age, university of graduation or any other variable that would gradually diminish the size of the overall overseas-born doctor population affected by the current legislation.

Implementation of this policy
The time-frame for progressive groups' exemptions would reflect the progress of the current glut of medical graduates through their postgraduate training – with a significant alteration to the current system.

At the present time there is a preponderance of metropolitan clinical training places for those on their path to fellowship. There is a relative dearth of such rural positions. We propose that regional training should be far more strongly emphasised via an alteration in the ratio of rural:metropolitan training places in existence.

When discussing the issue of rural workforce with doctors in the regions, an oft-repeated refrain is the desire for a *mandatory* rural component to postgraduate/pre-fellowship practise. ADTOA recognises the (likely unassailable) political and legal hurdles associated with such an approach. Rather, we advocate the application of the recognised and accepted economic principle of 'supply and demand'.

Simply put, there will soon be a 'bulge' of medical graduates seeking postgraduate training places. Concurrently, there is a sizeable number of experienced rural doctors (overseas and Australian-born) – aged in their mid-50s – who have much knowledge and experience to pass on to the junior medical practitioners. This represents a *unique* chance to start to infuse the regional workforce with new blood. This chance will cease to exist within a few years, as the current doctors retire.

A system whereby a controlled ratio of metro:rural training placements is instituted and kept under close review allows for a dynamism in the provision of a medical workforce to meet healthcare needs at any particular time and in any particular location. There are excellent trainers and training schemes already in situ – thanks to the regional training providers and rural medical schools. The network requires expansion, but the prime parts are in place and functioning excellently. ADTOA has given consideration to some of the specific details of such a 'ratio system' and is happy to supply them upon request.

Additional supporting workforce factors

It is clear from speaking to doctors (and rural medical students) just how impactive and enriching rural practise unfailingly proves to be. It provides opportunity, skills, enthusiasm and clinical confidence in a way that is so often absent from the equivalent postgraduate year in a metropolitan location. There is strong evidence that these early contacts with regional medicine positively affect the subsequent decision to return to rural practise on a longer-term basis.

The truth is that there is simply nowhere near enough practitioners so positively affected to fill the current gaping holes in rural workforce provision. These workforce deficits are set to enlarge and require far more numerically influential action now.

It is clear that, after a 'rural rotation' the majority of doctors will return to metropolitan practise. But three outcomes will eventuate:

1) A percentage of doctors will stay in the bush – providing ongoing medical provision and training to subsequent junior doctors
2) Those doctors returning to the cities will return enriched in knowledge and experience – able to utilise those enhanced clinical skills in the primary care setting, with an anticipated reduction in the current reliance on referral to the tertiary settings (either Emergency or Out Patients)
3) A great number of city doctors will be equipped with the ability and desire to undertake rural relief work for doctors in the regions – thus making the prospect of such work palatable to those who want to stay 'out bush'.

Rural Community Effects

One must also consider the impact on the broader rural community. One of the reasons for its general decline is that inhabitants lack access to good and timely healthcare – a situation that is untenable for many. A central plank in reviving rural communities is the provision of a strong health workforce. It would be hoped that the introduction of a training place ratio system as a central driver towards an increased regional workforce would go some way to reversing the current decline in rural life.

And there would be no deficit whatsoever in the medical provision to regional populations with such an advance-planned, steady 'workforce replacement' program – as ten year moratorium doctors are gradually replaced by Australian graduates. Such a plan would ensure that the numbers of doctors working

regionally would actually be boosted in the short and medium terms and, with appropriate governmental supports, those workforce numbers sustained in the longer term.

The future of ADTOA

ADTOA wishes and plans not to exist in ten years. We sincerely hope that there will be no need of our organisation and that there will be no 'plight' of overseas-born doctors about which to campaign. We anticipate that, if our recommendations are applied, immigration of doctors will drastically drop – as Australia satisfies its own workforce needs.

This reduction in medical immigration will greatly ease the pressure on assessment bodies, such as the AMC and colleges, allowing a timely passage of overseas-born doctors through the system and helping to remove many of the issues stemming from that quarter.

Additionally, and importantly, such a reduction in immigration will help stop the denuding of developing nations of *their* medical workforce. This has been a critical issue for many countries who lose their workforce to developed nations, such as Australia – a workforce they can scarcely afford to see depleted.

Australia has accepted the *World Health Organisation Global Code of Practice on the International Recruitment of Medical Personnel*10 – which is critical of systems such as ours and their effect on the medical workforces of less fortunate countries. It has called for the current recruitment practices to stop. We believe that our recommendations for the future of rural healthcare will provide such a mechanism.

Conclusion

s19AB and the ten year moratorium are legally discriminatory, morally incorrect and a pragmatic failure. The entire policy is wrongheaded and should be carefully removed from the statute book, to everybody's advantage.

S19AA – despite its intent and wording – is highly discriminatory in its effect. There is a legal and moral onus to swiftly review and change this part of the legislature.

This Hearing presents a unique opportunity to 'get it right' – in such a way that current and future generations of the rural populace survive and flourish. We present a potential pathway to achieving this outcome, the foundations of which are already firmly and successfully in place.

At this juncture in the history of Australian healthcare, the much vaunted 'fair go for all' requires *your* political vision and impetus.

References:

1 http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s19ab.html

2 http://www.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s19aa.html

3 http://www.austlii.edu.au/au/legis/cth/consol_act/rda1975202/s10.html

4 http://www.austlii.edu.au/au/legis/cth/consol_act/caca2010265/s2a.html

5 A Review of Section 19AB Guidelines and a Model for Revision, Dr. Eleanor Long, July 2006; File no. 2006/0422 212 (FOI Request No. 088-1011). *I am able to forward my copy of the document upon request.*

6 http://www.rdaa.com.au/Uploads/Documents/Rural%20health%20survey%20--%20interim%20results%20--%20August%202010_20100922023248.pdf

7 Section 5.2, 'Australia's Health, 2010', The twelfth biennial health report of the Australian Institute of Health and Welfare

8 AMA submission to House of Representatives Standing Committee on Health and Ageing Inquiry into registration processes and support for OverseasTrained Doctors

9 http://www.austlii.edu.au/au/legis/cth/consol_act/caca2010265/s2c.html

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PART TWO: GUILTY UNTIL PROVEN INNOCENT – THE EXPERIENCES OF INTERNATIONAL MEDICAL GRADUATES (IMGs) IN AUSTRALIA

Sue Douglas MD CCFP

Acknowledgements: The author would like to thank the IMGs who shared their stories with her and who have made an invaluable contribution to rural/regional Australia.

"We all eventually realise that our success or failure in Australia has very little to do with our ability, but rather the whim of some unknown agenda or bureaucrat. What is extremely sad is the fact that we all came here having burnt our bridges at home, believing in the Australian "fair go culture" only to find something vastly different."
(IMG specialist working in regional Australia)

In the last year, the author has received correspondence from approximately fifty IMGs who have shared their own stories with her. Some have sought specific advice but more have sought contact for the sole purpose of sharing their own experiences. This writer has analysed the correspondence that she has received from IMGs over the last year for recurrent themes, which are described below.

This is a description of the experiences and barriers that IMGs face in Australia, in their own words. None of these IMGs had any complaints from patients or colleagues about their clinical skills and/or knowledge. The vast majority had provided years of dedicated service to rural/regional communities.

Lack of a "Fair Go" - Personal, Professional and Financial Hardships

The vast majority of IMGs suffered significant personal, professional and/or financial hardships as a consequence of their problems with the Australian registration/accreditation system.

"Australia has destroyed my family, my career and my morale. It is all too difficult and we will have to scrape our things together and move on. I feel like a broken person having lost so much in coming here. We had a good life in XX and never should have come here. Good luck in your pursuit of the greater issue but I fear that it is all futile. There is nothing more here for me." (C3)

"I can not stand being alone in this country with no support from family, from community, government etc. Feel trapped here. I am so stressed... cant think clearly."(C4)

"This is not my country and I do not have strength on my side. I still struggle with what my family and I have already endured"(C3)

"We are now facing tremendous stress in our personal lives due to the unforeseen and unfair barriers enforced upon my wife XX as a result of the humiliating assessment by the college of anaesthetists" (C9)

"Since these doctors visas are linked to their registration, they have 28 days to leave the country. You can imagine the family drama these doctors go through. X has a son at school which now should interrupt the year and leave. X had two children, one in University and one at school. They left in the middle of the school year.
But can you imagine after years spent in Australia (Dr X is 8 years in Australia and Dr. X was 9) you have 4 weeks to pack and leave. Go where?
The current system destroys families and the lives of these people. Enough is enough..." (C31 – referring to the experiences of two IMGs)

"My working visa was cancelled, my medical career ruined and my young family are now suffering. 4 years ago I gave up my medical career in the Philippines to relocate to Australia. Now, I have nothing to go back in the Philippines." (C15 – IMG deported back to Philippines for failing PESCI – passed 2 RACGP modules!)

"There are quite a few of us who choose to remain quiet and just bow to the unfair rulings of various associations and colleges in order to continue to work and support our families. I'm one of the latest victims of the unjust system." (C17)

"Being a temporary resident, we are not entitled for any kind of benefits medically or financially even though we pay equal tax or more My wife was due for a total knee replacement last November had to be postponed"(C1)

"Living scarcely on the little savings that I have, paying rent, food and supporting two of my boys who are studying overseas "(C1)

"On top this the Medical Board had been making us do all these new exams they bring in now, for which they ask a huge fee, like $1600 plus, for a half an hour oral interview which I am sure that half of panel sitting there, would fail themselves"(C1)

"I have been without income for past 10 months and am the sole bread earner of the family" (C1)

"I financed thousand of dollars and my precious time to obtain AMC graduation and registration." (C2 – still not working because can not pass OET test which they had already passed in 2007)

"I financed thousands of dollars to complete all the above exams (AMC and OET), precious time and now have become mentally depressed person" (C6). I have 4 young children" (C6)

"My family and I have been temporary residents since our arrival in Australia. If deregistered, we must leave the country. I have been paying international fees for my children at university. If deregistered, my child now in fifth year medicine will be unable to finish the degree and will also have to leave. This is because without my registration to practice, my work visa will be cancelled and I will not be able to afford the university fees. I have already sent one of my children back to my home country to complete his tertiary education after one year of studying in an Australian University. This is something that is very demoralizing as a parent."
(C6)

"SADLY SO MANY OTHER DOCTORS (who had failed the PESCI) AND THEIR FAMILIES, EITHER GAVE UP, OR THEIR INDEMNITY INSURANCE DID NOT SUPPORT THEM AND THEY HAD TO LEAVE WITHIN 28DAYS SOME THEM AFTER DEDICATING THEIR SERVICE IN AUSTRALIA FOR UP TO 12YEARS."(C8)

"Now, I am in a very difficult situation as I have not been able to earn a living since a couple of months ago. In addition, I had to apply for the AMC exam and the soonest available test date is in February 2011. At the moment, I am relying on my continually dwindling meagre savings to support my family and pay for my ongoing bills and house mortgage. On top of that, I received notice from the Department of Immigration and Citizenship (DIAC) on 21st October that I have 28 days to provide evidence of medical board registration. Thus, I need to leave the country in a few days."(C16)

"Surely, other IMGs are having or had the same experience. We are not able to fight for this as we are too afraid of possible repercussion from AHPRA, ACRRM, RACGP, and even from the DIAC." (C16)

"THE REPERCUSSIONS OF DEREGISTRATION AND ENSUING CONSEQUENCES FOR THE DOCTORS AND THEIR FAMILIES STRUCK ME AS COLD AND CALLOUS WAY TO TREAT PEOPLE WHO HAVE BEEN SAVING AND TREATING PATIENTS IN AUSTRALIA FOR YEARS .I WAS SHOCKED THAT THE NATIONAL MEDICAL BOARD RECEIVED CONCENSUS TO CARRY OUT SUCH DRACONIAN MEASURES" (C8)

"I had to leave Australia on 1st July 2010 because of my Visa conditions. I had to sell all my properties and relocate back to the Philippines. I had to leave 5 years of my life in Australia and go back home. For me, this was the hardest part of my ordeal. To see all your belongings, you kids toys and their school uniforms be given away or sold. Plus the fact that my 9 year old daughter was leaving all her friends she has. It was really heart breaking."

(C17 – Failed PESCI then found out she passed her FRACGP after leaving the country!)

"My biggest frustration is the chronic uncertainty that my family and I have endured for the last 4 years which stems from our in ability to gain permanent residence because I cannot gain recognition for my skills." (C13)

"Each one of us (7 IMG specialists) came to South Australia as specialists on invitation to full vacant specialist posts that could not be filled by Australian graduates despite protracted periods of advertising. Each and every one of us has experienced great difficulty with integration into the "system"."(C13)

"I have a 15 year old daughter and a 14 year old son who hope and dream of going back to Australia and becoming General Practitioners. And I have a wife who is been battling her breast cancer." (C15 – GP passed 2 RACGP components – failed PESCI – deported back to Philippines)

"We should be supported and not be driven away." (Case 17)

"Last year, Australia welcomed a lot of "boat people"/ refugees. The government house them, give them food, give them land, give them work opportunities using the peoples tax.... why can't the government be just as welcoming to the IMGs" (C17)

"If Doctors are allowed to migrate for practice purposes, then implicit in that is, they are felt to be adequately trained to be allowed to practice in Australia. When the Royal Australasian College of Physicians (RACP) comes on the backside of a practice arrangement, such as an area of need position, and then tells you that your qualifications are inadequate, it is nothing short of devastating, not just from a professional standing, but even more so from a community and family perspective." (C29)

"The cost of applying for a Fellowship is huge, and we are informed that if our application is unsuccessful the money is not refunded so the whole process is very expensive but the outcome is hardly guaranteed" (C30).

"Currently I am 10 months without work and I am supported by social security. And I do not know what will happen in nearest weeks and months. I have done nothing wrong to deserve to be treated with such contempt."(C25)

"The above ordeal (failing pesci) had a severe negative impact on my personal and family life. I have lost my confidence and working seven days a weeks resulted in draining me both mentally and physically" (C23)

Health Problems

Many IMGs reported significant problems with their mental and physical health. Specifically two developed new chest pain following de-registration

after failing the PESCI and OET tests respectively. Both doctors had worked in Australia for many years with no concerns raised about their competency. Many described symptoms of and/or admitted to suffering from stress and/or depression.

"He (husband) is not handling situation well either. If it were not for him I would have committed suicide. Getting strong urges... and making plans. I just hit myself - cry alone. Don't worry... won't do it... my husband would be alone" (C4 – GP working in Australia x10 years – unable to pass OET)

"I am very frustrated and depressed. My whole family has been suffering from depression. I sometimes struggle to get a decent sleep because of this uncertainty of my future" (C2)

"Because of this I have been mentally and financially affected to the effect that my health has declined too much"(C1)

"This endless saga is continuing and now it is causing adverse effects on my performance and health" "I feel hopeless and helpless" *(C2)*

"I have been suffering from severe depression and diabetes type 2. I do not have any family history of the disease(s)" (C6)

"Following this incident (bullying) I became very depressed and anxious. I could not sleep or eat and needed to take time off work for stress related reasons." (C26)

"Although I have started the process, (fellowship) I find it very stressful at my age and it is affecting my health. By the time I complete my requirement I will be 57 years old and probably ready to retire then" (C12 IMG solo rural specialist)

Exploitation and Discrimination

A number of IMGs described feelings of exploitation and/or harsh working conditions, particularly compared to those of their Australian peers. They also described an impersonal uncaring system.

"There were 20 Filipino doctors working in that company, some of them were my former students and colleagues. It was owned by XX. We were treated badly. We did not see our work contract until we arrived in Australia. We bought and drove our own cars to attend patients in their homes or nursing homes. We also paid for our own petrol and were made to work to up to 80 hours a week. As a consequence, I had a car accident in the motorway due to fatigue, which damaged my car badly. Luckily, I was not injured. Moreover, we were treated like slaves by that company who threatened us with deportation if we would not follow their demands and abused us verbally. All of us were

working as temporary residents and made loans in the Philippines just to be able to come to Australia." (C15)

"The Board should not let the overseas doctors attend to patients in the first place, not to use them and abuse them in dire need" (C1)

"I addressed the SA Clinical Senate and informed them of the dichotomous system that exists between the service conditions of local graduates and IMGs and again was largely ignored" (13)

"I also do four nights a week on call at the hospital where I am considered to be the "Surgeon on Call', although Medicare is delighted to pay me for being a GP. The hospital does pay me for being on call but I am sure that those surgeons who cover other rural hospitals on a locum basis are paid vastly more as they hold Aussie Felloswhips." (C30)

"I have a long story and it is awful. I have been struggling with the college of physician for more than 15 years. I firmly believe that I am a victim and also I am mistreated and discriminated by the Australian medical system and the college of physician. ***The Australian' IMG assessment and registration system are "racially discriminatory, unfair, unreasonable and unlawful." (C31)***

Others reported the differences in treatment and/or standards expected for IMGs and their Australian cohort.

"We the senior doctors have passed the age of sitting exams like fresh students. If the local doctors of our age are asked to sit exams would face the same difficulty even though they are all practicing well"(C1)

"Can we not say that this is very discrimatory act on their part, The local doctors of our age are bestowed with grandfathers gift of fellowships, I feel after serving so many years in the workforce shortage areas we should at least be rewarded in some way instead of being pushed out of system"(C1)

"AUSTRALIAN GP REGISTRARS WHO FAIL THESE EXAMS WILL NOT BE SUBJECTED TO A SCI AND GET DEREGISTERED , INSTEAD THEY WILL BE ALLOWED TO WORK UNDER SUPERVISION, TILL THEY ACHIEVE THEIR EXAMS. WHY CAN'T DOCTORS (IMG) WHO HAVE DEDICATED SO MANY YEARS TO COMMUNITIES IN AREAS OF NEED BE HANDLED IN THE SAME MANNER" (C8)

"I was humiliated by the college of physicians. The people worked in the Australian medical system including the college of physician are so arrogant, prejudiced and conservative. In fact, the college of physiciasn has never ever recognized us as an overseas trained physicians as we are from the Non-English speaking countries". (C20)

"It is interesting also why the Australian graduates are not asked to go through the assessment if they fail the RACGP exam? This policy is strongly discriminatory." (C31)

"I am sick and tired to hear that the bureaucrats are protecting the society. My burning question has always been: How come this doctors had good standards to practice for years and years and suddenly after failing a simple assessment do not meet the standards any longer." (31)

Changing the Rules and Shifting the Goal Posts

Multiple IMGs described problems with ever-changing rules and regulations, which caused great stress and uncertainty. A number questioned whether they would have moved to Australia if they had been aware that the conditions of their registration would be changed. A number reported that they had been lured to Australia under false pretences.

"I also find it distressing that the pathway for registration unpredictably changes all the time making it unreliable as a predictor for any applicant." (C14)

"I was invited to Australia to work as a GP in 2007, and I thought at the time that I was capable enough to provide the services that Australia needed..., Then, things changed, and now I needed to prove myself through passing the fellowship exams, and I said, OK, I will do as the Medical Board asked."(C10)

"When the Queensland Medical Board was in existence, the condition imposed on my registration was that "the registrant must ***apply*** *for general, specialist or Section 138 registration* ***within 4 continuous years*** *of special purpose registration". Date imposed: 3 March* ***2008****. This would mean that I had until 3 March* ***2012*** *in which to achieve that.* In AHPRA's letter dated 27 July 2010 they had stated in writing that my "**new** registration **expiry**" was 5 July **2011.** *t (C2 – GP de-registered for failing PESCI)*

"They should start this new regulations on the new comers not to those serving the acute shortage areas for so many years" (C1)

"IN 2007 THE QUEENSLAND MEDICAL BOARD PROVIDED A TIMETABLE TO ACHIEVE FULL REGISTRATION BY 2011(WITHIN FOUR YEARS) THIS IS JUST 3YEARS AGO . THIS TIMETABLE HAS BEEN CHANGED 3 TIMES IN AS MANY YEARS THE LAST 2008 AND DECEMBER 2009 WHEN THE PESCI WAS MENTIONED" (C8)

"The NSW Medical Board changed its English proficiency requirement policy in early 2007. The policy states that all AMC graduates who are seeking a medical board registration must provide English proficiency examination results not more than two years old at the time of internship (one year supervised training). I provided my English proficiency examination result

which was a mandatory requirement of AMC before appearing in their MCQ theory and Clinical practical examinations." (C2 – IMG who passed OET and AMC exams but unable to pass OET subsequent attempts)

"We (seven IMG specialists) have all also experienced what we call the moving goal post syndrome, the additional hurdle syndrome and the too high crossbar syndrome. Demands are placed upon us that the various Colleges, Boards and Employers know we will never be able to attain. Not because we are incapable but because our conditions of service preclude us from participating in the required activities." (C13)

"On the basis and advice from the RANZCO college to the then superintendent XX that they would require supervision for one year and then registration . However after applying to RANZCO for registration I was told I would not require any clinical supervision but would have to write an academic exam which the registrars sit", After writing the exams twice in two years I realized these exams were extremely academically stringent. I was promptly advised by RANZCO that I was not comparable to an Australian trained Ophthalmologist and that I required further clinical and surgical training, this after having performed 1800 eye operations without any supervision or audit whatsoever and written previous advise stating that I required no clinical supervision" (despite having requested an Ophthalmic supervisor from them numerous times) (C14)

"My understanding was that I had to successfully complete a year of supervised practice before I could be considered for specialist registration. When I applied for specialist registration in early 2009, having successfully completed a year of supervised practice, I was told that my training and qualifications were not comparable to an Australian trained physician. I had migrated with my family, my wife of 20 years, XX, and 3 school age children, X, X and X." (C29 IMG specialist from US with 25 years experience in their field)

"I feel it is disingenuous to advertise to the rest of the world on the skills migration list that Australia requires Ophthalmologists only to find that when they arrive unblemished and they have proven their clinical and surgical abilities, that they have to retrain with the real possibility that they will have to leave the country within 28 days with an incomparable label around their necks for the rest of their lives"(C14)

Flawed/Unfair Assessment

A number of IMGs thought that the method of assessment was inappropriate for their level of experience. Others questioned the validity of assessment methods.

"The list of good things that I have rendered to the community will be beyond the scope of this letter except to say that knowledge and especially

experience cannot be quantified only by a 10 minute consultation-question in an examination scenario (AMC clinical). The feedback from AMC was absolutely inadequate." (C2)

"Surely observation in routine daily practice and emergency management of patients for these years is a true picture of an assessment than 45-60 minutes of interview by examiners who hardly know the candidates." (C11)

"THE SCI CONTINUES TO BE APPLIED ,DESPITE ITS "KANGAROO COURT REPUTATION".THE AUTHORITIES CONCERNED ARE CONTENT WITH THE TREATMENT OF THE IMG'S AND THE CONSEQUENCES TO THEIR FAMILIES" (C8)

A number also reported inadequate or no feedback on their performance and areas for improvement.

"In addition the medical board persisted in its refusal to provide me with information about what constituted successful performance in the exam in that I did not know if I would have failed if I had one error. This is similar to not knowing if you needed a 50% or 75% to pass an exam." (C23)

"Lastly, like all IMGs and Australian Medical Graduates I deserve feedback on my progress in the profession and to be given reasons for any criticism of my work .I think any good doctor is always harsh on himself and is willing to improve. Only feedback based on sound merit , not on prejudice, can provide opportunity for professional growth".(C25)

Three IMGs reported that they had failed their fellowship exams marginally, some by less than one percent, and that the pass mark seemed to shift significantly.

"UNFORTUNATELY I ACHIEVED 61.37% IN THE AKT EXAM IN AUGUST 2010 (TO MY SURPRISE AS I WAS VERY STRESSED BY MY CIRCUMSTANCES) BUT THE PASS MARK HAD RISEN TO AN ALL TIME HIGH OF 65%" (C8)

"My RACGP exam results were so close to pass mark, that basically what happen was : because I'm failing with so little on College exam to become a specialist, suddenly I'm not a doctor anymore. Imagine if that applies to all other specialists Colleges - if a candidate fails - does that mean is not a doctor at all?" (C33 – Worked 10 years in Australia - deported after failing PESCI and marginally failing RACGP exam)

Another complaint was inappropriate assessment. For example, one IMG who worked as a skin cancer specialist was given a case of an aboriginal girl with an unwanted pregnancy in their PESCI interview.

"One of the cases is a teenage aboriginal girl presented with lower abdominal pain. I requested for a chaperone while conducting an exam on a teenager girl, albeit sexually-active one, is appropriate, just as I request to confer with parent/guardian/adult advocate regarding the management of this person I believe that neglecting these factors would be medical-legally negligent. I am not sure why this is regarded as being insensitive of the aboriginal culture.
The result of my interview with ACT medical board I was lacking in communication skills, medical knowledge, diagnostic acumen and management skills. Also lacking in professionalism and sensitivity to ethical issues". (C21 – Passed PESCI in NSW – Practice principal had to close practice because of doctor shortage)

"Interestingly I passed way over with the real patients consultations and failed marginally when there was an examiner .....surely you will be nervous if someone's looking over your shoulder. I'm far from disputing the standards, but there's an obvious conflict there too, you do well in real life with real patients, but not that good otherwise?"(C33)

Lack of Transparency, Fair Due Process, Appeal Mechanisms and Assessment Irregularities

A number of doctors described problems with a lack of procedural fairness in regard to assessment and/or serious errors that were not addressed.

"I WAS SHOCKED WITH THE OUTCOME .THE REPORT DID NOT RECOMMEND ME FOR FURTHER REGISTRATION BASED ON MY PERFORMANCE CITING POOR COMMUNICATION SKILLS ,BORDERLINE CLINICAL JUDGEMENT AND UNSATISFACTORY UNDERSTANDING OF AUSTRALIAN CULTURE AND IDIOMS . ***NB THIS INTERVIEW WAS NOT AUDIO OR VIDEO RECORDED" (C8)***

"The College had changed their AEG policy six weeks after I had lodged my application for fellowship, and one week before the council met to discuss my application" (C34)

"I confidently sit up the clinical exam in 2007. I was shocked to have a conversation with Professor XX and XX before the clinical exam. Both professors were from the examination team of the college. They warned me before the examination that I could not pass the clinical exam without clinical practice. They persisted that I should go back for the AMC examination. I could not believe that the above Professors were my examiners when I entered the examination rooms for the 2007 clinical exam in XXhospital. Honestly, I prepared the 2007 clinical exam for a year. I felt confident to take the examination. However, I have not received any result for the 2007 clinical examination until today. I have no any idea for the total score of the examination. ***Professor XX wrote me a feedback letter only. I was shocked to find that that one female patient of long case was even***

replaced by a male patient in the feedback letter. The history of patient was also different. It was totally unacceptable and unbelievable. *" (C20)*

"I requested to the college, but had no answer. I found a solicitor, who wrote a letter to the college in 2007/2008. XX(CEO of the college) met me at her office later. She admitted that it was unacceptable and a huge mistake. She also promised me to involve my case and to give me an answer soon. But a few months later, I was told that XX had already left the college. No anybody give me any explanation." (C20)

"According to the Board I had made three "critical" errors. " I requested transcripts of the interviews. A subsequent review of my answers by GP experts and a literature search involving the questions found strong evidence that I had not made critical errors for two of the three alleged errors"(C23).

"The CEO (RACGP) went on to tell me that because I wasn't a member of the College, I wasn't entitled to appeal anyhow!" (C34)

"In other words even if the tribunal upheld the decision that I should have passed the exam I would still need to do at least an additional exam and probable interview. This decision meant that an appeal would be redundant as it would not alter the outcome and that I was effectively denied a fair appeal"(C23)

"The CEO (RACGP)went on to tell me that, as there was no application in my file, I had obviously never applied for fellowship in the first place and therefore was not entitled to an appeal" (C34)

"I am told that I have a right to appeal but that it won't make any difference. I am also told that it would be reasonable to review the AEG policy under the current circumstances but that the RACGP had no plans to do so because it was not in their strategic plan." (C34 – discussion with censor in chief)

"According to the RACGP appeals guidelines I should have received an answer within 14 working days (re. lodged appeal). As of April 1 2008 I have yet to hear anything further from the College." (C34)

Lack of Recognition of Qualifications and/or Experience

"When I applied to sit the RACGP exam, their requirement was that I have a minimum of 4 years' Australian GP experience even to qualify to sit their exam. Unfortunately, my more than 30 years' hospital experience was only recognized to be equivalent to one and a half years' Australian experience. RACGP also stipulated that my registration should be current before I could be accepted for sitting their exam" (C2)

"The college of anaesthetists have given Dr XX a completely unpredictable and unreasonable assessment asking her to complete basic examinations in

anaesthetics and completely ignored her overseas postgraduate qualifications inspite of the submission of the proof of postgraduate qualifications in anaesthetics from India as well as the UK."(C9)

"The college of O&G have interviewed me and said that I am partially comparable to an Australian Fellow! I have a total of 26 years of experience in Obstetrics and Gynaecology and the reason they say is, that I have had no structured training. No doctor who trained in UK or Australia at that time had structured training. I, more than fulfil the competencies criteria placed by the RANZCOG, yet they have assessed me as being partially comparable" (C12 IMG with UK fellowship)

"Surely the College could not be questioning my competence to practice? I had two years of postgraduate training in Family Medicine. In addition, I had 15 years of experience teaching and practicing Family Medicine. Ironically, I was recruited to teach the next generation of Australian GPs." (C34)

"I have been in the practice of Obstetrics and Gynaecology for the past 24 years, 10 years in Australia. I am hopeful that the Medical Board considers to continue my registration to enable me to pass the AMC exam. I am also pleading to the Medical Board to bestow my General Registration so that RANZCOG can allow me to attempt Membership Training.
I have approached RANZCOG and have undergone an interview. My interview was a success but I was declined as I need General Registration." (C24 – IMG specialist who is being made to do AMC exam first – none of 24 years of OBS-GYNE experience was recognised)

Harsh and/or Rigid Rules

"I failed the viva component during which there was a procedural error. The RACGP denied this. After appealing, I was able to resit the viva component but was failed again. I will not receive any credit for the 2 components I have already passed, and will have to resit all 3 parts if I chose to repeat the Practice Based Exam. However since 2009.1 candidates get credit for passing each section separately, but I will still not be given this same opportunity" (C7)

"DESPITE MY LETTER SHOWING CAUSE (IN MY SUPPORT I HAD PASSED TH KFP PART OF THE RACGP EXAM IN MARCH 2010 AND CAME WTHIN 0.98% OF PASSING THE AKT PART) I WAS INFORMED ON THE 27/8/2010 TO STOP WORKING IMMEDIATELY AS THE MEDICAL BOARD HAD TAKEN A DECISION ON THE 23/8/2010 TO DEREGISTER ME" (C8 – GP working x 6 years deregistered for failing PESCI)

"My(partner) XX is not only facing difficulties with the career progression but is also struggling to maintain registration to practice anaesthetics in Queensland due to the several restrictions imposed upon X initially by the Medical Board of Queensland and now the Medical Board of Australia"(C9)

"The Medical Board advised me in January 2010 that I need to sit the PESCI in order to renew my registration. I went for the interview in February 2010 but failed and was advised that I was not fit to practice in June 2010. I submitted several letter of support from politicians, loyal patients, and also a letter from the RACGP stating that I have my PBA results pending. The results were to be ratified 8th October 2010. I even argued that i still have until 2012 to complete all exams or gain fellowship under the medical board's rules of June 2008". (C17 – Later found out she passed RACGP exam but had already had to return to the Philippines))

"The Director of Education of RACGP, XX, wrote AHPRA a letter of request to have my registration renewed so that I could complete my exams. But, AHPRA turned it down and instead require me to sit and pass AMC, PESCI and IELTS first before I will be registered". (C15 – GP with 18 years experiences who has passed 2 components RACGP exam- deported to Philippines for failing PESCI)

"The Medical Board advised me in January 2010 that I need to sit the PESCI in order to renew my registration. I went for the interview in February 2010 but failed and was advised that I was not fit to practice in June 2010.
"I submitted several letter of support from politicians, loyal patients, and also a letter from the RACGP stating that I have my PBA results pending. The results was to be ratified 8th October 2010. I even argued that i still have until 2012 to complete all exams or gain fellowship under the medical board's rules of June 2008". (C17 – returned to Philippines – passed fellowship)

"I have already passed the AMC (MCQ) I was not successful in the first attempt of PBA component of RACGP in Nov 2009. I am now again doing my examination. Meanwhile I received a letter from the AHPRA that I have to do the SCI .
I wrote to the AHPRA (registering authority) that this is absolutely ridiculous and unjustified. In reply I got a mail saying that if I do not appear for the SCI I will be de-registered." (C19)

Lack of Educational Support and Difficulties Preparing for Exams

"Through out this time there was no educational support provided by, or approved by the RACGP. This left me with no guidance as to what exactly the RACGP expected from me" (C7)

*"I ATTEMPTED THE EXAMS AFTER STUDYING BEFORE AND AFTER WORKING HOURS IN **AUGUST 2009** THIS WAS **MY FIRST ATTEMPT AT A GP SPECIALIST EXAM"** (C8)*

Illogical, Unreasonable, and/or Obstructive Registration/Accreditation rules

"THE CONTRADICTIONS IN THE SYSTEM ARE AMAZING .EXPERIENCED DOCTORS (IMG)WORKING IN THE SYSTEM FOR YEARS ARE GETTING DEREGISTERED BUT NURSE PRACTITIONERS WILL BE ALLOWED TO ASSESS AND PRESCRIBE TREATMENT AND AUSTRALIAN GP REGISTRARS CAN WORK UNDER SUPERVISON TILL THEY ACHIEVE THEIR FULL REGISTRATION .THERE IS NO MIDDLE GROUND" (C8)

"I my case, XX is currently subjected to various unforeseen barriers in the name of screening, such as PESCI interviews and subsequently AMC MCQ and clinical examinations as a result of the shocking and unreasonable assessment enforced upon XX by the college of anaesthetists."(C9)

"We are now facing tremendous stress in our personal lives due to the unforeseen and unfair barriers enforced upon XX as a result of the humiliating assessment by the college of anaesthetists mandating x to go through the entire three years of advanced training in anaesthetics only after completing the basic examination (unlike other overseas graduates who are not only exempted from basic examination but only asked for two years of advanced training)"
(C9)

"So, right now I am in a curious situation. I passed the AKT, which makes me eligible to attempt the OSCE segment for the fellowship, which the Medical Board demanded from me back in July 2008. But I failed the PESCI, which tells them I am not suitable to work here" (C10)

"After many months and even years the totally unreasonable demands for original documents from, for example, people long dead regarding proof of primary and secondary education conducted in the English language. The list of documents required is almost endless and frequently requires official documents from dysfunctional countries that have undergone regime change making their acquisition almost impossible. Many have experienced the frustration of once obtaining the required documentation to be informed that additional or supporting evidence is required. Another area of intense frustration is that of obtaining the necessary clinical oversight. We have all experienced supervisors who refuse to acknowledge our presence on ward rounds, bar us from attending clinical meetings, refuse to accept our logbooks etc." (C13 – referring to the collective experiences of seven IMG specialists working in a regional hospital)

"Surprisingly, the final decision of AHPRA was that I have to pass the AMC MCQ and PESCI as requirements for a new registration and that there is no waiver for these mandatory requirements. I wasn't alone in expressing disappointment and frustration as a number of my colleagues who are also RACGP members and on the same pathway concurred that the AKT and KFP segments should have been considered as even higher qualifications than the AMC MCQ. Moreover, I have not had any problems with my registration for almost five years working as a GP with the same company. Was I suddenly

judged as incompetent only because I am moving to another job and I have not met their new requirements (AMC MCQ and PESCI) to be re-registered?"(C17)

"The Colleges all state that their stringent standards are there to protect the Australian Public from inappropriately trained doctors. I am confident when I state that I have yet to learn of a single IMG who has been formally observed or accredited by any College representative in their own work place. In fact we have all concluded that IMGs can work unsupervised provided it is on rural patients." (C15)

"I received excellent news on 8th October 2010 that I passed the PBA. I immediately started applying for fellowship with the RACGP. But I was advised that they will reconsider my application since I was de registered. They require that I get re-registered first before I can be considered for the Fellowship" (C17 – Deported because failed PESCI but passed FRACGP exam)

"I resigned my job and prepared for another 10 months in full time for the 2010 FRACP clinical examination. I went to overseas to practice in an American hospital for the clinical examination for a few months time (I am not allowed to practice in Australia). I was quite confident to pass the clinical examination this time. But I was wrong again. My total score was lower enough and hard to be believed. I only received an email after examination that was sent from the college. There were no formal letter and feedback letter again this time. The college told me that I needed to talk to the college staff; otherwise I would not be able to receive any letters from the college."

"As of November 20 I still have not heard from the Medical Board about my limited registration even though it has been over a year since I was told that they intended to grant it." (C25)

"I was a little confused. English was my native and only language. How did a native English speaker from an English speaking country prove their proficiency in English?"(C34)

"My next question was whether I required an exact translation of my degree (in contrast to providing evidence that I obtained one) and if yes, where could I find a 'government approved Latin translator'? I was told 'why don't you try the yellow pages'?... The translator, obviously a little taken aback by my query about government approved Latin translators patiently explained there were no official government approved Latin translators in Australia. In fact there were none in all of Australasia. He suggested I try the Vatican. He also kindly offered to contact an old priest who might be able to help."
(C34)

Contribution to the Community and/or Community Support

"I have enjoyed working in XX because of the small community that's friendly and accommodating, and I like the challenge of working alone and able to follow up each of my patients. There are women who have had up to four pregnancies where I looked after them. The hospital staff have come to know and trust me. I would not like to relocate and go through the whole exercise of establishing myself in another place." (C12)

"I have served the people of XX well and the only cases I refer to Adelaide are women with preterm labour as we do not have a Paediatrician here and women with cancer as the Oncology service is only available in X I cannot see any other doctor doing more than this in XX. (solo IMG specialist in rural community)"(C12)

"I RECEIVED TREMENDOUS SUPPORT FROM X, SPECIALISTS AND THE COMMUNITY OF WHOM I HAVE DEVELOPED A CLOSE BOND WITH OVER THE YEARS .I HAVE TO DATE ABOUT 5 000 PETITIONS AND HUNDREDS OF LETTERS OF SUPPORT FROM PATIENTS, LOCAL XXGENERAL HOSPITAL AND A NUMBER OF RECOGNIZED SPECIALISTS" (C8)

"I had cleared the patient waiting list on the Sunshine Coast and the need had become so great that we now had 2000 new patients on our waiting list because the service had become available. Was I now to apologize to 1800 patients for my academic shortcoming and seemingly inadequate service that I delivered to the community in three and a half years? Did they have reason for a legal class action against me?"(C14)

"As this letter from RANZCO immediately labeled me a public liability to XX hospital and surrounding community I resigned with immediate effect- however there was such an outcry from the community after press radio and TV coverage that I was told by RANZCO that I should appeal the decision." (C14)

"I have performed 2000 operations in Australia with an extremely low complication rate. I have made an impact on the local waiting list. I made a commitment to achieving residency in Australia and making a difference to the local need (proven by numerous references from fellow doctors ,patient, nurses sent to RANZCO in June 2010) So far there have been no Australian ophthalmologist who have been prepared to take up this post full time and work for the fixed salary that I receive."(C14)

"I preceptored year 5 medical students from the James Cook University College of Medicine. Furthermore, I was active with the local community. I participated with the Townsville Catholic Pastoral Council Committee and the local Filipino Australian Community Association".(C15)

"Whilst all of these unnecessary things are happening, XXMedical Practice have been running on only 3 full time doctors, from a previous 7 full time doctors. Most of patients are now waiting for several days to get seen. They

are being advised to present to another surgery or go straight to Townsvillle Hospital for medical care. For me this is unacceptable. It is the patients and the people of X, X, and Townsville that are the ones who are greatly affected and disadvantaged. They are being denied basic medical care because of politics, finger pointing between government agencies and just plain old "I don't care" attitude." (C17)

"Here are hundreds of greetings & letters from my patients who thanked me for my good job. I gave myself 250 % to patient services, I consider myself a very good caring competent doctor, who is been stopped from working. Specialists from XX, XX, & Townsville etc, used to come specially to speak to me to take care of their patients, who did not even lived in XX". (C28)

Bullying, Collusion and Abuse of Power

"For a number of years I was the Surgical Consultant on the Clinical Governance Committee of Country Health South Australia and must inform you that on numerous occasions I informed the CEO, XX and the Chief Medical Officer, XX (both verbally and in writing) of the serious inconsistencies, victimisation, double standards, bullying and exploitation of IMGs by the Colleges."

"There is no doubt that IMG service conditions, workplace environments, employer/employee relationships often fall well within what constitutes bullying. I believe the only thing that has prevented such an action(class action) in the past is the fear IMGs have of having their visas revoked." (C13)

"This bullying has meant that I have been unable to work because the Medical Board(s) have made it impossible for me to get registered because of the evaluations of the bully. I have tried to explain to the Medical Boards that my evaluations were the result of the bullying but the Medical Boards have ignored this." (C25)

"When I asked him why I could not give myself very good marks in areas of obvious strength Dr XX answered
***"Because top marks are reserved for the top 3% of best performers, and as you are overseas trained you can not belong to this group"** (C25)*

"I left the emergency department shocked and shaken up. I could not understand what had happened and what I had done wrong?.. I was also humiliated by this outburst, which had occurred in a very public place. It was completely unwarranted to threaten me with security – I had not threatened anyone or been a threat to public security? I found the situation highly stressful, threatening and humiliating," (C25)

"Dr X then said that for the next term...

"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" *(C25)*

"A few days later I received a call from XX Hospital informing me that this matter (bullying) will be investigated by..... XX! I was in shock...this was the man who was central to the bullying, who had compared me to a dog on a leash!,
I felt like a victim of rape asked to...reconcile with the rapist!" (C25)

"I contacted the bullying hotline for NSW health about the bullying. They advised me to .resolve the issue with the persons involved and not to **'make a hulabalooo" of this matter"** and **"not to get into bullying process'**."(C25)

"I feel that in practical terms the promise of bullies to ruin my career is about to come true. I feel completely powerless facing a system that is basically applying principle "guilty until proven innocent" and is in practice implementing bullies' agenda not to allow me any work as a doctor." (C25)

Advice for Australia

"I wish the politician and those people trying to run the Medical Board get out there and see for themselves what's happening with the people. Sitting all day in their offices will not solve the crisis that Australia is on right now. The country's medical force is made up of 45 % IMGs. We should be supported and not be driven away"

"If a Doctor's training is inadequate then it is quite disingenuous to allow them to migrate for anything other than training purposes. If Doctors are allowed to migrate for practice purposes, then implicit in that is, they are felt to be adequately trained to be allowed to practice in Australia." (C29).

Discussion and Conclusions

The experience of the Australian accreditation and registration system by IMGs is one of a highly unpredictable, dysfunctional, and uncaring system which threatens the personal and professional lives of doctors. As these cases show, the problems are at every level of the system including the Medical Boards, AMC and Specialist colleges. The experiences described by these IMGs support the hypothesis that IMGs in Australia are assumed guilty until proven innocent. There is the underlying assumption that even though these doctors have dedicated years of service to this country, without any patient complaints, there may still be some other Dr. Patels out there that are lurking in the background. The only way to flush out these invisible threats to the public is to raise the accreditation bar even higher, not just for the newcomers, but also for those who have already proved themselves in the

workplace. Of course there is no thought of subjecting Australian doctors to the same standards, even though there have been a number of Australian rogue doctors who have been implicated in causing the same, if not more widespread suffering, as Patel.

The problems described by the IMGs are remarkably similar to those described in previous reports, particularly the 'Race to Qualify' and Specialist Colleges reports. This raises the question: why have we not been able to fix these long-standing problems? The answer lies in the fact that subsequent governments have refused to take the steps to make the legislative changes that would require accreditation organisations to be directly accountable to both the government and public for their actions and decisions.

To date, the Medical establishment has fiercely opposed government/public involvement in the registration/accreditation process. They have persistently argued that this would potentially undermine the high professional standards which are necessary to protect the public. The Medical Boards have also argued that they use a "risk based" approach to the registration of IMGs without Australian qualifications. We would argue that the evidence clearly refutes these claims.

For example, it is difficult to understand what "risk" an IMG poses to the public when they have demonstrated their clinical competence by providing care to rural Australians for a decade and who is then deregistered for failing an English test - particularly when that doctor had 8000 patients on their books.

It is also difficult to understand why only IMGs who have conditional registration need to prove their proficiency in English every few years, while those with unconditional registration do not. Upon what basis is the logic that IMGs with unconditional registration have better language skills, and therefore pose less risk to the public, than those with conditional registration? Finally, what is the evidence that the English language standards needed to be raised, in order to further protect the Australian public?

Similarly it is hard to understand why the public is at risk when a specialist IMG is denied fellowship, and therefore registration, because they do not have highly specialised skills (i.e. laparoscopic hysterectomy) when these procedures are not even available in the communities where they work, and are not skills that their Australian cohort of the same age group would be expected to have?

While there is no evidence that the doctors who have been recently de-registered because of the PESCIs, difficulties with the OET, and failure to attain college fellowship pose a threat to the public, there is strong evidence that this has put tens to hundreds of thousands of Australians at unnecessary risk of inadequate health services. While it is one thing to support IMGs to attain their Australian qualifications it is another matter to de-register those who do not! If we do not do that to Australian trainees, why do we do it to

IMGs, who provide a critical service that Australian doctors refuse to undertake?

IMGs make up the backbone of rural healthcare in Australia. This is likely to continue to be the case for at least another decade. Consequently, the fates of IMGs and rural Australians are inextricably linked. What is unfair for IMGs is unfair for rural Australians. What hurts IMGs hurts rural Australia. It is not a coincidence that the majority of people making key decisions that impact on the rural medical workforce are housed in the ivory towers of Melbourne and ACT. For the government to turn its back to IMGs, is to also turn its back on rural Australia. The Australian government has the responsibility to take control and take action to fix this sick system once and for all.